Dr. Tamzin Morley, ND

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Health History Intake Form:

Care Card # (PHN): _____ Date: _____

First Name: _____ Last Name:_____

Gender: _____ Date of Birth (DD/MM/YY): _____ Age:_____

Address:_____

City:_____ Province:_____ Postal Code: _____

Home phone: _____ Work phone: _____ Ext:_____

Cell Phone: _____

Email address:_____
If needed, can the clinic contact you via email (circle): YES NO

Occupation:_____
Please circle: Single Married Divorced Separated Widowed

Emergency contact Name: _____ Phone:_____
Relationship:_____

How did you hear about Dr. Tamzin Morley: _____

Current Health Concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

Medications (Prescription and Non-Prescription):_____
_____
Allergies (Medication, Food, Environmental):_____
_____
Supplements (Vitamins, Minerals, Herbs, etc.): _____
_____
Do you or anyone in your family suffer from a Glucose-6-Phosphate Dehydrogenase (G6PD) Deficiency?
_____

Past Medical History:

□ Heart Disease	□ Asthma	□ Easy bruising/bleeding
□ High Blood Pressure	□ Hepatitis	□ Thyroid Disease
□ Elevated Cholesterol	□ Seizures	□ Depression/Anxiety
□ Diabetes	□ Drug/Alcohol Abuse	□ Colitis/Crohn's Disease

Past Procedures/Surgeries/Hospitalizations: (Description & Date):_____
_____
_____
_____

Family Medical History (Blood Relatives, NOT including yourself):

	Which Relative and Age of Onset?	Doctors notes
□ Cancer		
□ Diabetes		
□ Heart Attack		
□ Stroke		
□ Seizures/Epilepsy		
□ High Blood Pressure		
□ Asthma		
□ Hearing Loss		
□ Allergies		
□ Addiction		
□ Hepatitis		
□ Gout		
□ Obesity		
□ Osteoporosis		
□ Arthritis		
□ Thyroid Disease		
□ Kidney Disease		
□ Depression/Anxiety		
□ Colon Cancer		
□ Breast Cancer		
□ Uterine Cancer		
□ Ovarian Cancer		
□ Other Cancer (list):		

Please check if you have OR are currently experiencing any of these symptoms:

General:

□ Weight-loss	□ Chills	□ Excessive sweating
□ Weight-gain	□ Fatigue	□ Excessive thirst
□ Fevers	□ Cold hands or feet	□ Bleed or bruise easily

Hair, Skin and Nails:

□ Eczema/Psoriasis	□ Changes in moles	□ Loss of hair
□ Itching	□ Easy bruising	□ Dandruff
□ Dryness	□ Ulcers	
□ Rashes	□ Changes in nails	

Head/Eyes/Ears/Nose/Throat:

□ Headaches	□ Corrected vision	□ Mouth sores
□ Neck pain	□ Glaucoma	□ Bleeding gums
□ Head trauma	□ Earaches	□ Toothaches/jaw pain
□ Eye pain/strain	□ Ringing in ears	□ Mercury fillings #_____
□ Blurred vision	□ Facial pain	□ Hoarseness of voice
□ Dry eyes	□ Sinus congestion/infection	□ Recurrent sore throats
□ Floaters	□ Nose bleeds	
□ Cataracts	□ Post-nasal drip	

Heart and Circulation:

□ Heart palpitations/Arrhythmias	□ Heart Disease	□ Blood clots in legs or lungs
□ High Blood pressure	□ Heart Attack	□ Swelling in feet or legs
□ Low blood pressure	□ Stroke	□ Varicose veins
□ Heart murmurs	□ Pacemaker	□ Peripheral artery disease

Lungs:

□ Difficulty breathing	□ Wheezing	□ Pneumonia
□ Chest pain or tightness	□ Asthma	□ Tuberculosis
□ Persistent cough	□ Bronchitis	
□ Coughing up blood	□ Emphysema	

Digestion:

□ Ingestion/Heartburn	□ Vomiting	□ Colitis/Crohn's disease
□ Gas/Bloating	□ Difficult or painful swallowing	□ Hernia
□ Diarrhea	□ Stomach ulcers	□ Hemorrhoids
□ Constipation	□ Abdominal pain	□ Anal Fissures
□ Poor/Excessive appetite	□ Blood in stool	□ Gallbladder disease
□ Bad breath	□ Mucus in stool	□ Parasitic infection
□ Nausea	□ Undigested food in stool	□ Liver disease

Genito-Urinary:

□ Frequent Urination	□ Incontinence	□ Kidney stones
□ Pain with urination	□ Urinary tract infections	□ Blood in urine
□ Frequent urination at night	□ Kidney disease	

Muscoloskeletal:

□ Back pain	□ Joint swelling	□ Osteoarthritis
□ Neck pain	□ Muscle weakness	□ Rheumatoid Arthritis
□ Joint pain/sprain	□ Bone pain	□ Osteoporosis

Neurological/Psychological:

□ Numbness	□ Paralysis or weakness	□ Sudden mood changes
□ Dizziness	□ Epilepsy/Seizures/Convulsions	□ Eating Disorder
□ Loss of Balance	□ Stress	□ Chemical Dependency
□ Problems with walking	□ Depression	□ Alcohol Dependency
□ Problems with speaking	□ Anxiety	□ Suicidal thoughts
□ Problems with coordination	□ Difficulty concentrating	

Women's Health: □ check if the following section is not applicable to you

First day of last period:	Number of days between periods:
Number of days of menstrual flow:	
PMS Symptoms (check all that apply): □ None □ Pain with menstruation □ Breast tenderness □ Bloating □ Acne □ Mood swings □ Fatigue □ Headache □ Other: _____	
Birth Control use? If so, which type and for how long?:	
# Pregnancies:_____ # Births:_____ # Miscarriages:_____ # Abortions:_____	
Date of last PAP exam:	Any abnormal PAP exams?:
Ovarian cysts?:	Uterine fibroids?:
Menopause?: How many months since your last period?:	
Menopause Symptoms (check all that apply): □ Hot Flashes □ Night Sweats □ Vaginal dryness □ Vaginal atrophy □ Difficulty concentrating □ Difficulty sleeping □ Depression/Mood changes □ Decreased libido □ Urinary incontinence	
Hysterectomy?:	
Have you ever had a mammogram?: If so: Normal/Abnormal	
Are you sexually active?:	Concerns about sexually transmitted infections?:

Men's Health: □ check if the following section is not applicable to you

	Yes	No	Details
Testicular Pain/Swelling?			
Impotence/Sexual difficulties?			
Prostatitis/Prostate concerns?			
Sexually active?			
Concerns about sexually transmitted infections?			

Lifestyle and Social History:

Habits:	**Yes**	**No**	**Details**
Tobacco usage?			How much per week?:
Do you consume alcohol?			Which type?: How drinks per week?:
Recreational drug use?:			Which type:? How much per week?:
Caffeine use?:			Which type?: How much per week?:
Do you exercise?:			How often per week?:
Social:	**Yes**	**No**	**Details**
Are you currently in a Relationship?			
Are you happy in your relationship?			
Do you have a social support network?			
Lifestyle:	**Yes**	**No**	**Details**
Do you enjoy your work?			
Do you feel stressed?			Level (circle): Low Medium High
Source of stress?			(circle): work family money other:
What do you do to relieve stress?:			

Sleep:	Yes	No	Details
Problems falling asleep?			
Problems staying asleep?			
Wake up feeling rested?			# hours sleep per night?:
Do you dream?			

Diet	Details
Do you follow a particular diet?	
Known food allergies/intolerances?	
What is your typical breakfast?	
What is your typical lunch?	
What is your typical dinner?	
How much water do you drink per day?	
What is your current weight?	
What was your weight one year ago?	
What is your height?	

Is there anything else about your health history you need me to know about?_____
_____

Thank you for taking the time to fill out this intake form.
I look forward to working with you on your healing journey!