



Dr. Tamzin Morley, ND

Phone & Fax: 778-471-0909

Address: 306-153 Seymour St., Kamloops, BC, V2C 2C7

Email: doctortamzin@gmail.com

Website: www.doctortamzin.com

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 Common-Law 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:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Easy bruising/bleeding
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Seizures	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> 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
<input type="checkbox"/> Addiction		
<input type="checkbox"/> Allergies		
<input type="checkbox"/> Arthritis		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Cancer		
<input type="checkbox"/> Depression/Anxiety		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> Dementia		
<input type="checkbox"/> Gout		
<input type="checkbox"/> Hearing Loss		
<input type="checkbox"/> Heart Attack		
<input type="checkbox"/> Hepatitis		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> High Cholesterol		
<input type="checkbox"/> Kidney Disease		
<input type="checkbox"/> Multiple Sclerosis		
<input type="checkbox"/> Obesity		
<input type="checkbox"/> Osteoporosis		
<input type="checkbox"/> Seizures/Epilepsy		
<input type="checkbox"/> Stroke		
<input type="checkbox"/> Thyroid Disease		

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

General:

<input type="checkbox"/> Weight-loss	<input type="checkbox"/> Chills	<input type="checkbox"/> Excessive sweating
<input type="checkbox"/> Weight-gain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Fevers	<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Bleed or bruise easily

Hair, Skin and Nails:

<input type="checkbox"/> Eczema/Psoriasis	<input type="checkbox"/> Changes in moles	<input type="checkbox"/> Loss of hair
<input type="checkbox"/> Itching	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Dandruff
<input type="checkbox"/> Dryness	<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Rashes	<input type="checkbox"/> Changes in nails (cracked or brittle)	

Head/Eyes/Ears/Nose/Throat:

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

Heart and Circulation:

<input type="checkbox"/> Heart palpitations/Arrhythmias	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Blood clots in legs or lungs
<input type="checkbox"/> High Blood pressure	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Swelling in feet or legs
<input type="checkbox"/> Low blood pressure	<input type="checkbox"/> Stroke	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Peripheral artery disease

Lungs:

<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Chest pain or tightness	<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Persistent cough	<input type="checkbox"/> Bronchitis	
<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Emphysema	

Digestion:

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

Genito-Urinary:

<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Pain with urination	<input type="checkbox"/> Urinary tract infections	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Frequent urination at night	<input type="checkbox"/> Kidney disease	

Musculoskeletal:

<input type="checkbox"/> Back pain	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Joint pain/sprain	<input type="checkbox"/> Bone pain	<input type="checkbox"/> Osteoporosis

Neurological/Psychological:

<input type="checkbox"/> Numbness	<input type="checkbox"/> Paralysis or weakness	<input type="checkbox"/> Sudden mood changes
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Epilepsy/Seizures/Convulsions	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Stress	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Problems with walking	<input type="checkbox"/> Depression	<input type="checkbox"/> Alcohol Dependency
<input type="checkbox"/> Problems with speaking	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Suicidal thoughts
<input type="checkbox"/> Problems with coordination	<input type="checkbox"/> 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): <input type="checkbox"/> None <input type="checkbox"/> Pain with menstruation <input type="checkbox"/> Breast tenderness <input type="checkbox"/> Bloating <input type="checkbox"/> Acne <input type="checkbox"/> Mood swings <input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> 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): <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Night Sweats <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Vaginal atrophy <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Difficulty sleeping <input type="checkbox"/> Depression/Mood changes <input type="checkbox"/> Decreased libido <input type="checkbox"/> 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!