Dr. Elaina Mansour, ND Inc

Glow Acupuncture & Wellness Centre
410 – 1008 Homer St.
Vancouver, BC V6B 2X1

Naturopathic Medicine Confidential Intake Form

Patient Information

Date: ____________________________

First Name: _____________________________ Last Name: _______________________________

Female □ Male □ Birth Date: Month_____________ Day_______ Year________

Age:______________

Home Address:_____________________________________

City:_______________________________ Postal Code:_____________________

Home phone number: ______________________ Cell phone number: ___________________

Email: _______________________________

Care Card Number (PHN): ____

Occupation: ________________________________ Employer: _____________________________

May we (doctor and/or staff) contact you at work? Yes No

Emergency Contact Name: ___________________________________

Relation to you: __________________________ Contact Number: _________________________

Name of current family medical doctor: __________________________________

Date of last visit to medical doctor: ______________________________________

Are you currently seeing a medical specialist? Yes No

If yes, please indicate name of specialist: ____

If yes, please indicate reason for seeing specialist: ___________________________________

Are you currently being treated by any other physician(s) and/or health practitioner(s): Yes No

If yes, please list name(s) and phone number(s):

____

____

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Health Information

Please list your main health concerns:

1. ___________________________________ 2. ______________________________________

3. ___________________________________ 4. ______________________________________

5. ____________________________________ 6. ______________________________________

Height: ____________________________

Current Weight: ____________________

Blood Type (if known): A B AB O

Please list all prescription and non-prescription medications you are taking and dosages (including birth control pill, aspirin, laxatives, etc.):

____

____

____

Please list all vitamins and supplements you are taking with dosages (if known):

____

____

____

Please list all known life threatening allergies, and those to medication, environment, and food:

____

____

Please list any hospitalizations, serious injuries, and/or surgeries (please include date):

____

____

____

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Health History

Family Medical History: Please check if you have a family history of any of the following:

Arthritis Asthma Anxiety Cancer Depression☐
Diabetes Drug/alcohol abuse Epilepsy Eating Disorder Heart disease/stroke High Blood Pressure
High Cholesterol Kidney Disease Mental Illness
Obesity Liver Disease Other: ___________________
I don't know my family history

Immunizations:
Did you receive the normal childhood vaccinations? Yes No
Other immunizations received:

Hepatitis A
Hepatitis B
HPV (Gardasil)
Influenza (flu shot)
Other, please list: ____

Lifestyle:
How many hours of sleep on average do you get per night? ___________________________

How often do you exercise? ___________________________

Do you consume any tobacco products? Yes No

Do you consume alcohol? Yes No

Do you consume any recreational drugs? Yes No

Do you consume caffeine? Yes No

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Review of Systems
Please check off any of the following conditions/symptoms that pertain to you presently, and include any significant past health concerns as well.

General
- Insomnia
- Fatigue
- Stress
- Dizziness
- Night sweats
- Exposure to chemicals

Gastrointestinal
- Change in appetite
- Difficulty swallowing
- Bloating/gas
- Heartburn
- Excessive belching
- Nausea/vomiting
- Bowel movements How often?____________
- Abdominal cramping/pain
- Ulcers
- Loose stools/diarrhea
- Constipation
- Intestinal polyps
- Liver disease/jaundice
- Gallbladder disease
- Blood and/or mucus in stools

Skin
- Rashes
- Itching/hives
- Eczema
- Psoriasis
- Acne
- Change in mole appearance
- Excessive dryness
- Hair changes
- Nail changes

Eyes
- Change in vision
- Blurred vision
- Redness/itchiness of eyes
- Eye pain
- Excessive tearing

Ears
- Hearing loss
- Ringing in ears
- Ear infections

Nose and Sinuses
- Frequent sinus infections
- Nasal congestion
- Sinus pain
- Nosebleeds
- Hay fever/allergies
- Loss of smell

Mouth/Throat
- Hoarseness of voice
- Mouth sores
- Bleeding gums
- Dental problems
- Silver/mercury fillings
- Root canals
- Diminished sense of taste
- Swollen glands

Head
- Headache
- Dizziness
- Head trauma
- Fainting

Respiratory
- Persistent cough
- Difficult/painful breathing
- Shortness of breath
- Coughing phlegm
- Coughing blood
- Asthma
- Positive TB Test
- Emphysema
- Persistent infections

Cardiovascular
- Angina
- Heart attack
- High blood pressure
- Low blood pressure
- High cholesterol
- Chest pain
- Heart disease
- Murmurs
- Palpitations
- Ankle swelling
- Poor circulation
- Pale feet/hands
- Cold feet/hands
- Varicose veins
- Anemia
- Easy bruising
- Clots/DVT

Urinary
- Painful urination
- Blood in urine
- Excessive urination
- Insufficient urination
- Frequency at night
- Bladder/kidney infections
- Frequent bladder infections
- Incontinence
- Urgency/inability to hold
- Bed-wetting

Neurological
- Seizures/epilepsy
- Stroke
- Numbness
- Tingling sensation
- Muscle weakness
- Memory loss
- Fainting
- Difficulty speaking

Musculoskeletal
- Joint pain/stiffness
- Muscle pain/stiffness
- History of or current broken bones
- Osteoarthritis
- Rheumatoid Arthritis
- Back/neck pain
- Fractures
- Dislocations

Endocrine
- Diabetes
- Hypoglycemia
- Thyroid problems
- Heat or cold intolerance
- Excessive thirst
- Hair loss
- Weight gain
- Weight loss
- Hot flashes

Immune System
- Frequent colds/flus
- Never get colds/flus
- Autoimmune disease

Emotional
- Mood swings
- Depression
- Anxiety
- Phobias
- Panic attacks
- Anger/frustration

Female Reproduction
- Irregular cycles
- Heavy periods
- Clots
- Cramps
- Breast tenderness
- PMS
- Excessive fatigue with menses

Date of last period? ___________________

How many days does your period last?
____

Do you bleed between periods?
Yes No

Frequency of cycle (how many days apart are your cycles?)
____

Are you currently pregnant?
Yes No Maybe

Number of pregnancies: _______________
Number of live births: ___________
Number of miscarriages/abortions: ____________

Difficulty conceiving? Yes No
Are you currently attempting conception?
Yes No

Have you had a PAP? Yes No
If yes, when was it? __________________

Have you had a mammogram? Yes No
If yes, when? ____________________________
Are you currently sexually active?
Yes No

Any sexual difficulties? Yes No

History of STI's? Yes No

Male Reproduction

Hernias
Prostate problems
Testicular masses/pain
Sexual difficulty
Discharge or sores
Difficulty starting or stopping urination
Decreased flow or force of urination

Are you currently sexually active?
Yes No

History of STI's Yes No