Wallace
Integrated Health Centre

Dr. Kelly Wallace, B.Sc., N.D.

Adult Intake Form

General Information:

Name:_______________________________ Occupation:___________________________
Age:________________________________ Employer:____________________________
Date of Birth:________________________
Address:_____________________________ **Emergency Contact:**
_____________________________________ Name:_______________________________
Phone (h):___________________________ Relationship:__________________________
Phone (w):___________________________ Phone (h):_____________________________
Phone (cell):_________________________ Phone (w):_____________________________
Marital status:_______________________ Phone (cell):__________________________
Email address:____
(please include your email address if you wish to be informed of upcoming events, and receive quarterly newsletters from the Wallace Integrated Health Centre)

Allergies to medications:____

How did you hear about our clinic?____

Please list the medical professionals that you currently see, including phone number:
____
____
____
____

Chief Concerns:

____
____
____
____

How long has this condition persisted?____

Previous treatment & results?____
____

Secondary Concerns:

____
____
____
____
____

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Medical History:

Surgeries, hospitalizations:

Condition: ______________________ Year: ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Allergies:

Food:____

Chemical/drug:____

Other:____

Traumas:

Physical:____

Emotional:____

Family History: (please check any that apply, and indicate the family members affected)

Diabetes______________________

Heart problems______________________

Thyroid conditions______________________

Cancer______________________

Psychiatric conditions______________________

Lung problems______________________

Smoker______________________

Gallbladder problems______________________

Others______________________

Arthritis______________________

High blood pressure______________________

Glaucoma______________________

Kidney problems______________________

Tuberculosis______________________

Stroke______________________

Alcohol problems______________________

Liver problems______________________

Personal History:

How many hours of sleep do you get in a night?____________ Do you wake up? Y N

Do you smoke? Y N If yes, how much?_________ For how many years:___________

Do you exercise? Y N If yes, how often?____________ What type?______________

Do you consider yourself to be under stress? Y N From home or work?____________

How is the emotional/physical atmosphere in your home?________________________

Are you currently taking any prescription medications? (please list, with dosage)

____

____

____

____

____

____

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Are you currently taking any nutritional supplements (vitamins, herbs…): (please list, with dosage)

____
____
____
____
____
____

Please indicate what a typical day's diet is like for you:

____
____
____
____
____
____
____

Thank you for taking the time to fill out this form. Is there anything else you would like to add?____
____
____
____
____

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