**Integrative Touch Natural Health Sciences**
**Dr. Kiara Galbreath & Associates**
**905 333-8860**

**Welcome! Please fill this form out entirely and bring it with you to your first office visit.**

Name ________________________________________ Birthdate_________ _______________

Address ________________________________ City ____________ Prov______ Pcode_______

Home/Cell Telephone _________________ E-mail address __________________________

□ Ok to leave message with detailed information □ Ok to e-mail with detailed information

□ Leave message with call back number only

Work Phone ______________________ Cell phone _________________________

Emergency Contact _____________________________________ Phone _________________________

□ Okay to leave messages with detailed information on work or cell phone

□ Leave messages with call back information only

How did you hear about Integrative Touch Natural Health Sciences? _____________________________

Today's Date _____________ Age ______ Male / Female (circle one) Occupation ________________

Employer ____________________________________ Hrs per Week _______

**What are your primary health concerns? Please list in the order of their importance to you.**
1) ___________________________________ Past treatment: __________________________________
2) ___________________________________ Past treatment: __________________________________
3) ___________________________________ Past treatment: __________________________________

**What are the primary expectations you have for your visit today?**
1) ______________________________________________________________________
2) ______________________________________________________________________

**Are you currently receiving health care?** Y N
**If yes,** where and from whom? Please provide contact information (phone and address) if available.
______________________________________________________________________________
______________________________________________________________________________

**If no,** when was the last time you received medical care and why?
______________________________________________________________________________
______________________________________________________________________________

**General Information:**
Height _______ Weight _______ Weight 1 yr ago _______ Maximum weight _______ When ______

**Blood pressure:** Most recent blood pressure reading: ____/____ When was this taken? ________

**Childhood Illness** (Please circle any that you have had):
□ Diphtheria □ Measles □ Scarlet Fever □ German Measles
□ Mumps □ Rheumatic Fever □ Chickenpox □ Other: ___________

**Immunizations:** (Please circle any that you have had. If you don't know if you've had one, place a question mark beside it):
□ Diphtheria □Measles/Mumps/Rubella □ Meningitis □ Polio □ Tetanus
□Chickenpox □ Hepatitis A/B/C □ Pertussis □ Flu □Other: ________________

**Hospitalizations and Surgeries:**
__________________________________________________________________________When?___________
__________________________________________________________________________When?___________
__________________________________________________________________________When? ___________

**Diagnostic Studies:**
□ Electrocardiogram (EKG) □ X-Ray □ Bone Density Scan (DEXA) □ CT Scan
□ Electroencephalogram (EEG) □ Mammogram □MRI □ Other: __________
When? ______________________________________________________________________________

**Are you aware of having allergies or sensitivities to any of the following? If so, describe your reaction to each one:**
Drugs: _________________________________________________________________________
Foods: _________________________________________________________________________
Chemicals/Perfumes: ____________________________________________________________
Animals: _______________________________________________________________________

**Which medications, either by prescription or over-the-counter, are you taking or have you taken in the past 6 months?**
□ Laxatives □ Pain Relievers □ H2 Blockers/Ulcer Medication □ Antacids
□ Cortisone/Prednisone □ Appetite Suppressants □ Antidepressants □ Antibiotics
□ Tranquilizers □ Thyroid medication □ Cholesterol-lowering medication
□ Sleeping medication □ Other: ________________________________________________

**Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known..**

***Note: Please bring each of these with you to your first office visit.***
1) _____________________________________________________________________
2) _____________________________________________________________________
3) _____________________________________________________________________

| **Family History:** | **Mother** | **Father** | **Siblings** | **Spouse/Partner** | **Children** |
|---|---|---|---|---|---|
| Age (if living) | ______ | ______ | ______ | ______ | ______ |
| Health (good/fair/poor) | ______ | ______ | ______ | ______ | ______ |
| Age at death (if deceased) | ______ | ______ | ______ | ______ | ______ |
| Cause of death | ______ | ______ | ______ | ______ | ______ |

**Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.**

☐ Anemia ☐ Cancer ☐ Heart Disease ☐ Mental Illness ☐ Alzheimer's
☐ Arthritis ☐ Diabetes ☐ Hypertension ☐ Multiple Sclerosis ☐ Stroke
☐ Asthma ☐ Epilepsy ☐ Kidney Disease ☐ Parkinson's ☐ Other (list below)

**Please list other significant family medical history not listed above:**

_______________________________________________________________________________
_______________________________________________________________________________

**Lifestyle:**
**Circle the appropriate answer: Yes No**

Get 8 hours of sleep nightly (if no, write how much sleep you get) **Yes No**
Sleep Well **Yes No**
Awaken Rested **Yes No**
In an intimate relationship? **Yes No**
If yes, is it satisfying? **Yes No**
Satisfied with friends/family? **Yes No**
History of abuse **Yes No**
Suffered trauma in past 3 years **Yes No**
Use recreational drugs **Yes No**
Treated for drug/alcohol dependence **Yes No**
Drink alcohol? **Yes No** How many drinks per night _____ / Per week _____
Use tobacco? **Yes No** If yes, how many cigarettes daily ____? How many years? ____
If you've quit, how long has it been? _____
Enjoy your work? **Yes No**
Take vacations? **Yes No**
Exercise? **Yes No** What type? ________________________________ How often? __________________
Watch TV? **Yes No** Hours daily ____
Read? **Yes No** Hours daily ____
Eat 3 meals daily? **Yes No**
Go on diets? **Yes No**
Drink tea? **Yes No** Herbal, caffeinated or both? (please circle)
Drink coffee? **Yes No**
Drink soda? **Yes No** Regular or diet? (pls circle)
Add sugar/splenda/nutrasweet/salt to food? **Yes No**
Microwave food? **Yes No**
Eat meals out regularly (more than 3 times weekly) **Yes No**
Eat prepared/processed/fast foods? **Yes No**

**Review of Systems**
In this section, check (✓) the box if you have the symptom currently or if you have experienced it in the past 6 months. Some questions are yes/no, in which case check the box to indicate “yes.”

| **Mental/Emotional** | **Energy and Immune** |
|---|---|
| Mood swings | Swollen glands |
| Poor concentration | Ongoing infections |
| Mental Tension | Colds/flu more than once yearly |
| Depression | Reaction to vaccines |
| Considered/Attempted suicide | Slow wound healing |
| Anxiety or nervousness | Chronic fatigue syndrome |
| Memory problems | General fatigue |
| | |
| **Endocrine** | **Neurological** |
| Hair loss | Muscle weakness |
| Excessive thirst | Vertigo/dizziness |
| Fatigue after meals | Numbness or tingling |
| Cold intolerance | |
| Chronic fatigue syndrome | **Ears** |
| Fatigue | Earaches |
| Seizures/Epilepsy | Itching inside or outside |
| Loss of memory | Impaired hearing |
| Paralysis | Ringing |
| Involuntary shaking or unsteadiness in hands | |
| **Nose and Sinuses** | **Eyes** |
| Stuffiness | Blurriness |
| Nose bleeds | Eye pain/strain |
| Loss of smell | Glaucoma |
| Allergies | Spots in vision |
| **Mouth and Throat** | Double vision |
| Teeth grinding | Uncomfortable tearing or dryness |
| Dental cavities | **Skin** |
| Hoarseness | Acne |
| Frequent sore throat | Lumps or boils |
| Gum bleeding/pain/disease | Hives |
| Sore tongue/lips | Rashes |
| Jaw clicks | Color changes |
| **Neck** | Eczema/rash |
| Pain or stiffness | Generalized itching |
| Lumps | **Urinary** |
| **Head** | Frequency at night; If so, how often |
| Headache | Frequent infections |
| Migraines | Kidney stones |
| Jaw pain/TMJ | Pain with urination |
| Head Injury | Wake to urinate each night __ |
| Pain or difficulty moving muscles | Unable to hold urine |
| | Splitting of stream |

| **Respiratory** | **Intestinal** |
|---|---|
| Cough | Change in thirst |
| Asthma | Nausea/vomiting |
| Emphysema | Jaundice |
| Shortness of breath at night | Liver disease |
| Shortness of breath lying down | Gallbladder disease |
| Wheezing | Heartburn |
| Pleurisy | Frequent belching or excess gas |
| Difficult taking a full deep breath | Constipation or Diarrhea |
| Spitting of blood | Blood in stools |
| Pneumonia | How often are BMs: ______________ |
| Pain on breathing | Trouble swallowing |
| Shortness of breath daily | Change in appetite |
| Lung congestion/sputum | Burning pain in stomach |
| Bronchitis | Hemorrhoids |
| Difficulty breathing | |
| Frequent head colds | **Musculoskeletal** |
| Sinus pain | Joint pain or stiffness |
| Hay fever | Muscle spasms or cramps |
| | Weakness |
| **Male Reproduction** | Broken bones |
| *(questions apply to to lifetime, not just last 6 months)* | Arthritis |
| Hernias | Sciatica or pain down one leg |
| Are you sexually active? Yes No | |
| Use birth control? What type __________ | **Blood/Peripheral Vascular** |
| Premature ejaculation | Deep leg pain |
| Discharge or sores on penis | Anemia |
| Gonorrhea | Cold feet |
| Genital herpes | Cold hands |
| Impotence | Easy bleeding/bruising |
| Prostate disease | Varicose veins |
| Impotence | |
| Testicular masses or pain | **Cardiovascular** |
| Chlamydia | High blood pressure |
| Condyloma/genital warts | Low blood pressure |
| Syphilis | Blood clots |
| Sexual Orientation? | Phlebitis |
| | Rheumatic fever |
| | Angina/chest pain |
| | Fainting |
| | Heart Murmurs |
| | Heart palpitations/fluttering |
| | Ankle swelling |
| | |
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| **Female Reproduction/Breasts** *(questions apply to lifetime, not just last 6 months)* |
|---|
| Age at first menses (first period) ______ |
| Usual length of cycle (monthly): _______ |
| Age of last menses (if menopausal)______ |
| Sexual Orientation ___________________ |
| Do you think you may be pregnant? |
| Painful menses |
| Light flow |
| Clotting |
| PMS |
| Endometriosis |
| Date of last annual exam/Pap _______ |
| Duration of menstruation (days of bleeding) |
| Last menstrual period _______________ |
| Irregular cycles |
| Heavy flow |
| Bleeding/spotting between periods |
| Discharge |
| Menopausal symptoms |
| Ovarian cysts |
| Difficulty conceiving |
| Sexual difficulties |
| Genital herpes |
| Condyloma/genital warts |
| Regular self breast exams |
| Breast lumps |
| Number of pregnancies _______ |
| Number of miscarriages ________ |
| Use of birth control; if so, what type |
| Pain during intercourse |
| Cervical dysplasia |
| Gonorrhea |
| Chlamydia |
| Syphilis |
| Breast pain/tenderness |
| Nipple discharge |
| Number of live births _______ |
| Number of abortions ________ |

| **Are there any other health concerns that you questionnaire?** |
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| ***Signature:*** |
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| ***Date:*** |
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