Dr Ayla Wilson ND

Sports Medicine + Prolotherapy Intake Form

Personal Information

Name _____ Date of First Visit _____
Address _____
City _____ Province _____ Postal Code _____
Telephone # (home/cell)_____ (work)_____
E-mail Address _____
Age _____ Date of Birth (M/D/Y)_____ Gender: female ____ male ____
Occupation _____
Has any other family member already been a patient at the clinic? _____
Next of kin or other to reach in an emergency _____
Relationship _____ Phone _____
How did you hear about Dr. Wilson? _____

Health Overview

Name of current general practitioner (MD) _____
Are you seeing a medical specialist? Y N
If yes, for what reason? _____
Name of medical specialist _____
Do you have any known contagious diseases at this time? Y N If yes, what?_____

What is the main reason for your visit today?_____
_____

What are your most important health concerns? List as many as you can in order of importance.
1. _____
2. _____
3. _____
4. _____

Consent Policy

I hereby consent to receive treatment by Dr. Ayla Wilson, ND. I understand that Dr. Ayla Wilson is a licensed Naturopathic Physician providing prolotherapy, nutritional and lifestyle counseling, acupuncture and traditional oriental medical care, naturopathic spinal manipulations, botanical/herbal medicine, homeopathic medicine, Bowen technique, and intravenous/intramuscular injections.

Cancellation Policy

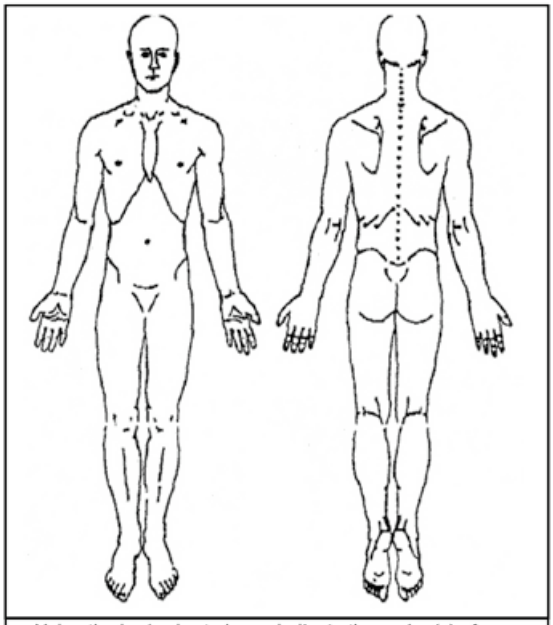
I understand that I am solely responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

Signature: _____

(Parent or Guardian if patient is a minor)

Health History

Height _____ Weight _____ lbs. Weight 1 year ago _____lbs.



Using the body chart above, indicate the region(s) of your complaint using the following symbols:

Ache x x x x x	Burning / / / / / /
Pins & Needles o o o o	Stabbing + + + +
Throbbing = = = =	Other - - - - - -

Past Medical History

Have you had any major illnesses, accidents, hospitalizations or surgeries?

_____

year: _____

_____

year: _____

Have you had any X-rays, CAT scans, MRI's, Ultrasound, EEG's or EKG's?

_____

year: _____

_____

year: _____

Allergies + Sensitivities

Drugs: _____

Foods: _____

Environmentals or Chemicals: _____

Have you ever had an allergic reaction to dental anesthesia? Yes / No

What are the symptoms you experience?

_____

Anaphylaxis? Yes / No

Medications + Supplements

Please list any prescription or over the counter medications you are currently taking:

1) _____ 3) _____

2) _____ 4) _____

Are you currently taking Coumadin, Warfarin or any other anti-clotting drug? Yes / No

Do you ever take Aspirin, Ibuprofin, or other NSAID? Yes / No

Please list any naturopathic remedies (herbal, vitamin/mineral, nutritional, homeopathic, etc) you are currently taking:

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____
4) _____ 8) _____

Review of Systems

*Circle any of the following conditions that you have currently or have had in the past

Current / Past	Tremors	Current / Past	Vertigo or dizziness
Current / Past	Muscle weakness	Current / Past	Difficulty sleeping
Current / Past	Numbness or tingling		

Current / Past	Headaches	Current / Past	Head injury
Current / Past	Migraines	Current / Past	Jaw / TMJ problems

Current / Past	Teeth grinding	Current / Past	Jaw clicks

Current / Past	Blurry vision	Current / Past	Recent changes in vision
Current / Past	Impaired vision		

Current / Past	Impaired hearing	Current / Past	Impaired balance
Current / Past	Earaches	Current / Past	Ringing in the ears

Current / Past	Heart disease	Current / Past	Angina / Chest pain
Current / Past	High or Low blood pressure	Current / Past	Murmurs
Current / Past	Blood clots	Current / Past	Fainting
Current / Past	Phlebitis	Current / Past	Palpitations/ Fluttering

Current / Past	Joint pain or stiffness	Current / Past	Arthritis
Current / Past	Broken bones	Current / Past	Weakness
Current / Past	Muscle spasms or cramps	Current / Past	Sciatica
Current / Past	Ligament or joint injury		

Current / Past	Easy bleeding or bruising	Current / Past	Varicose veins
Current / Past	Deep leg pain		

Thank you for your time in providing this information.