KAWARTHACARE
Wellness Centre

282 Kent St. West, Lindsay, Ontario, K9V 2Z6
P: 705-878-8558 F: 705-878-9057 www.kawarthacare.com
Patient Intake Form Version 0714

Health History

Patient's Information

◯ Mrs. ◯ Miss. ◯ Ms. ◯ Mr. ◯ Dr.

First Name _____ Initials _____ Occupation _____

Last Name _____ Marital Status _____ Employer _____

Date of birth *(DD/MM/YY)* _____ Height _____ Weight _____ Age _____

Contact information:

Street address _____ Home phone _____

City _____ Province _____ Cell phone _____

Postal Code _____ Work phone _____

Email _____ Call me first at: ◯ Home ◯ Cell ◯ Work

Emergency Contact

Primary Contact (Name) _____ Emergency phone _____

Relationship _____

Other Healthcare Providers

Family Medical doctor:

Name _____ Phone _____

Address _____

Specialist/ other Practitioner:

Name _____ Phone _____

Address _____

Specialist/ other Practitioner:

Name _____ Phone _____

Address _____

How did you hear about our clinic ?

◯ Kawartha Care website
◯ Dr Grover's website/fb page
◯ Google search
◯ Facebook/ Instagram/ other social media
◯ Workshop/ talk at community
◯ Referral from your medical doctor or other health care provider
◯ Referral from friend or family member
◯ Existing patient at Kawartha Care wellness centre
◯ Other (please specify) _____

What are your most important health concerns? Please list them in order of Importance:

1 _____

2 _____

3 _____

4 _____

5 _____

Please list all Prescription medications, Over the counter medications, supplements or vitamins you are presently taking with dosages and frequency:

Please list any allergy:

What are your expectations from your first visit?

Is there any additional information you would like to provide?

Thank you for filling out this form. Please know that this information will be kept confidential and only released with your permission.