RICHMOND ALTERNATIVE MEDICAL CLINIC INC.
Suite 150- 7340 Westminster Hwy. Richmond, BC V6X 1A1
Tel: 604-207-0167 Fax: 604-273-2213

Dr. Martin Kwok, ND, DrTCM

ADULT PATIENT PROFILE

Date:_____

FULL NAME _____ AGE ____ BIRTHDAY__MM / DD / YY__ (MM/DD/YY) SEX_____

ADDRESS _____ Postal Code: _____

HOME PHONE #: _____ WORK PHONE #: _____

CELLPHONE #: _____ PREFERRED CONTACT #: (please circle) work / home / cell

E-MAIL: _____

OCCUPATION_____EMPLOYER_____

NAME OF EMERGENCY CONTACT_____ PHONE#_____

NAME OF YOUR PRIMARY PHYSICIAN_____ PHONE#_____

KNOWN ALLERGIES (food, drugs, vaccines, or environmental) _____

_____

How did you hear about the clinic? (mark one or more) ☐Friend ☐BCNA ☐ Internet
☐ Yellow Pages ☐ Newspaper ☐others, specify _____

Note to patients: Please complete this two-sided questionnaire as thoroughly as possible in order to aid the physician in his diagnosis and treatment. This is a confidential record, and will **NOT** be released unless you have authorized us to do so. Thank you.

PRESENT HEALTH PROBLEMS/CONCERNS: Please list in the order of priority to YOU

1) _____
2) _____
3) _____
4) _____
5) _____

LIST OF MEDICATIONS CURRENTLY TAKING: (prescription & over-the-counter drugs, vitamins, herbs, homeopathic remedies, etc.)

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

PAST MEDICAL HISTORY:

Hospitalization (when, for what, and how long): _____

_____

Accidents and injuries: _____

Psychiatric illnesses: _____

Patient Name: _____

Last complete physical exam date: _____ Describe any abnormal findings: _____
Last PAP smear (woman only) date _____ Were the results: ☐normal ☐abnormal
Last mammogram (woman only) date: _____ Were the results: ☐normal ☐abnormal
Do you do monthly self-breast-exam? ☐Y ☐N

PERSONAL LIFESTYLE: (check & fill in applicable ones)
Habits:
Smoking? ☐N ☐Y, how many years?_____, how many cigarettes per day now?_____
Caffeine (coffee, tea, or pop)? ☐N ☐Y, how much daily _____
Alcohol? ☐N ☐Y, how much _____
Recreational drugs? ☐N ☐Y, what kind _____, how much _____
Regular exercises? ☐N ☐Y, what kind _____, how often _____

Diet:
Describe your average day meals:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
List foods that you crave: _____
Are there any diet restriction or regimens that you follow? Please describe: _____
_____

Sleep:
Time you go to bed: _____ Wake up time: _____ Do you take pills to help you sleep? ☐Y ☐N
Do you have difficulty sleeping? ☐daily ☐often ☐sometimes ☐never
Do you dream? ☐daily ☐often ☐sometimes ☐never

SOCIAL HISTORY:
Marital status: ☐single ☐married ☐significant other/common law ☐widowed
Sexually active: ☐Y ☐N Type of birth control: _____
How many children?____,ages: _____

FAMILY HISTORY: Check and fill in applicable boxes (blood relations)

	Who	Comments		Who	Comments
Allergies			Heart Disease		
Anemia			Hepatitis		
Arthritis			High Blood Pressure		
Auto Immune			Kidney disease		
Asthma			Mental Illness		
Cancer			Stroke		
Diabetes			Tuberculosis		
Epilepsy			Other		