File No. ________________

Welcome to *The Prana Group* & congratulations on taking a critical step in your journey to health, vitality and longevity!

Please print up and complete the following form and bring it with you, along with any additional reports or diagnostics you would like the Doctor to review on your first visit to The Prana Group.
If you have any questions please call us at 613.230.0909.
NOTE: We require 48 hours notice to change/cancel your initial visit or a $150 fee applies.

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent on your ability to respond thoughtfully and accurately to both these written questions & those posed by the Doctor during your consultation. Health issues are usually influenced by many factors. Accurately assessing all these factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help us to identify the underlying causes of your problems & also assist us to formulate a treatment plan.

Your First Visit

Your journey begins with an extensive analysis of your level of health. We will determine your current health status and gather further information through appropriate exams and diagnostics to help us determine the underlying cause of your health challenges.

Additional Visits

A second visit is usually scheduled for your Report of Findings. During this visit the Doctor will discuss the exam findings, the cause and severity of your problems and outline your personalized, step by step program of care.

Our Goal

Our goal is to help our patients live the most vital and productive lives possible by creating personalized, step-by-step health, vitality and longevity programs that address their health needs.

Your Goal

It is important that we understand your primary reason for seeking care. Please mark the one that most closely reflects the reason for your visit.

- ❑ **Chiropractic/Injury Rehabilitation**
- ❑ **Natural/Functional Medicine**
- ❑ **Detoxification/Toxicity Assessment**
- ❑ **CORE Cleanse Technology**
- ❑ **Far Infrared Sauna Therapy**
- ❑ **Patient Advocacy Consultation**
- ❑ **Nutritional Testing**
- ❑ **Therapeutic Lifestyle Counselling**
- ❑ **Weight Management**
- ❑ **Wellness Check-up**

Where are we located?

The Prana Group is located at 151 Second Ave. just west of Bank Street in the heart of the Glebe. We are located just behind the Urban Pear Restaurant on the ground level. You will see our sign as you turn into the parking lot. Parking is complimentary.

Thank you and again, we look forward to partnering with you and your family to bring your health to a new level.

Dr. Monique Andrews & Dr. Tamara MacIntyre

File No. ________________

The Prana Group
New Practice Member Intake Form 2009

Last Name: ____ First: ______________________ Middle. _______

Age: __________ Birth date (m/d/y): ________________ Gender: (circle one) Female Male Other

Address: ____Postal Code:__________________

Home Phone: ___________________ Work Phone: ___________________Cell Phone: ______________________

Email Address: ____

Occupation: _______________________________ Employer's Name: ____________________________________

Partner / Spouse's Name: ____________________________________

Partner / Spouse's Employer: ____ Work No. ___________________

Number of Children & Ages: ____

Other nearest Relative or Contact Person: _______________________________ Phone No. ___________________

How did you discover Prana? ___________________ If referred, name of the person who referred you: _________________

Have you received Alternative health care in the past? (circle one) Yes No Specialty:_____________________________
If Yes, how would you describe your experience? ____
Please describe the reason for previous care: ____
____
Name of your Medical Doctor: ________________________________
What other health care providers are you seeing, and their specialty? ____
____
____
What diagnoses have you been given: ____
____

How do you hope to benefit from care at Prana?

- ❑ Improvement of my physical symptoms
- ❑ Improvement of emotional/mental symptoms
- ❑ Improvement in my ability to respond to stress
- ❑ Overall improved quality of life
- ❑ Other: ______________________________
  ____
  ____

Please rank current & ongoing problems by priority and complete:

Describe Problem	Date	Mild/Mod/Severe	Treatment Approach	Success
Example: Post nasal drip	Jan'06	Moderate	Elimination Diet	Moderate
1.				
2.				
3.				
4.				
5.				

Please continue on other side of paper or separate sheet if necessary.

Empowering you with a greater understanding of health, the human body & its expression.
The Prana Group

File No. ________________

HEALTH QUESTIONNAIRE

Gender & Age Specific Information

How was your health as a child? (circle one): excellent good fair poor
Were there any complications with your delivery? Please explain: ____
Were you breastfed? ____________ How long: __________________________________
Did you have any serious emotional or mental traumas as a child? Please Explain: ____________________________
____

Circle diseases for which you have been immunized:
Measles Mumps Rubella Small Pox Influenza Tetanus Diphtheria Pertussis Chickenpox Hepatitis
Other: ____

Women Only (next two lines):

Age at onset of menstruation: ____________ Number of children: __________________
No. of miscarriages/c-section: ____________ Age of onset of menopause: ___________

Health Concerns

In general, would you say your health is? (circle one)
Excellent Very Good Good Fair Poor

Compared to one year ago, how would you rate your general health now?

- ❑ Much better than one year ago
- ❑ Somewhat worse now than one year ago
- ❑ Somewhat better now than one year ago
- ❑ Much worse than one year ago
- ❑ About the same

Which best describes your current feelings about yourself and your situation?

- ❑ I feel helpless like little or nothing works.
- ❑ This is terrible. I am scared and hope you can help me.
- ❑ I feel stuck and am unable to help myself.
- ❑ I would like you to assist me in my healing.
- ❑ Other: ____

Please circle any condition you have now or have had in the past: (circle all that apply)

Back pain	Chest pain	Colon/Stomach trouble	Auditory difficulties/deafness
Neck pain	Respiratory difficulty	Eye problems	Gall bladder problems
Shoulder/arm pain	Asthma	Liver trouble/Hepatitis	Mononucleosis
Hip/leg pain	High blood pressure	Seizures/convulsions	Thyroid disease
Sciatica	Poor circulation	Kidney problems	Skin problems
Arthritis	Heart attack/angina	Easy bruising	Difficulty urinating
Frequent infections	Stroke	Cancer	Orthotics (past or current)
Allergies/Sinusitis	Environmental Sensitivities	Prostate problems (Men)	Menstrual problems (Women)

Other:____

Personal Health History

Have you ever (circle all that apply):			If yes, explain when and why.
Been hospitalized	Yes	No	______________________
Had a broken bone	Yes	No	______________________
Had surgery	Yes	No	______________________
Been treated for an emotional disorder?	Yes	No	______________________
Been bedridden for more than a week?	Yes	No	______________________
Had x-rays, CAT scan or MRI?	Yes	No	______________________
Had a work/vehicular accident related injury?	Yes	No	______________________

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Are you considering any elective surgery or medical procedures in the near future? ____________________________________

Serious Illnesses/Injuries/Surgeries/Hospitalizations	Date	Reason/Outcome

Y/N	Allergies/Sensitivities (please specify)	Allergy Tested/confirmed Y/N	Typical Reaction	Typical Treatment
	Food:			
	Chemicals:			
	Drugs, Medications:			
	Dust, moulds:			
	Animal hair/dander:			
	Grasses, weeds, pollen			
	Others:			

Family Health History

Please list the medical history of any family member & their relation to you (i.e. mother, father, sibling, grandparent):

Relation	Age	State of Health	Age of Death	Cause of Death	Check (x) if your blood relatives have/had:	Disease	Relationship
Mother						Arthritis, gout	
Father						Allergies, Asthma, Autoimmune	
Sister(s)						Cancer, tumour	
						Chemical Dependency	
						Diabetes	
						Digestive Disorder	
						Emotional Disorder	
						Genetic Disorder	
Brother(s)						Heart Disease, Stroke	
						High Blood Pressure	
						Kidney or Liver Disorder	
						Lifestyle related illnesses	
						Thyroid problem	
						Other:	

Medications & Examinations

Please list the date of your most recent procedures and circle any tests that were abnormal:

Test	Year	Test	Year	Test	Year	Test	Year
Chest x-ray		TB test		Pap Smear		Others:	
Kidney x-ray		EKG		Mammogram			
G.I. Series		MRI		Sigmoidoscopy			
Colon x-ray		CAT scan		Rectal Exam			
Spine x-ray		Cardiac stress test		Complete Physical Exam			
Blood tests		Cholesterol		PSA			

Please list any medications you are currently taking, include both prescription & non-prescription drugs.

Medication Name	Date Started	Dosage	Purpose

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How often have you taken antibiotics? (circle one) ‹ 5 times › 5 times

How often have you taken oral steroids (e.g. Cortisone, Prednisone etc.)? (circle one) ‹ 5 times › 5 times

Please list any of the vitamins, minerals and other nutritive supplements you are currently taking now. Indicate whether 'mg' or 'IU' and the form (e.g. calcium carbonate VS calcium citrate) when possible.

Vitamin/Mineral/Supplement Name	Date Started	Prescribed by?	Dosage	Purpose

Nutrition & Exercise

How much of the following do you consume? (circle day or week, as appropriate):

Tobacco	__________packs per day/week	Candy	__________per day/week
Caffeinated coffee	__________cups per day/week	Chocolate	__________per day/week
Decaffeinated coffee	__________cups per day/week	Margarine	__________pats per day/week
Black tea	__________cups per day/week	White bread	__________slices per day/week
Alcohol	__________cups per day/week	Sugar	__________packets per day/week
Soda	__________cups per day/week	Artificial sweeteners	_______packets per day/week

How many cups of purified or filtered water do you drink per day? ____________ Tap water? _________
Do you eat organically grown foods? (circle one) Yes No If yes, what percentage of diet? ________________
How many times a week do you eat in a restaurant? Breakfast _____________Lunch _________Dinner________________
What types of restaurants? ____
What are your favourite foods: ____
Do you crave sweets?__________________ At what time: ____________ Do you salt your food at the table_____________
Do you have symptoms after eating? (circle) Yes No Are these symptoms immediate or delayed? (circle one)
Are there other foods you crave? _________________________ Foods do you avoid/dislike? _________________________
Are you on any specific diet? If so, Please specify: ____
Are you on a restricted diet (e.g. diabetic, dairy restricted, vegetarian, vegan, raw etc.)? ______________________________

Would you like to increase or decrease your weight? If so, by how much: ________________________________
When did you last have a significant (more than 10 pounds) change in weight: ______________________________
What exercise do you do and how often? ____

How many hours of sleep do you get each night? ________ Do you wake rested? (circle) Yes No Do you have difficulty falling asleep? (circle) Yes No Difficulty staying asleep? Yes No Do you wake early? Yes No

Rate your current stress level from 1-10: _________________How much does this affect you (1-10)? _________________
What are the major stress factors in your life now?____
Please rate your current emotional health (please circle): Excellent Good Fair Poor Unstable
Do you have a good support network/team? ______________________
Does your home environment have a supportive effect on your health? ______________________________
How many hours of relaxation (not including sleep) do you give yourself during the work week? ______________________
During weekends? ________________ Favourite recreational activities? ________________________________

Do you have an air purifier in the room you sleep in? ____
Do you have amalgam (silver/mercury) fillings? ________ Do you have artificial joints or limbs?____________________
Are you exposed to second hand smoke? (circle one) Yes No Do odors affect you? (circle one) Yes No
Have you to your knowledge, been exposed to toxic chemicals or metals in your home or job? (circle one) Yes No
Do you live or work in a newly renovated home or office (‹ 5 yrs) OR an old home or office (› 25 yrs)? (circle one) Yes No

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Can you think of any other habit or activity that has a positive or negative effect on your health? (circle one) Yes No
If yes, please explain: ________________
Do you have an exercise, meditation, prayer, nutritional or dietary program? (circle one) Yes No

Health and Lifestyle Overview

What areas of your lifestyle are involved with your condition and you would like to improve upon (prioritize #1, 2, 3, etc.):

___ My level of anxiety
___ My pace of living
___ My diet & nutrition
___ My exercise program
___ Not enough time spent in nature
___ Not enough quiet time & rest
___ My social & family life
Other: ________________
___ My creative expression
___ My feelings around my career
___ My communication skills

Health Care History

Have you had experience with any of the following health, treatment or healing modalities?
If so, please describe when you went, for how long, and what the end results have been.

Massage/Bodywork ________________
Reiki/Energy work ________________
Emotional therapy/psychotherapy ________________
Music/Dance/Sound/Light/Aromatherapy ________________
Naturopathy/Homeopathy/Herbalist ________________
Ayurvedic Medicine/Acupuncture ________________
Yoga/Movement/Dance/Tai Chi/Chi Gong ________________
Craniosacral Therapy ________________
Other: ________________

Health Care with The Prana Group

The Prana Group offers a unique health care approach. Our goal is to bridge the gap between traditional medicine and natural health care. While other professions are concerned with changing the environment to suit a weakened body, The Prana Group focuses on strengthening the body to adapt to the environment. We accomplish that by identifying the underlying cause of your health challenges and then by creating a step by step plan to help you regain your health. Prana is dedicated to providing an exceptional health experience for everyone. We look forward to helping you create change in health and life.

Again, if you have any questions regarding this form or starting care at Prana, please call us at 613.230.0909 OR visit our website at www.thepranagroup.com.

I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE.

New Patient's Signature: ________________ Date: ________________

If New Patient is a minor (under 18 years of age):

Signature of parent or legal guardian: ________________ Date: ________________