

## Welcome to *The Prana Group* & Congratulations on taking an important step toward creating change in your life with **The CORE Cleanse!**

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Please complete the following form and bring it along with any additional health commentary you would like the Doctor to review with you on your CORE consultation at Prana. If you have any questions please call us at 613.230.0909.

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 customize your CORE Cleanse Program.

### Your First Visit

Your journey begins with an analysis of your current level of health. Toxicity analysis using Bio Impedance Analysis (BIA) will be used. Body measurements will be taken as baseline. You will be provided a CORE portfolio which will include all of the information necessary to begin your program. Your sessions will be scheduled.

### Additional Visits

All CORE sessions are 40 minutes in length. We typically recommend a program of 12 sessions over 4-6 weeks along with an individualized CORE Nutrition Plan. Additional maintenance sessions are optional and recommended to maintain the changes experienced during the program.

### 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 and experiencing the CORE Cleanse. Please mark the one that most closely reflects the reason for your visit.

- Detoxification/Toxicity Reduction**
- Weight Management**
- Increased Energy & Vitality**
- Improved Sleep Patterns**
- Bowel Health/Colon Cleanse**
- Lymphatic Drainage**
- Rehabilitation/Toning**
- Post Surgical Recovery**
- Improved Overall Wellness**

### 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  
Chiropractors & Doctors of Natural Medicine

**The Prana Group  
CORE Cleanse Intake Form 2008**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

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

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer's Name: \_\_\_\_\_

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(s): \_\_\_\_\_

What other health care providers are you seeing, and their specialty? \_\_\_\_\_

What diagnoses have you been given: \_\_\_\_\_

Please rank current & ongoing problems by priority and complete:

Describe Problem	Date	Mild/Mod/Severe	Treatment Approach	Success
<b>Example:</b> 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.

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**HEALTH QUESTIONNAIRE**

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**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           | Artificial joints/limbs        |
| 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):

	Yes	No	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	_____

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

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

**Diet & Nutrition**

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 fruits do you normally eat each day (for example: ½ C fruit, 1 medium piece or 1 C unsweetened juice)? \_\_\_\_\_

How many vegetable servings do you normally eat each day (1 C leafy greens, ½ C any veggie raw or cooked)? \_\_\_\_\_

How many different varieties of vegetables do you eat in a normal month (less than 2 or more than 9)? \_\_\_\_\_

How many times do you eat dried beans or peas (legumes, lentils or chickpeas) in a normal week? \_\_\_\_\_

How many times do you eat red meat in a normal week? \_\_\_\_\_

How many times do you eat in fast food restaurants in a normal week? \_\_\_\_\_

**Are you willing & interested in exploring a CORE Cleanse Nutrition Plan? (circle one) Yes No****Exercise**

Would you classify your level of activity/exercise – light, moderate or high? \_\_\_\_\_

Are you currently in training or introducing a new form of exercise, please describe? \_\_\_\_\_

What forms of exercise do you do? and how often? \_\_\_\_\_

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: \_\_\_\_\_

**Sleep Patterns & Stress Level**

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 At what hour(s) do you typically wake if sleep is interrupted? \_\_\_\_\_

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

How many hours of relaxation (not including sleep) do you give yourself during the work week? \_\_\_\_\_

During weekends? \_\_\_\_\_ Favourite recreational activities? \_\_\_\_\_

**Toxicity Exposures**

Do you live or work in a newly renovated home or office (&lt; 5 yrs) OR an old home or office (&gt; 25 yrs)? (circle one) Yes No

Do you have amalgam (silver/mercury) fillings? \_\_\_\_\_ Do you consider yourself environmentally sensitive? \_\_\_\_\_

Are you exposed to second hand smoke? (circle one) Yes No Do odors affect you? (circle one) Yes No

Have you had any experience with or exposure to:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Chemotherapy   | <input type="checkbox"/> Artificial Sweeteners     | <input type="checkbox"/> Addictive substances |
| <input type="checkbox"/> Radiation      | <input type="checkbox"/> Paints, glues, adhesives  | <input type="checkbox"/> Other toxins _____   |
| <input type="checkbox"/> Heavy metals   | <input type="checkbox"/> Fertilizers or Pesticides |   |
| <input type="checkbox"/> Chemical fumes | <input type="checkbox"/> Plastics                  |   |

**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:** \_\_\_\_\_*Empowering you with a greater understanding of health, the human body & its expression.*

The Prana Group

**Health Care with The Prana Group**

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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](http://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: \_\_\_\_\_