POLO
HEALTH + LONGEVITY CENTRE

INTAKE FORM

Date: _____

First Name: _____ Last Name: _____

Preferred Name (if different): _____

Pronouns: _____

Mobile Phone: _____ Home Phone: _____
Okay to leave message:☐ Okay to leave message:☐

Email: _____

Street Address: _____ Suite Number: _____

City: _____ Province: _____ Postal Code: _____

Guardian (if applicable): _____

Guardian Contact Phone (if applicable): _____

Guardian Contact Relationship (if applicable): _____

Emergency Contact: _____

Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Occupation: _____

List all persons currently living in your household (name and relation). Indicate "none" if you live alone.

Family Doctor: _____

Family Doctor Phone/Email (if known): _____

Name of referring professional: _____

Referring professional phone/email (if known): _____

How did you hear about us?

What has led you to seek counselling at this time?

How long have you been having these difficulties and/or concerns?

How do these difficulties/concerns affect you?

Have you received counselling in the past? If yes, when was this?

What would you like to gain from counselling now?

Do you have any health concerns?

Please list all medication or supplements currently taking:

Please note any other therapies you are receiving right now:

Family History

Which health conditions run in your family?

☐Allergies	☐Diabetes	☐Kidney Dysfunction
☐Alcoholism	☐Drug Abuse	☐Mental Illness
☐Arthritis	☐Gall Bladder Issues	☐Osteoporosis
☐Asthma	☐Heart Disease	☐Skin Conditions
☐Autoimmune disease	☐Hypertension	☐Ulcers
☐Cancer	☐Intestinal Disease	

Other Diseases (please list):

Do you smoke cigarettes? ☐Yes ☐No Do you drink alcohol? ☐Yes ☐No

Do you use recreational drugs? ☐Yes ☐No

If yes, which type?

What level of stress do you feel you are experiencing at this time? Please rate on a scale of 1-10 (1 being low and 10 being extremely high):

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What are the major causes or factors of your stress? Check all that apply.

☐Financial	☐Family	☐Spiritual
☐Career	☐Marriage/relationship	☐Unfulfilled expectations
☐Health	☐Personal	☐Other

If other, please explain:

Do you actively participate in any spirituality (i.e. religious group, healing, meditation)?

Client Signature:_____ DATE:_____

Parent/Guardian Signature (If applicable):_____ DATE:_____