

# Intake Form

Date (DD.MM.YYYY)

We collect this information to help us communicate respectfully with you and provide you with the best possible care. We protect your information by following professional and privacy rules and laws.

Legal first name\*: \_\_\_\_\_ Legal last name\*: \_\_\_\_\_

Chosen first name: \_\_\_\_\_ Chosen last name: \_\_\_\_\_  
(if different) (if different)

Date of birth: (DD.MM.YYYY) \_\_\_\_\_ Pronouns: (Examples: she, he, they) \_\_\_\_\_

Language: English French Other: \_\_\_\_\_ Gender: \_\_\_\_\_  
(Examples: cis woman, trans woman, cis man, trans man, genderqueer, agender, nonbinary)

Health card number: \_\_\_\_\_

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

Phone number: \_\_\_\_\_

\*As stated on your Health Card. This information is collected to access your health records. We recognize that a person's name and gender can differ from what is stated on their government-issued ID.

Allergies: yes no	Specify reaction
To medications:	
To food:	
Other:	
Intolerances: yes no	
To medications:	
To food:	
Other:	

Weight:	kg	lbs	
Height:	m	ft	
Pregnancy:	yes	no	planned
Expected date of delivery: (DD.MM.YYYY)			

Smoking:	yes	#cig per	day	week	no
Vaping:	yes	mg cartridge per	day	week	no
Cannabis:	yes	times per	day	week	no
Alcohol:	yes	standard drinks	day	week	no

Medications in a different pharmacy: yes no

Attach your list of medications or contact information of pharmacy:

Reason for your visit today:	Specify:
<ul style="list-style-type: none"> <li>new prescription(s)</li> <li>transfer of prescription(s)</li> <li>consultation</li> <li>vaccination</li> <li>renewal</li> <li>update of my information</li> </ul>	