For Individuals with MCA, hEDS and POTS

Please complete this page with information that you need to send me that is too large to fit in the boxes on the Intake and Service Option Form.

Name:

Date:

All physical and mental health conditions *in your immediate family* (both parents, 4 grandparents, any siblings (brothers, sisters)

Health Condition:	Relative:
Health Condition:	Relative:
Health Condition:	Relative:
Health Condition:	Relative:
Health Condition:	Relative:
Health Condition:	Relative:

All *physical* and/or ***mental health conditions*** **that *you* have been diagnosed with and the date of diagnoses of each condition.**

Health Condition:	Date Diagnosed:
Health Condition:	Date Diagnosed:
Health Condition:	Date Diagnosed:
Health Condition:	Date Diagnosed:
Health Condition:	Date Diagnosed:
Health Condition:	Date Diagnosed:
Health Condition:	Date Diagnosed:
Health Condition:	Date Diagnosed:
Health Condition:	Date Diagnosed:
Health Condition:	Date Diagnosed:

All physician-diagnosed *IgE mediated allergies* that *you* have been diagnosed with (i.e., by a medical doctor, not a naturopath) e.g. eggs, shellfish, tree nuts, environmental (latex, birch, alder), mold

All *food intolerances* that you have (foods that make you feel unwell)

List all medications that you take, and their dosages:

Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:
Medication:	Dosage:

List all nutritional supplements that you take, and their dosages.

Supplement:	Dosage:
Supplement:	Dosage:
Supplement:	Dosage:
Supplement:	Dosage:
Supplement:	Dosage:
Supplement:	Dosage:
Supplement:	Dosage:
Supplement:	Dosage:
Supplement:	Dosage:
Supplement:	Dosage:

Info that didn't fit in one of the boxes above (specify):