ADULT INTAKE FORM

Calgary Centre for Irritable Bowel Syndrome
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www.IBScalgary.com

Patient Privacy: Patient information will never be disclosed or sold to an individual or company. The information you provide herein is used solely by CCIBS for administrative, diagnostic and/or treatment purposes, and will be treated in the strictest confidence.

NAME _____ DATE _____

AGE _____ BIRTH DATE_____/_____/_____ (D/M/Y) SEX: M / F

ADDRESS _____ CITY _____ POSTAL CODE _____

TELEPHONE: (Home) _____ (Work) _____

E-MAIL _____

OCCUPATION _____ EMPLOYER _____

EMERGENCY CONTACT _____ RELATION_____

EMERGENCY PHONE NUMBER_____

MARITAL STATUS (circle one) S M D W Sep NUMBER OF CHILDREN _____

FOUND OUT ABOUT CLINIC BY _____

PLEASE LIST YOUR MAJOR COMPLAINTS IN ORDER OF IMPORTANCE

COMPLAINT	SINCE	POSSIBLE CAUSE(S)

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

MEDICATION	SINCE	ADVERSE EFFECTS

PLEASE LIST ALL OF YOUR KNOWN ALLERGIES: (FOOD, ENVIRONMENTAL OR DRUG)

_____

_____

PLEASE LIST YOUR SUPPLEMENTS/VITAMINS WITH DOSAGES

_____

_____

WHAT, IF ANY, OPERATIONS HAVE YOU HAD?

OPERATION	WHEN	COMPLICATIONS?

WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECTS?

Family History

	Age if living	Age at Death	Cause of Death	Health Concerns
Mother				
Father				
Brother(s)				
Sister(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Any other blood relatives with notable health conditions (ie. Heart disease, cancer, etc.)				

Personal Habits/Lifestyle

On average, how many hours of sleep do you get per night? _____
Do you have interrupted sleep? **Y / N** Do you wake rested? **Y / N**
How many glasses of water do you drink per day? _____
What do you enjoy most in life? _____
What are your main interests or hobbies? _____
What do you worry about most? _____

Typical Diet

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages _____

Any dietary restrictions? (Religious or otherwise) _____
_____
_____

Digestion (circle or fill in the answer)

Do you have any problems with gas, bloating or fullness after eating? **Y / N**
Any heartburn? **Y / N** How often? _____
How often do you have bowel movements? _____
Do you ever have any **blood, mucus, undigested food** or **black stools**?(circle)
Do your stools tend to be formed or loose? _____
Do you ever have alternating constipation and diarrhea? **Y / N**
How often do you have thin, long and narrow stools? **Often / Sometimes / Never**
Do you ever have small and hard stools? **Often / Sometimes / Never**
Do your stools have a strong disagreeable odor? **Often / Sometimes / Never**

Kidneys and Bladder:

Have you had recurrent bladder infections? **Y / N**
Do you have any burning sensation during or after urination? **Y / N** Past___ Present ____
Do you have difficulty starting or stopping when urinating? **Y / N**

(Men only)
Male Reproductive System

How often do you get up in the night to urinate? _____
Do you have difficulty with maintaining or achieving an erection? **Y / N**
Last prostate exam _____ PSA (blood test done) **Y / N**
Are you currently sexually active? **Y / N** Do you use birth control? **Y / N**
What type of birth control? _____Any problems with sex drive? **Y / N**

(Women only)
Female Reproductive System

Age of first menses _____ Have your periods stopped? **Y / N** At what age?_____
Are your cycles regular? **Y / N** Periods begin every _____ days, and last _____days
Are your periods: **Heavy Medium Light**? Are there any clots? **Y / N**
Any cramps with your periods? **Y / N** Any spotting/bleeding between periods? **Y / N**

Do you have any premenstrual symptoms? (Please circle) **Water retention Depression**

Breast tenderness Headaches Mood swings Bloating Acne Cravings

Are you pregnant? **Y /N / Possibly**
Number of pregnancies _____Number of abortions_____ Number of miscarriages_____
Any problems getting pregnant? **Y / N** Last Menstrual Period _____
Last PAP (date) _____ Any abnormal PAP's? **Y / N**
Last Breast Exam (date) _____ Do you do monthly breast exams? **Y / N** Are you currently sexually active? **Y / N** Do you use birth control? **Y / N**
What type of birth control? _____ Any problems with sex drive? **Y / N**

Do you have anything else you would like to comment on? _____
_____
_____

IRRITABLE BOWEL SYNDROME
PATIENT SEVERITY SCORE QUESTIONNAIRE

PART 1 : SEVERITY SCORE

For office use only

SCORE

1. a) ***Do you currently suffer from abdominal (tummy) pain?*** **YES** **NO**

Circle appropriate box

b) ***If yes, how severe is your abdominal (tummy) pain?***

0% ——— **100%**

no pain | not very severe | quite severe | severe | very severe

c) ***Please enter the number of days that you get the pain in every 10 days.***
For example if you enter 4 it means that you get pain 4 out of 10 days. If you get pain every day enter 10

Number of days with pain [ ] x10

2. a) ***Do you currently suffer from abdominal distension* (bloating, swollen or tight tummy)*** **YES** **NO**

Circle appropriate box

*(*women, please ignore distension related to your periods)*

b) ***If yes, how severe is your abdominal distension/tightness***

0% ——— **100%**

no distension | not very severe | quite severe | severe | very severe

3. ***How satisfied are you with your bowel habit?***

0% ——— **100%**

very happy | quite happy | unhappy | very unhappy

4. ***Please indicate with a cross on the line below how much your Irritable Bowel Syndrome is affecting or interfering with your life in general***

0% ——— **100%**

not at all | not much | quite a lot | completely

IBS SEVERITY SCORE: [ ]

PART 2 : OTHER IBS DATA

BOWEL HABIT

5. a) ***What is the most number of times you open your bowels per day/week/month?***

Number of times ____ per day / week / month *(Circle appropriate)*

Note: For some people the answer to part a and b could be the same

b) ***What is the least number of times you open your bowels per day/week/month?***

Number of times ____ per day / week / month *(Circle appropriate)*

6. In the following questions you may circle more than one answer:

Are your motions ever:

a)	***normal***	often / occasionally / never	*(Circle appropriate)*
b)	***hard***	often / occasionally / never	*(Circle appropriate)*
c)	***very thin (like string)***	often / occasionally / never	*(Circle appropriate)*
d)	***in small pieces (like rabbit pellets)***	often / occasionally / never	*(Circle appropriate)*
e)	***mushy (like porridge)***	often / occasionally / never	*(Circle appropriate)*
f)	***watery***	often / occasionally / never	*(Circle appropriate)*

7. In the following questions you may circle more than one answer:

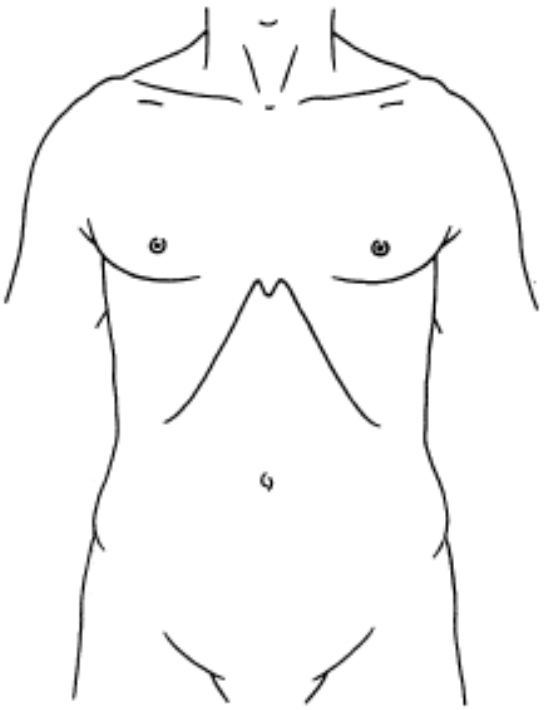
Do you ever:

		Circle appropriate box	
a)	***pass mucus (or slime or jelly) with your motions***	**YES**	**NO**
b)	***pass blood with your motions***	**YES**	**NO**
c)	***have to hurry/rush to the toilet to open your bowels***	**YES**	**NO**
d)	***strain to open your bowels***	**YES**	**NO**
e)	***feel you haven't emptied your bowel completely after you have passed a motion***	**YES**	**NO**

PART 2 : Continued

SITE OF PAIN

Please mark with a cross (x) on the diagram below where you get your pain
(use more than one x if necessary)



8. ***Do you ever:***

a) ***notice your stools are more frequent or loose when you get pain***

YES **NO**
Circle appropriate box

b) ***notice whether the pain is frequently eased by opening your bowels***

YES **NO**
Circle appropriate box

9. ***In the last year on approximately how many weeks were you:***

i) ***absent from work due to IBS***
(enter 52 if you have given up completely work because of IBS) _ _ _ _ _ _ _

ii) ***at work suffering from IBS*** _ _ _ _ _ _ _

PLEASE READ THIS CAREFULLY

ON THE FOLLOWING PAGES YOU WILL FIND STATEMENTS CONCERNING BOWEL PROBLEMS (IRRITABLE BOWEL SYNDROME) AND HOW THEY AFFECT YOU.

FOR EACH STATEMENT, PLEASE CHOOSE ***A SINGLE RESPONSE*** THAT BEST APPLIES TO YOU AND CIRCLE THE NUMBER OF YOUR RESPONSE. IF YOU ARE UNSURE ABOUT HOW TO RESPOND TO A STATEMENT, PLEASE GIVE THE BEST RESPONSE YOU CAN. **THERE ARE NO RIGHT OR WRONG RESPONSES**.

YOUR RESPONSES WILL BE KEPT STRICTLY CONFIDENTIAL.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT: Dr. Roberts (403) 247-4646

ABOUT HOW YOU FEEL

1. I feel helpless because of my bowel problems.

   1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

2. I am embarrassed by the smell caused by my bowel problems.

   1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

3. I am bothered by how much time I spend on the toilet.

   1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

4. I feel vulnerable to other illnesses because of my bowel problems.

   1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

5. I feel fat / bloated because of my bowel problems

   1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

6. I feel like I'm losing control of my life because of my bowel problems.

   1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

7. I feel my life is less enjoyable because of my bowel problems.

   1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

8. I feel uncomfortable when I talk about my bowel problems.

   1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

9. I feel depressed about my bowel problems.

   1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

10. I feel isolated from others because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

11. I have to watch the amount of food I eat because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

12. Sexual activity is difficult for me because of my bowel problems. (Please circle one number)
    (If not applicable, please circle “NOT AT ALL”)

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

13. I feel angry that I have bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

14. I feel like I irritate others because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

15. I worry that my bowel problems will get worse.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

16. I feel irritable because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

17. I worry that people think I exaggerate my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

18. I feel I get less done because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

19. I have to avoid stressful situations because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

20. My bowel problems reduce my sexual desire.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

21. My bowel problems limit what I can wear.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

22. I have to avoid strenuous activity because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

23. I have to watch the kind of food I eat because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

24. Because of my bowel problems, I have difficulty being around people I do not know well.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

25. I feel sluggish because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

26. I feel “unclean” because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

27. Long trips are difficult for me because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

28. I feel frustrated that I cannot eat when I want because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

29. It is important to be near a toilet because of my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

30. My life revolves around my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

31. I worry about losing control of my bowels.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

32. I fear that I won't be able to have a bowel movement.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

33. My bowel problems are affecting my closest relationships.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

34. I feel that no one understands my bowel problems.

    1. NOT AT ALL 2. SLIGHTLY 3. MODERATLEY 4. QUITE A BIT 5. EXTREMELY

Cancellation Policy:

We will call to confirm 48-72 hours prior to your scheduled appointment, and we require a return confirmation phone call from you.

Appointments cancelled with less than 24 hours notice may be charged $35. Appointments cancelled the same day or missed appointments will be charged the full appointment fee.

I understand and agree: _____ Date:_____
Signature

Informed Consent:

As one of our patients, we hold both your health and your privacy in the highest esteem. We ask your permission to confer with other members of your health care team as well as with practitioners who we feel may be of assistance.

I, the below named person, agree that information obtained by Calgary Centre for Irritable Bowel Syndrome can be used for research purposes. I understand that in no way will this information identify me personally to others without my further permission. I also understand that I can withdraw my permission at any time with a request.

Dated this _____day of _____, 20_____.

_____ _____
Patient Signature (Legal Guardian) **Witness Signature**

_____ _____
Patient Name (please print) **Witness Name (please print)**

Thank you for taking the time to fill in this form.
It will be a valuable tool in assessing your health care needs.

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