Rebalance LONDON | Naturopathic & Wellness Clinic

ADULT INTAKE FORM

Name _____ **Date** _____

Date of birth _____ (M/D/Y) Sex: _____

Address:_____

Town/City: _____Province: _____ Postal Code:_____

E-mail Address:_____

Telephone number: Home:_____ Work:_____

May we leave messages relating to your visits? Y / N

Emergency contact

Name: _____

Phone number:_____ Relation:_____

How did you hear about Rebalance (We love details so we can understand if our advertising is working ie what did you put in google search):_____

Referred by:_____

Other health care providers you are seeing:

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
(_____)_____	(_____)_____	(_____)_____

Chief Concern:

How long has this condition persisted?_____

Previous Treatment and Results_____

Other health concerns, in order of importance to you:

1. _____
2. _____
3. _____
4. _____

If you are female are you currently pregnant? Yes No (Please circle one)

205 OXFORD ST E. UNIT 109
LONDON, ON N6A 5G6
PH: 519-601-2002

Medical history

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with dates.

_____
_____
_____
_____

Do you have any allergies (medicines, environmental, food etc.)?

_____
_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____
_____
_____
_____

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections

Alcohol—how much/day or week _____

Tobacco—form and amount/day_____

Caffeine—form and amount/day _____

Recreational drugs—what and how often_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc)? Y/N

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____
_____

Describe a typical day's diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Beverages (and total quantity) _____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

How much effort are you willing to put into your health and how are you wanting to approach this visit: Ex. Let's get started with as much as we can today, I'd like to start with some labs and gentle start, lets start with a few small steps that are easy to maintain, I'd prefer to begin with a moderate amount of homework and treatment options?

_____

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Arthritis		Other mental illness	
Asthma		Drug abuse/alcoholism	
Heart disease		Thyroid Condition	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

☐ I don't know my family medical history

Environment

Occupation_____

Hobbies_____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____

_____

How many hours of sleep do you get a night: _____

Do you wake up during the night ? Y / N If so, at what time: _____

How would you describe the emotional climate of your home?

_____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

_____

Is there anything that you feel is important that has not been covered?

_____

_____

Based on our website/your own interests was there any forms of therapy that really caught your eye/you are interested in: Ex acupuncture, diet and lifestyle counselling, nutritional supplements, herbs, B12/Vitamin D shots, IV Vitamin Therapy (Please Circle any/all).

_____

_____