Adult Intake Form

Dr. Jennifer R. Strong BSc., ND
Naturopathic Doctor

Walkerville Chiropractic
1275 Walker Road
Windsor, ON N8Y 4X9
ph: 519 258-7979

Name ___________________________________ Date ________________________

Date of Birth ______________________(M/D/Y) Sex: M / F

Address _________________________________ Town/City ___________________________

Postal Code _____________________ Occupation __________________________

Email Address ____

Phone # (home) __________________ (work) __________________ (cell)______________________

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

How did you hear about Dr. Strong? ____

Emergency Contact

Name:________________________ Phone #:__________________ Relation:________________

Fee Schedule:

Initial visit (1 - 1.5 hours) $150.00
Second Visit (1 hour) $100.00
Following Visits (30 mins.) $55.00

Child (12 & under) $125.00
Second Visit - (1 hour) $80.00
Following Visits (30 mins.) $45.00

Bloodwork (price varies)
Food Sensitivity Testing (IgG) $235
Hair Analysis $90

Female Salivary Hormone Panel $220
Male Salivary Hormone Panel $188

Please note that supplements may be prescribed to you to improve your health condition, and they can be purchased from our in-house dispensary, or elsewhere.

Kindly give 24 hours notice if you need to cancel or reschedule your appointment; otherwise a cancellation fee of $25.00 will be applied to your account.

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.
A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet, lifestyle counselling, clinical nutrition (AKA supplementation), botanical medicine, homeopathy, acupuncture, hydrotherapy, and physical medicine.
I acknowledge that my Naturopathic Doctor, Jennifer Strong, may be required to perform certain diagnostic techniques, such as a physical exam, orthopedic tests, laboratory tests, or history taking.

Signature: ____

Extended health Care:
1) Plan name:___________________ policy #___________________ member ID:___________________
2) Plan name: ___________________ policy #___________________ member ID:___________________

Please note that only Greenshield will be billed directly; all other plans require you to pay up front and then submit the receipt to your respective insurance company.
Please note you are responsible for any fees that are not covered by your extended health care provider, and that these fees are due at the time of consultation.

Main Health Concern:
____
____
____

How long has this condition persisted?____

Previous treatments and results:____

Other health concerns, in order of importance to you:
1.____
2.____
3.____

Other health care providers you are seeing:
1.________________________ 2.____________________________ 3._________________________
________________________ ____________________________ __________________________
(____)___________________ (____)_______________________ (____)___________________

Medical History:
How would you describe your general state of health? Excellent Good Fair Poor
Please indicate your energy level (out of 10, with 10 being the greatest):
in the morning _____ mid day_________ in the evening: ________

Please indicate any serious conditions, illnesses, injuries, or hospitalizations, along with dates:
_______________________________________ ____
_______________________________________ ____
_______________________________________ ____

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

Please list all current medications (over the counter and prescribed), and supplements:
____________________________________ ____
____________________________________ ____
____________________________________ ____

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 frequency: ____

Do you get regular screening tests done by another doctor (pap, blood tests, etc.)? Y / N
Do you have any dietary restrictions?

____

Do you cook your own meals? Y / N # of days per week you eat out: _________
# of bowel movements per day: ________ Do you experience gas/bloating on a regular basis: Y / N

Describe a typical day's diet:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Beverages: ____

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/ alcohol abuse	
Heart disease		Thyroid condition	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes		Other	

- o I don't know my family history.

Do you exercise regularly? Y / N If yes: what form of exercise, how often, and at what intensity?

____
____
____

How many hours of sleep do you get at night? ____________________________________

Do you wake during the night? Y / N If yes, how often? __________________________________

How would you describe the emotional climate of your home?

____
____

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

____
____
____

Are you regularly exposed to toxins and other hazards (work, home, hobbies, etc.)? Please describe.

____
____
____

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

____
____
____