

Adult Intake Form

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

Walkerville Chiropractic
1275 Walker Road
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P: 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 hrs)	\$160.00	Child (12 & under)	\$125.00
Second Visit (1 hr)	\$100.00		
Following Visits (30 mins.)	\$60.00		

Bloodwork (price varies)	Female Salivary Hormone Panel \$220
Food Sensitivity Testing (IgG) \$250	Male Salivary Hormone Panel \$188
Hair Analysis \$90	

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:

If you would like us to bill your extended health care plan on your behalf, please fill out the information here, or provide your card for us to copy.

- 1) Plan name: _____ policy # _____ member ID: _____
- 2) Plan name: _____ policy # _____ member ID: _____

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	

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?
