dr. jennifer hendry-lynn
Naturopathic Doctor

ReAlign Body Mind Chiropractic

Naturopathic Adult Intake Form

Date:________________________

PERSONAL INFORMATION:

<table>
<tr><td>First Name:</td><td colspan="2"></td><td>Last Name:</td><td colspan="2"></td></tr>
<tr><td>Date of Birth:</td><td colspan="3">Year/Month/Day</td><td>Age:</td><td></td></tr>
<tr><td>Address:</td><td colspan="3"></td><td>Unit:</td><td></td></tr>
<tr><td>City:</td><td></td><td>Province:</td><td></td><td>Postal Code:</td><td></td></tr>
<tr><td>Phone #</td><td colspan="2"></td><td>Alternative #</td><td colspan="2"></td></tr>
<tr><td>Email:</td><td colspan="3"></td><td>Preferred Contact:</td><td></td></tr>
<tr><td>Sex:</td><td></td><td>Married?</td><td></td><td># Children:</td><td></td></tr>
<tr><td>Emergency Contact:</td><td colspan="2"></td><td>Emergency Number:</td><td colspan="2"></td></tr>
<tr><td colspan="3">How did you hear about the clinic?</td><td colspan="3"></td></tr>
<tr><td colspan="3">Have you seen a Naturopath in the past?</td><td colspan="3"></td></tr>
<tr><td colspan="3">Occupation and Employer:</td><td colspan="3"></td></tr>
</table>

Current Health Care Providers:

Name	Phone #

What is your MAIN concern for your visit today?

List other health problems you are experiencing:

MEDICATIONS/ SUPPLEMENTS

Please list CURRENT medications and/or supplements

Name	Brand	Dose

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drjen@realignhealth.com
www.realignhealth.com, www.drjennd.com

Please list PAST medications and/or supplements

Name	Brand	Dose

HEALTH HISTORY

Please list all known allergies (include foods, environmental and medications):

Please list previous surgeries/hospitalizations/injuries (Birth-Present):

Incident	Date

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LIFESTYLE

Do you exercise?	
Preferred method of exercise:	
How often do you exercise?	
How is your body temperature on average?	
How much water do you drink daily?	
How would you rate your overall Wellbeing? (0-10)	*(10 is the most)*
How would you rate your STRESS level? (0-10)	*(10 is the most)*
What are your sources of stress?	
How would you rate your ENERGY level daily? (0-10)	*(10 is the most)*
How would you rate your SLEEP? (0-10)	*(10 is the most)*
Which position do you sleep in?	
How many hours of sleep do you get nightly?	
Do you wake feeling refreshed?	
Do you sweat at night?	

Please indicate if you use any of the following: ***(Please check the box)***

Alcohol		Artificial Sweeteners		Coffee		Tea	
Energy Drinks		Recreational Drugs		Soda Pop		Tobacco	
Sedatives		Laxatives		Antacids		NSAIDs/Tylenol	

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PAST MEDICAL HISTORY

Please indicate which of the following you have **NOW (N)** or in the **PAST (P)**

Condition	N	P	Condition	N	P	Condition	N	P
Alcoholism			Gallstones			Ringing in Ears		
Allergies			Gas/Bloating			Scarlet fever		
Anemia			Gout			STI/STD		
Arthritis			Hay fever			Sinusitis		
Asthma			Headaches			Sleep Problems		
Back Pain			Heart Disease			Speech Problems		
Balance Problems			Hemorrhoids			Strep Throat		
Bladder Infections			Hepatitis			Stroke		
Broken Bone			Hypertension			Thyroid Problems		
Cancer			Jaundice			Tonsillitis		
Canker Sores			Measles			Tuberculosis		
Chicken pox			Mental Illness			Varicose Veins		
Cold Hands/Feet			Migraines			Vision Problems		
Constipation			Miscarriage			Warts		
Depression			Mononucleosis			Weight Problems		
Diabetes			Mumps			Whooping Cough		
Diarrhea			Muscle Tension			Yeast Infections		
Ear Infection			Numbness/Tingling			Child Abuse		
Eczema			Parasites			Physical Abuse		
Epilepsy			Pneumonia			Sexual Abuse		
Fainting			Poor memory			Emotional Abuse		
Frequent Urination			Psoriasis			Hair Loss		

FAMILY HISTORY

	Main Health Concerns	Cause of Death
Mother		
Father		
Brother(s)		
Sister(s)		
Children		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

☐*I would like to receive email updates, newsletters or offers. I understand my information will not be sold or distributed. I understand that I can unsubscribe at any time.*

"Thank-you for filling out this lengthy questionnaire, it is a valuable tool in understanding your health history."

Dr. Jennifer Hendry-Lynn ND