NATURAL BALANCE
HEALTH CLINIC

Adult Intake Form

Contact information

Name _____ Date (D/M/Y) _____

Date of birth (D/M/Y) _____ Sex ☐M ☐F

Address _____

City _____ Province _____ Postal Code _____

E-mail _____

Phone numbers Home _____ Work _____ Cell _____

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

Emergency contact

Name _____

Phone number _____ Relation _____

How did you hear about our Clinic? _____

Referred by _____

Other health care providers you are seeing

1) Name, Address, Phone number	2) Name, Address, Phone number	3) Name, Address, Phone number
Name	Name	Name
Address	Address	Address
Phone	Phone	Phone

Chief concern

Describe your concern _____

How long has this condition persisted? _____

Previous treatment and results _____

Other health concerns, in order of importance to you

1 _____

2 _____

3 _____

4 _____

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Medical history

If you are female, are you currently pregnant? ☐ Y ☐ N

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, etc.)?

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

Do you frequently use any of the following?

☐ 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

Diet

Do you have any food allergies or intolerances?

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

Describe a typical day's diet:

Breakfast

Lunch

Dinner

Snacks

Beverages (and total quantity)

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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		Diabetes	
Other			

☐ 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?

_____

_____

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

Are you frequently exposed to animals (work, pets, etc.)? ☐ Y ☐ N

How is your home heated? _____

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

_____

_____

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

_____

_____

Email completed form to info@naturalbalancehealthclinic.com or print and bring to your appointment

P 226.301.4890 | 481 Water Street South, St Marys ON N4X 1A5 | **naturalbalancehealthclinic.com**