ADULT INTAKE FORM
Dr. Sara Henderson, BSc, ND

Name: ___________________________________ Date:__________________________
Date of Birth: ____________________________ Sex: M / F
Postal Code:______________________________ City:__________________________
Address: _________________________________ Occupation:____________________
Email:___________________________________
Phone #(home)_____________________ (work) __________________ (cell)___________________
May we leave messages relating to your visits: Y/N

Emergency Contact
Name:_________________________________ Phone:_________________________
Relation:_______________________________

How did you hear about Dr. Henderson? ____

FEE SCHEDULE	ADULT	CHILD
Consultation (1-1.5 Hours)	$150	$130
Second Visit (45 min)	$100	$80
Follow-up Visits (30 min)	$55	$55

I.V. Therapy $85

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.

EXTENDED HEALTH CARE:

Plan Name:_____________________ Policy #_________________________ member ID _______________
Plan Name: ___________________ Policy#_________________________ member ID _______________

Please note if your insurance allows assignment of benefits we will bill directly, otherwise payment is due at time of visit, and we will provide you with an itemized receipt.
Please note that you are responsible for any fees that are not covered by your extended health care provider.

CONSENT TO DIAGNOSTIC TECHNIQUES AND TREATMENT:
I consent to have diagnostic techniques performed by Sara Henderson, ND as deemed necessary to my case. These include a physical exam, orthopedic tests, laboratory tests, Chinese diagnosis, and history taking.
I consent to have treatment techniques performed as deemed necessary to my case. These include clinical nutrition, botanical medicine, homeopathy, hydrotherapy, traditional Chinese medicine, lifestyle counselling, and spinal manipulation.

Signature:____

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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.____ 4.____

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? Morning ______ Mid day_____ Evening_____

Please indicate any serious conditions, illnesses, injuries, or hospitalizations, along with date:
_______________________________ __________________________________
_______________________________ __________________________________
_______________________________ __________________________________

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/ implant/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 test, etc)? Y/N
Do you have dietary restrictions?
Do you cook your own meals? Y/N # of days per week you eat out: _______
Of bowel movement 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	

Do you exercise regularly? Y/N If yes; what form of excercise, 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.)? Describe
____
____
____

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