131 Union Street East,
Suite #103
Waterloo, ON
N2J 1B8

The Natural Way
HEALTH CLINIC
where healing begins

(T) 519-772-2116
(F) 886-731-5603
www.thenaturalwayclinic.com

CHIROPRACTIC INTAKE FORM

A Multidisciplinary approach to medicine is holistic and seeks to understand all factors that may be affecting your health. Please answer the following questions to the best of your ability.

Name: _____ Date: _____
Date of Birth: _____ (m/d/y) Age: _____ Sex: Male / Female
Mailing Address: _____
City: _____ Postal Code: _____
Email: _____

Telephone		May we leave a message?
Home/Eve:	(____) _____	YES / NO
Work/Day:	(____) _____	YES / NO
Cell:	(____) _____	YES / NO

What is the best way to contact you? HOME / WORK / CELL

☐ **I give my consent to include my e-mail address on the clinic newsletter mailing list**

How did you hear about The Natural Way/ who may we thank?

☐ Google	☐ Website	☐ Preferred Card	☐ Talk
☐ Website	☐ Total Woman Show	☐ Newsletter	☐ Student Care Network
☐ Yellow Pages	☐ Patient Referral: _____	☐ The Natural Way Staff: _____	☐ External Practitioner: _____

☐ Other: _____

Occupation _____
Ethnic Background _____
Marital Status _____

DO YOU HAVE DIFFICULTY CLIMBING STAIRS? YES / NO

EMERGENCY CONTACT
Name: _____
Phone: _____
Relation: _____

PREVIOUS CARE
Have you seen a Naturopathic Doctor before? YES / NO
If **yes**, was it a positive experience? YES / NO
Please explain: _____
Have you had chiropractic treatment before? YES / NO
If **yes**, was it a positive experience? YES / NO
Please explain: _____
Are you interested in preventative maintenance care? YES/ NO
Is your current condition the result of a motor-vehicle accident? YES / NO

Dr. Michelle Cruickshank

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Is your current condition the result of a work-related injury? YES / NO

For women: Is it possible that you are currently pregnant? YES/NO

CHIEF COMPLAINT

What are your health concerns? (Please list in order of importance):

1. _____ 2. _____

3. _____ 4. _____

HEALTH PROFESSIONALS

Please list health professionals from which you currently receive care (ex. Medical Doctor, Specialists, Physiotherapist, Massage Therapist, Naturopathic Doctor, and Chiropractor).

In addition, please circle YES or NO, beside each practitioner, indicating your permission for us to contact each practitioner, as necessary, regarding your case.

Permission for Exchange of Information

1. Name: _____ YES / NO
   Address: _____
   Phone: _____
   Fax: _____
   Type of Practitioner: _____

2. Name: _____ YES / NO
   Address: _____
   Phone: _____
   Fax: _____
   Type of Practitioner: _____

What other types of treatment or health-care practitioners have you consulted for treatment of these health issues?

_____

List any lab work, x-rays, or consultations with specialists related to your condition (include dates):

_____

Please provide information regarding the following health tests, if applicable:

Test	Date	Normal	Abnormal
Blood Pressure			
Bone Density			
MRI/CT Scan			
Nerve Conduction Studies			

MEDICATIONS

List any **prescribed** medications you are currently taking along with doses and the date this medication was started:

Name of Medication:	Date started:	Dose:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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List any **over-the-counter** medications, dietary supplements, or herbs you are currently taking:

Name:	Date started:	Dose:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please List Any Drug, Food, or Environmental Allergies:

_____

Please circle (o) any condition/symptom currently causing you problems. Please underline conditions/symptoms that were a problem in the past:

GENERAL SYMPTOMS
Loss of consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of sleep
Numbness
Pain
Tingling
Nervousness
Weight loss
Eating disorder
Anemia

EMOTIONAL
Depression
Anxiety
Mood swings/irritability
Phobia
Alcohol/Drug Abuse

MALE REPRODUCTIVE
Testicular mass
Prostate trouble
Hernia

FEMALE REPRODUCTIVE
Painful menstruation
Excessive flow
Hot flashes
Cramps/backache
Vaginal discharge/itching
Yeast infections
Ovarian cysts/PCOS
Endometriosis
Fibroids
Swollen breasts
Lumps in breasts
Nipple discharge

GASTROINTESTINAL
Bloating
Poor appetite
Indigestion
Heart burn/acid reflux
Excessive hunger
Belching or gas
Bad breath
Nausea
Vomiting blood
Abdominal pain/cramps over stomach
Constipation
Diarrhea
Hemorrhoids
Gall bladder trouble
Ulcer
Diabetes

CARDIOVASCULAR
High cholesterol
High blood pressure
Low blood pressure
Bleeding disorder
Pain over heart
Stroke
Varicose veins
Swelling of ankles
Poor circulation
Heart or blood disease
Angina
Palpitations

E.E.N.T
Blurred vision
Impaired vision
Double vision
Eye redness
Eye pain
Eye itching
Eye discharge
Eye dryness
Floaters
Deafness
Earache
Ringing/buzzing in ears
Ear discharge
Wax build-up
Frequent ear infections
Allergies
Sleep apnea
Post nasal drip
Loss of smell
Nasal polyps
Frequent colds
Frequent sore throats
Sinus infection
Enlarged glands/nodes
Enlarged thyroid
Speech problems
Difficulty swallowing
Cavities
Gum problems

MUSCLES & JOINTS
Stiff neck
Back ache
Swollen joints
Foot trouble
Shoulder pain
Arm/forearm pain
Elbow pain
Wrist pain
Hand pain
Arthritis
Weakness

RESPIRATORY
Asthma
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing

SKIN
Rashes
Itching
Dryness
Eczema
Psoriasis
Hives
Boils
Dryness
Lumps
Hair loss
Nail change

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PAST MEDICAL AND HEALTH HISTORY

Please list any past serious injuries or illnesses, including when they occurred and any complications that you may have experienced:

_____

Please list any hospitalizations or operations, including why, when they occurred and any complications that you may have experienced:

_____

Have you ever experienced, or are you currently experiencing any of the following:

Night sweats YES / NO

Significant or unexplained weight changes YES / NO

Pain that awakes you from sleep YES / NO

Date of last physical exam: _____

FAMILY HEALTH HISTORY

Please indicate if any family members (parents, siblings, grandparents), have had or have the following conditions:

- □ Diabetes
- □ Heart Disease
- □ High Blood Pressure
- □ High Cholesterol
- □ Stroke
- □ Cancer
- □ Seizures
- □ Kidney Disease
- □ Thyroid Dysfunction
- □ Asthma
- □ Allergies
- □ Arthritis
- □ Autoimmune disease
- □ Osteoporosis
- □ Depression
- □ Schizophrenia
- □ Alcohol/Drug abuse
- □ Other Mental Illness
- □ Other

ACTIVITY/EXERCISE

How active are you? _____ Very _____ Moderately _____ Sedentary

Do you have any physical problems that limit your activity? Yes / NO

If **yes**, please describe: _____

If you are not yet engaged in a routine exercise program, are you interested in starting? YES / NO

SLEEP/REST

Number of hours of sleep per night? _____

LIFESTYLE

*Do you currently smoke cigarettes? YES / NO

Do you use any form of Recreation drug? YES / NO

If **yes,** please indicate which drug and how often: _____

Do you drink alcoholic beverages? YES / NO

If **yes,** please estimate how much: _____ wine (glasses/wk);_____ beer (glasses/wk);_____ liquor (glasses/wk)

Do you drink caffeinated beverages? YES / NO

If **yes,** please indicate the equivalent number of regular sized cups per day:

_____ coffee (cup/day); _____ tea (cup/day); _____ cola (glasses/day)

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Is there anything else that you would like to mention that has not been covered or feel it is important for me to be aware of? _____

By signing this form, I certify that all of the information provided herein is complete and accurate to the best of my knowledge. If there are any changes to this information I will notify The Natural Way Health Clinic in a timely manner. I give permission to be contacted by The Natural Way Health Clinic as indicated in this form and for messages to be left at the indicated numbers. I give permission for an exchange of medical information to occur with those practitioners indicated within this form. I give permission for exchange of medical information to occur with other practitioners of The Natural Way Health Clinic, as needed for the purpose of consultation.

Please list exceptions: _____

Name of Patient or Guardian: _____

Signature: _____ **Date:** _____

Dr. Michelle Cruickshank License# : _____

Signature:_____ Date: _____