radiance from within
WELLNESS

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North River
CHIROPRACTIC

CLIENT INTAKE FORM

Please fill out this form as honestly, fully and completely as possible and bring with you to your scheduled appointment.

Name			
Address			
City		Zip	
Phone		Email	
Occupation		Hours per week	
DOB		Gender	
Relationship Status			

MEDICAL HISTORY

Please indicate whether you or any relatives have been diagnosed with any medical condition. *relatives include: Parents, Grandparents, Siblings.

Illness/Disease	Self: Age Diagnosed	Specify Family & Age Diagnosed	Describe

List all medications and supplements you are currently taking, along with the reason for use, and dosage:

Medication/Supplement/OTC	Reason	Dosage/Duratiom

List any known allergies (food, environmental, medications)

LIFE

Time I go to bed and time I wake up:

Is waking up difficult or do you feel rested?

Do you struggle to fall asleep or stay asleep?

Do you experience dips or slumps in energy during the day?

Do you get 30 minutes of movement in at least 3 times a week?

DIGESTIVE HISTORY

Do you associate any digestive symptoms with eating certain foods? Please explain.

How often do you have a bowel movement?

Please indicate how often you experience the following symptoms:

Heartburn	Often	Sometimes	Rarely
Gas	Often	Sometimes	Rarely
Bloating	Often	Sometimes	Rarely
Stomach Pain	Often	Sometimes	Rarely
Nausea/Vomiting	Often.	Sometimes	Rarely
Diarrhea	Often	Sometimes	Rarely
Constipation	Often	Sometimes	Rarely

DIET HISTORY

Do you have diet restrictions or limitations for any reason (health, cultural, religious, or other)? Please list any food allergies, sensitivities, or intolerances.

Are you currently on a special diet? Ie. Low-carb, gluten-free, FODMAP, Paleo etc

Please indicate the beverages you drink, and how often you drink them.

	Daily Amount
Water	
Tea: What type?	
Coffee	
Milk Alternative: Type_____	
Soda: Regular or Diet	
Energy Drinks	

The nutrition/eating habits that are most challenging for me:

The nutrition/eating habits that I am most pleased with:

List any food cravings you may have.

What foods do you eat most often (list top five):

Are there any foods you are not willing to give up?

Food you hate or will not eat?

A typical day of food I consume looks like:

Breakfast: **Lunch:** **Dinner:**

Snacks:

CONFIDENTIALITY AGREEMENT & INFORMED CONSENT

I,_____, take full responsibility for my health, progress and healing on my suggested nutritionand supplementation plan. I acknowledge that changes in health take time and I am ready for a plan that is not about quick fixes but rather about smaller changes over a period of time that lead to sustainable change. All information shared within this professional relationship will be held in strict confidence. Information may be shared at the client's request with a medical doctor, naturopathic physician or any other healthcare practitioner the client deems to be appropriate.

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. Any activity or program may have inherent risks which may be relative to your state of health, fitness, awareness, care and skill to which you conduct yourself.

You agree to inquire about any activities or suggestions with which you are not familiar, and provide any information which may limit your participation in suggested activities. Results and changes in your general health and wellness may vary depending on medical conditions, medications, and accuracy in following suggested guidelines. Never reduce or eliminate physician prescribed medications without the direction of a medical care provider.

Name (print) : _____ Date: _____

Signature (guardian if under 18): _____

Name (guardian if under 18): _____
(please print)