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**ADULT INTAKE FORM**

Please complete as thoroughly as possible and return to front desk when finished. A complete form is needed before the initial visit.

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
City: \_\_\_\_\_  
Telephone No: Home: \_\_\_\_\_ Work: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Would you like to be a part of our monthly health tip email list? Y/N  
May we leave messages related to your visits? Y/N

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M/F  
Education: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Marital Status: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_  
Phone No: \_\_\_\_\_ Relation: \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

**CURRENT HEALTH CARE**

Are you currently receiving health care? Y/N  
Please list all current health care practitioners you are currently seeing (Chiropractor, MD, Physiotherapist etc.)

Name: _____	Name: _____	Name: _____
Phone: _____	Phone: _____	Phone: _____
Fax: _____	Fax: _____	Fax: _____
Name: _____	Name: _____	Name: _____
Phone: _____	Phone: _____	Phone: _____
Fax: _____	Fax: _____	Fax: _____

Do you get regular screening tests done? Y/N If so, which ones? \_\_\_\_\_

If no, when did you last receive medical care/screening tests? \_\_\_\_\_

Do you have any know contagious disease at this time? Y/N If so, what is it? \_\_\_\_\_

If you are a female, are you currently pregnant? Y/N

What are your most important health concerns? List as many as you can in order of importance.

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

**GENERAL**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ Maximum Weight: \_\_\_\_\_

When during the day is your energy the best? \_\_\_\_\_ Worst? \_\_\_\_\_

Main interests and hobbies: \_\_\_\_\_

Exercise: Y/N If so, how often and what type? \_\_\_\_\_

Watch TV: Y/N If so, how many hours? \_\_\_\_\_

Read: Y/N If so, how many hours? \_\_\_\_\_

Do you have a religious or spiritual practice? Y/N If so, what type? \_\_\_\_\_

How many hours do you sleep each night? \_\_\_\_\_ Do you wake rested? Y/N

Do you sleep well? Y/N If not, is sleep something you would like to improve? Y/N

How would you describe your general state of health? Excellent Good Fair Poor

What behaviours or lifestyle habits that you engage in regularly do you believe are supporting your health? \_\_\_\_\_

What behaviours or lifestyle habits that you engage in regularly do you believe are negatively impacting your health? \_\_\_\_\_

**STRESS**

How stressful is your job on a scale of 1 to 10 (10 being the most stressed)? 1 2 3 4 5 6 7 8 9 10

How stressful are other aspects of your life on the same scale? 1 2 3 4 5 6 7 8 9 10

How do you handle these stresses? \_\_\_\_\_

**TYPICAL FOOD INTAKE**

Briefly describe a typical day's diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages (Quantity): \_\_\_\_\_

Do you have any dietary restrictions? (vegan etc) \_\_\_\_\_

**PAST MEDICAL HISTORY**

Weight at birth? \_\_\_\_\_

Please circle if you had any of the following as a child:

Rheumatic fever          Diphtheria          Scarlet fever          Chicken pox  
German Measles          Measles          Mumps

Past Hospitalizations / Surgeries / Imaging

What hospitalizations, surgeries, x-rays, CAT scans, MRIs, EEG, ECG testing have you had? Please indicate why each was done and in what year.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please circle if you have had any of these conditions in the past.

- |             |                     |                             |                 |                |
|-------------|---------------------|-----------------------------|-----------------|----------------|
| Abscesses   | Epilepsy            | Malaria                     | Rheumatic fever | Typhoid        |
| Alcoholism  | Gallstones          | Measles                     | Rubella         | Venereal warts |
| Allergies   | Gonorrhea           | Migraines                   | Scarlet fever   | Whooping cough |
| Amnesia     | Gout                | Miscarriages                | Sexual abuse    | Worms          |
| Arthritis   | Hay fever           | Mononucleosis               | Skin disease    | Yellow fever   |
| Asthma      | Heart disease       | Mumps                       | Strep throat    |                |
| Cancer      | Hepatitis           | Parasites                   | Sinusitis       |                |
| Chicken Pox | Herpes              | Pelvic Inflammatory Disease | Stroke          |                |
| Cold Sores  | High blood pressure | Peritonitis                 | Syphilis        |                |
| Depression  | Influenza           | Pleurisy                    | Thyroid disease |                |
| Diabetes    | Kidney disease      | Pneumonia                   | Tonsillitis     |                |
| Emphysema   | Leukemia            | Prostatitis                 | Tuberculosis    |                |

Other: \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

What is your family heritage? \_\_\_\_\_

Do you or anyone in your family have a history of any of the following? Please circle and say who.

- |                     |                    |                       |
|---------------------|--------------------|-----------------------|
| Cancer              | Diabetes           | Arthritis             |
| Kidney disease      | Epilepsy           | Anemia                |
| Heart disease       | Stroke             | Hives                 |
| Asthma              | Hay fever          | Tuberculosis          |
| High Blood Pressure | Glaucoma           | Mental Illness        |
| Osteoporosis        | Autoimmune disease | Drug Abuse/Alcoholism |

Any other relevant family history not listed above? \_\_\_\_\_

**ALLERGIES**

Please list:

Are you sensitive to any foods? Y/N If yes, please list. \_\_\_\_\_

Are you sensitive to any drugs? Y/N If yes, please list. \_\_\_\_\_

Are you sensitive to any chemicals or environments? Y/N If yes, please list. \_\_\_\_\_

**ENVIRONMENT**

Are you exposed to any toxins or other hazards on a daily basis? Y/N If yes, explain. \_\_\_\_\_

**CURRENT MEDICATION**

Please list all current medication including prescriptions, over the counter medications, vitamins and/or supplements that you may be taking. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list all PAST medication. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

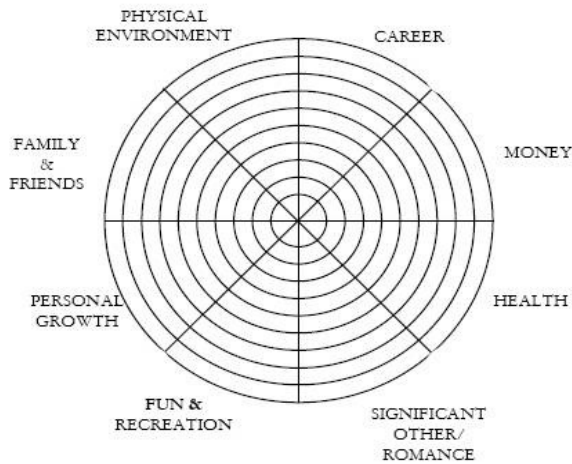
Do you regularly use any of the following? If yes, how often/how many?

- Advil/Ibuprofen Y/N \_\_\_\_\_
- Tylenol/Acetaminophen Y/N \_\_\_\_\_
- Aspirin Y/N \_\_\_\_\_
- Caffeine Y/N \_\_\_\_\_
- Tobacco Y/N \_\_\_\_\_
- Alcohol Y/N \_\_\_\_\_
- Recreational Drugs Y/N \_\_\_\_\_
- Laxatives Y/N \_\_\_\_\_
- Diet Pills Y/N \_\_\_\_\_
- Oral Birth Control Pill Y/N \_\_\_\_\_
- Antacids Y/N \_\_\_\_\_
- Sedatives Y/N \_\_\_\_\_

What are your ultimate health goals? \_\_\_\_\_  
 \_\_\_\_\_

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

**BALANCE WHEEL**



Shade your level of satisfaction in each area as it relates to you.

For example, if you are 20% satisfied with your career then shade the first two levels of the career section.

Repeat for all areas.

Start in the centre and radiate outwards.

This exercise will help to determine the areas of your life which need balancing in order to create harmony within your life.