Shavone Doherty, ROHP
Telephone: 1-226-748-8427
Email: shavone.doherty@gmail.com
Website: www.dohertydynamic.com

CLIENT INTAKE FORM

Name: _____Date: _____ Date of Birth: _____

Address: _____

E-mail: _____ Occupation: _____ Age: _____

Telephone Home: _____ Work: _____ Mobile: _____

Emergency Contact: _____ #: _____ Relation: _____

Do you have health insurance with flexible health coverage? □ Y □ N

How did you hear about Shavone Doherty? (Referral, online, media?) _____

Stay up to date with Shavone Doherty, including cooking classes, newsletter, and clinic promotions. Please include me on the clinic email list. □ Y □ N

HEALTH INFORMATION

Please list past experiences with other health practitioners (i.e. Chiropractor, Naturopath, Therapist, Homeopath):

_____

_____

List your health concerns (physical, emotional, psychological) in order of priority including the date of onset.

	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Please list your past most stressful experiences:

1. _____	Age: _____
2. _____	Age: _____
3. _____	Age: _____

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SUPPLEMENTS & MEDICATIONS

Please list all **current** vitamins/minerals, herbs, and homeopathic remedies.

Supplement	Dose/day	How long?	Reason for supplement
1.			
2.			
3.			
4.			

Please list all **current** medications:

Medication	Dose/day	How long?	Reason for medication

In the last 10 years, how many courses of antibiotics have you taken? _____

Please list any past surgeries with the approximate dates

1. _____ _____

2. _____ _____

3. _____ _____

Please list any injuries (broken bones, sprains, accidents) with the approximate dates.

1. _____ _____

2. _____ _____

3. _____ _____

List all dental work (root canals, mercury fillings/removals, bridge, implants) with dates.

1. _____ _____

2. _____ _____

3. _____ _____

FAMILY HISTORY

Indicate and include the **relation** of any family members that have had any of the following:

□ Alcoholism _____ □ Allergies _____ □ Alzheimer's disease

_____ □ Arthritis _____ □ Asthma _____ □ Cancer

_____ □ Depression _____ □ Diabetes _____
□ Drug abuse _____ □ Heart disease _____

□ High blood pressure _____□ Osteoporosis _____

□ Thyroid condition _____ □ Other condition (specify) _____

Is there a life situation, particular time, work condition or season where your concerns are aggravated or improved? _____

Is there anything about your present or past relationship, which is disturbing to you and possibly affecting your health? _____

ENVIRONMENTAL ASSESMENT

RESIDENTIAL

Have you lived near an industry that emits waste into the air or water? □ Y □ N
What type of pollution and how long? _____

Have you ever lived in house built before 1978? □ Y □ N

Have you ever lived on or adjacent to agricultural land? □ Y □ N

Have you ever lived in a home where mould is a problem? □ Y □ N

Have you ever lived in a home with a water leak/damage? □ Y □ N

Are pesticides used inside or outside the home? □ Y □ N

Are there animals in the home? What kind? □ Y □ N

Do you have a water filtration system? What kind? □ Y □ N

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LIFTSTYLE

Do you regularly go to the salon for hair treatments (colouring)? □ Y □ N

Do you ever get acrylic fingernails? □ Y □ N

Do you use perfumes, scented soaps, and detergents? □ Y □ N

Have you ever use recreational drugs? □ Y □ N What compounds? _____

Do you consume alcohol? □ Y □ How much? _____

Do you chew gum? □ Y □ N

Do you or have you ever smoked? □ Y □ N How long? _____

Have you lived with others who smoke? □ Y □ N How long? _____

Do you exercise? □ Y □ N What type & how often? _____

Do you breathe deeply or shallow? _____

Do you take time to relax or meditate? □ Y □ N How often? _____

Do you work shifts? □ Y □ N

Do you work irregular hours? □ Y □ N

DIET

Do you have a strong appetite? □ Y □ N

Are you generally thirsty? □ Y □ N

How much water do you drink per day? What type? _____

Do you drink pop? □ Y □ N Is it regular or diet? _____

Do you use artificial sweetener? □ Y □ N

Do you drink coffee? □ Y □ N How often? _____

Do you consume white sugar? □ Y □ N _____

Do you use table salt? □ Y □ N How much? _____

List any particular food **cravings**: _____

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List your **favourite** foods: _____

What tastes do you prefer? □ Bitter □ Sweet □ Salty □ Spicy

Do you eat meat? □ Y □ N What type and how much? _____

Do you have regular eating patterns? □ Y □ N Why not? _____

Give a general idea of the foods you eat:

For Breakfast: _____

For Lunch: _____

For Dinner: _____

For Snacks: _____

Number of bowel movements per day: _____

What bowel type best describes yours?

□ Strained □ Loose □ Soft □ Hard □ Very thin □ Diarrhea □ Explosive

□ Constipation □ Undigested food □ Blood in stool

ELECTROMAGNETIC

Does you use a cell phone? □ Y □ N How many hours per day? _____

Do you talk on your cell phone against your ear or by speaker/headphone? _____

Where do you carry your cellphone (chest pocket, purse)? _____

Do you use a laptop/tablet on your lap? □ Y □ N

How many hours a day do you spend on a wireless device? _____

Do you live close of a cell tower? □ Y □ N

Do you use a cordless phone at home/work? □ Y □ N

Do you use a microwave oven? □ Y □ N