Dr. Jenny Henderson, HBSc, ND
Momentum Chiropractic & Sports Therapy
15165 Yonge St, unit 2
Aurora, ON, L4G 1M1
905-727-3029

ADULT NEW PATIENT INTAKE FORM

Name:_____ Date of birth: mm / dd / yyyy Age:_____

Address:_____

Phone numbers
Home_____ Cell_____ Email: _____

Do you consent to receive occasional emails from Dr. Jenny and/or Momentum Therapy? ☐Yes ☐No

Gender: _____

Occupation
Current: _____ Occupations in the past: _____

Emergency contact
Name: _____ Phone number: _____ Relation: _____

Family doctor
Name: _____ Address: _____

Phone number: _____

May Dr. Jenny communicate with your family doctor about your treatments and progress? ☐Yes ☐No

Other health care providers
Name: _____ Specialty: _____ Phone number: _____

How did you hear about Dr. Jenny? _____

Please describe your primary health concerns

_____

_____

_____

Which therapies have you already tried? Have they helped?

_____

_____

_____

Please list any other health concerns you may have

_____

_____

_____

Personal medical history

Height_____ Weight_____

Please list any illnesses and medical conditions you currently have or have had in the past, dates, and how they were diagnosed

_____

_____

_____

_____

Are you currently pregnant? ☐ No ☐Yes How far along? _____

Have you ever been hospitalized? ☐ No ☐Yes: _____

Have you ever had any surgeries? ☐ No ☐Yes: _____

What medications do you take (including over the counter and birth control)?

_____

_____

What supplements/vitamins do you take?

_____

_____

Do you have any allergies and/or sensitivities (including food, environmental, and medical)?

☐ No ☐Yes: _____

Do you get regular screening tests done with another doctor? ☐ No ☐Yes

Family medical history

Please indicate which conditions are present in your family, and which family member has the conditions in relation to you (eg. father, sister, maternal grandmother, etc)

☐ Check here if you do not know your family history

✓		✓	
	Alcoholism/addiction		Heart disease
	Allergies		High blood pressure
	Anemia		High cholesterol
	Arthritis		Kidney disease
	Asthma		Liver disease
	Cancer		Osteoporosis
	Diabetes		Stroke
	Eczema/psoriasis		Tuberculosis
	Epilepsy		Depression/other mental illness
	Headaches/migraines		

Any other conditions that have not been listed? _____

Lifestyle

Do you exercise regularly? ☐ No ☐Yes What do you do? _____

What are you hobbies and pastimes? _____

Do you smoke tobacco? ☐ No ☐Yes How much? _____

Do you use recreational drugs? ☐ No ☐Yes Which ones? _____

Do you consume alcohol? ☐ No ☐Yes How often and how much? _____

Are you sexually active? ☐ No ☐Yes

Please describe the stress levels in your life, and how you cope with stress

_____

_____

_____

Please describe your home life

_____

_____

Have you experienced any significant physical and/or emotional trauma, grief, or loss recently or in the past?

_____

_____

_____

Review of body systems

*Please place a check mark ✓ beside any issues you currently experience, or a **P** beside issues that you have had in the past*

General ☐Unintentional weight loss ☐Unexplained weight gain ☐Fatigue ☐Weakness ☐Poor sleep/insomnia ☐Sweating and/or night sweats	**Skin and hair** ☐Rashes/hives ☐Acne ☐Discoloration ☐Dryness ☐Eczema ☐Psoriasis ☐Itching ☐Temperature changes ☐Moles ☐Thinning/losing head hair ☐Thinking/losing body hair	**Head** ☐Headaches ☐Head injury ☐Dizziness
Emotional ☐Depression ☐Anxiety ☐Mood swings ☐Fears/phobias ☐Substance abuse ☐Eating disorder		**Ears** ☐Impaired hearing ☐Earache ☐Discharge ☐Frequent ear infections ☐Ringing
Eyes ☐Impaired vision ☐Glasses/contacts ☐Eye pain ☐Redness ☐Itchiness	**Nose and sinus** ☐Impaired sense of smell ☐Frequent colds/ sinus infections ☐Congestion ☐Itching ☐Discharge	**Mouth and throat** ☐Frequent sore throat ☐Tonsillitis or laryngitis ☐Hoarseness ☐Canker sores ☐Cold sores

Eyes continued
☐Discharge
☐Dry eyes
☐Blurring/double vision
☐Glaucoma
☐Cataracts

Nose continued
☐Nose bleeds
☐Post-nasal drip
☐Polyps or deviated septum

Mouth and throat continued
☐Loss of taste
☐Dental/gum issues
☐Jaw pain
☐Goiter
☐Swollen glands

Gastrointestinal
☐Change in appetite
☐Change in thirst
☐Trouble swallowing
☐Heartburn
☐Indigestion
☐Abdominal pain
☐Nausea/vomiting
☐Belching
☐Ulcers
☐Excessive gas
☐Bloating
☐Constipation
☐Diarrhea
☐Changes in stool quality
☐Changes in stool frequency
☐Liver disease
☐Gall bladder disease
☐Worms/parasites
☐Hernias
☐Prolapse
☐Rectal bleeding
☐Polyps

Cardiovascular
☐Chest pain/angina
☐Heart disease
☐Palpitations/fluttering
☐Heart attack
☐Stroke
☐High blood pressure
☐Heart murmurs
☐Rheumatic fever

Respiratory
☐Asthma
☐Wheezing
☐Sleep apnea
☐Cough
☐Phlegm
☐Bronchitis
☐Pneumonia
☐Shortness of breath
☐Emphysema
☐Coughing up blood
☐Tuberculosis

Female reproductive
Age of first period _____
Length of cycle _____
Length of period _____
☐Irregular cycle
☐Very short or very long cycle
☐No periods
☐Bleeding between periods
☐Heave periods
☐Scanty periods
☐Painful periods
☐PMS
☐Breast tenderness
☐Ovarian cysts
☐Uterine fibroids
☐Vaginal discharge
☐Vaginal itching
☐STIs
☐Yeast infections
☐Infertility/trouble conceiving
☐Trouble lactating/breastfeeding
☐Menopause
☐Pregnancies _____
☐Abortions _____
☐Miscarriages _____

Breast
☐Lumps
☐Pain
☐Nipple discharge

Endocrine
☐Heat/cold intolerance
☐Thyroid problems
☐Changes in thirst/hunger
☐Diabetes
☐Blood sugar problems
☐Hormonal problems

Urinary
☐Pain on urination
☐Difficult urination
☐Frequent urination
☐Waking up to urinate
☐Frequent infections
☐Blood in the urine
☐Urgency
☐Incontinence
☐Kidney stones
☐Kidney disease

Male reproductive
☐Hernia
☐Testicular mass
☐Testicular pain
☐Sexual difficulties
☐Discharge
☐Sores/rashes
☐STIs
☐Infertility

Peripheral circulation
☐Deep leg pain
☐Cold hands/feet
☐Varicose veins
☐Swollen hands/ankles/feet
☐Extremity numbness/coldness
☐Extremity ulcers
☐Anemia
☐Easy bruising

Neurological
☐Fainting
☐Seizures
☐Paralysis
☐Numbness
☐Tingling
☐Memory loss
☐Balance/gait problems
☐Difficulty with movement

Musculoskeletal
☐Joint pain/swelling
☐Stiffness
☐Muscle weakness
☐Muscle pain
☐Muscle spasms/cramps
☐Back pain
☐Broken bones