ReAlign Body Mind Chiropractic
DR. MARK GUKER

2445 Eagle St. North, Suite 1
Cambridge, ON, N3H4R7
Tel. (519) 650-1630
Fax. (519) 650-5277
www.realignhealth.com

Dr. Mark Guker, DC
Dr. Jennifer Hendry-Lynn, ND

Nutritional Detoxification Questionnaire

Patient Information

PATIENT NAME		SEX ☐ Male ☐ Female	DATE OF BIRTH (YEAR/MONTH/DAY) AGE _ _ _ _/_ _/_ _ ___
ADDRESS: Number and Street Apt#		City/Town	Province Postal Code
TELEPHONE: Home: ( )		Work: ( )	Cell: ( )
OCCUPATION		EMAIL	
MARITAL STATUS	SPOUSE/PARTNER NAME		NUMBER OF CHILDREN
IF UNDER 18 YEARS OF AGE: Parent/Guardians Name			Emergency Contact Telephone
HOW DID YOU HEAR ABOUT THE CLINIC			
CURRENT HEALTH CARE PROVIDERS: 1)_____PHONE #_____ 2)_____PHONE #_____ 3)_____PHONE #_____			

Current Health Status

LIST YOUR TOP 3 HEALTH CONCERNS

1)_____

2)_____

3)_____

WHAT ARE YOUR EXPECTATIONS FROM THIS DETOXIFICATION PROGRAMME?

_____

_____

HAVE YOU EVER PARTICIPATED IN A DETOXIFICATION OR CLEANSE BEFORE? IF YES, WHAT HAVE YOU DONE?

_____

_____

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HOW WOULD YOU RATE YOUR CURRENT HEALTH? (CIRCLE THE NUMBER THAT BEST APPLIES TO YOU)

I'VE NEVER FELT WORSE 0----1----2----3----4----5----6----7----8----9----10 WOW! I FEEL GREAT

Medical History

CURRENT MEDICATIONS/SUPPLEMENTS

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PLEASE LIST ANY CURRENT DIAGNOSED CONDITIONS

_____
_____
_____
_____

LIST AND DESCRIBE ANY SURGERY, AUTO ACCIDENTS, ACCIDENTS AND FALLS (INCLUDE MONTH AND YEAR) IN YOUR LIFETIME:

_____
_____
_____
_____
_____
_____
_____
_____

DO YOU HAVE ANY KNOWN ALLERGIES? (Environmental, Food, Medications, Etc.)

_____
_____
_____

DO YOU HAVE THE PRESENCE OF:
PINS: _____ WIRES: _____ ARTIFICIAL JOINTS: _____ SPECIAL EQUIPMENT: _____ SCREWS: _____
PLATES: _____ PACEMAKER: _____ OTHER:_____

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Lifestyle

HOW MUCH OF THE FOLLOWING DO YOU CONSUME DAILY?

COFFEE/TEA: _____ CUPS CIGARETTES: _____ PACKS ALCOHOL: _____ DRINKS WATER: _____ CUPS

SODA : _____ CANS TOBACCO: _____ PACK RECREATIONAL DRUGS: ____

HOW MANY MEALS DO YOU EAT OUT WEEKLY?

LESS THAN 3_____ BETWEEN 3 AND 8_____ OVER 9_____

DO YOU MAKE YOUR OWN MEALS? YES_____ NO_____

DO YOU HAVE ANY DIETARY RESTRICTIONS?
VEGETARIAN_____ VEGAN_____ CELIAC_____ OTHER_____

ARE YOU SATISTIFED WITH YOUR DIET? YES_____ NO_____

DO YOU EXERCISE REGULARLY? YES_____ NO_____ HOW OFTEN?_____/WEEK

HOW WOULD YOU RATE YOUR SLEEP?

AWFUL! I DON'T SLEEP! 0----1----2----3----4----5----6----7----8----9----10 AMAZING! COULDN'T BE BETTER!

Please check all that apply to you within the last 6 months

ALCOHOLISM		GALLSTONES		RINGING IN EARS	
ACNE		CHRONIC INFECTIONS		FREQUENT COLDS	
ALLERGIES		GAS/BLOATING		EATING DISORDER(S)	
ANEMIA		GOUT		HEARTBURN	
ARTHRITIS		HAY FEVER		SINUSITIS	
ASTHMA		HEADACHES		SLEEP PROBLEMS	
BACK PAIN		HEART DISEASE		SPEECH PROBLEMS	
FATIGUE		ITCHING		WEIGHT LOSS/GAIN	
BALANCE PROBLEMS		HEMORRHOIDS		STREP THROAT	
BLADDER INFECTIONS		HEPATITIS		STROKE	

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BROKEN BONE		HIGH BLOOD PRESURE		THYROID DISEASE	
CANCER		JAUNDICE		TONSILLITIS	
INCONTINENCE		SEXUALLY TRANSMITTED DISEASES		MENSTRUAL IRREGULARITIES	
CANKER SORES		MEASLES		TUBERCULOSIS	
CHICKEN POX		MENTAL ILLNESS		VARICOSE VEINS	
COLD HANDS/FEET		HEADACHES		VISION PROBLEMS	
CONSTIPATION		MISCARRIAGE		WARTS	
DEPRESSION		MONONUCLEOSIS		WEIGHT PROBLEMS	
DIABETES		MUMPS		WHOOPING COUGH	
DIARRHEA		MUSCLE TENSION		YEAST INFECTIONS	
EAR INFECTION		NUMBNESS/TINGLING		ABUSE	
ECZEMA		PARASITES		PREGNANT	
EPILEPSY		PNEUMONIA		BREASTFEEDING	
FAINTING		POOR MEMORY		SWELLING	
FREQUENT URINATION		PSORIASIS		HIGH CHOLESTEROL	

Thank-you for filling out this questionnaire!

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Informed Consent and Terms of Acceptance

IN ORDER FOR THE DOCTORS TO MAKE A DETERMINATION ON THE SUITABILITY FOR CARE, I ACKNOWLEDGE AND UNDERSTAND THAT I MUST COMPLETE A THOROUGH INITIAL ASSESSEMENT AND SPINAL HEALTH EVALUATION, WHICH MAY INCLUDE A DIAGNOSTIC RADIOGRAPHIC EXAMINATION IF CLINICALLY INDICATED. I DO HEREBY REQUEST AND CONSENT TO THE PERFORMANCE OF SUCH AN EVALUATION BY THE DOCTORS, OR ANY PARTY AUTHORIZED TO DO SO BY THAT DOCTOR(S).

I, ACKNOWLEDGE THAT I AM VOLUNTARILY PARTICIPATING IN THIS SUPERVISED NUTRITIONAL DETOXIFICATION PROGRAM. I UNDERSTAND THIS PROGRAM IS INTENDED TO PROVIDE THE TOOLS NECESSARY TO AID MY BODY IN ITS DETOXIFICATION PROCESS. DURING THE DETOXIFICATION PROGRAM I AGREE TO CONTINUE TAKING ALL MY CURRENT PRESCRIBED MEDICATIONS UNLESS MODIFIED BY THE PRESCRIBING PHYSICIAN.

I AGREE TO DISCLOSE AND/OR CONSENT TO RELEASE ALL INFORMATION, INCLUDING THAT KNOWN BY OTHER HEALTH PROVIDERS, WHERE THAT INFORMATION MIGHT AFFECT MY RESPONSE TO THE DETOXIFICATION PROGRAM. I UNDERSTAND AND ACKNOWLEDGE THAT REALIGN HEALTH, ITS DIRECTOR, CLINICAL AND ADMINISTRATIVE STAFF ARE NOT RESPONSIBLE FOR POSSIBLE ADVERSE OR SIDE EFFECTS OF THE DETOXIFICATION PROGRAM AND RELEASE THEM FROM ANY LIABILITY FOR MY HEALTH THAT MAY ARISE BECAUSE OF MY PARTICIPATION IN THIS DETOXIFICATION PROGRAM.

THIS NUTRITIONAL DETOXIFICATION PROGRAM IS NEITHER USED TO ASSESS YOUR CURRENT HEALTH STATUS OR TO DIAGNOSE ANY POTENTIAL ILLNESSES AND AILMENTS YOU MAY BE SUFFERING FROM AT THIS TIME. DURING THIS NUTRITIONAL DETOXIFICATION PROGRAM, NO TREATMENT WILL BE PRESCRIBED OUTSIDE THE DETOXIFICATION PROGRAM ITSELF. AT THE END OF THE NUTRITIONAL DETOXIFICATION PROGRAM, SHOULD YOU SEEK AN ASSESSMENT OF YOUR HEALTH FROM THE CHIROPRACTOR, NATUROPATHIC DOCTOR, AND/OR REGISTERED MASSAGE THERAPIST, COMPLETION OF THE EACH RESPECTIVE INITIAL ASSESSMENT/VISIT WILL NEED TO BE BOOKED IN ORDER TO BECOME A PATIENT.

PATIENT NAME / GUARDIAN (IF PATIENT UNDER 18 YRS)	SIGNATURE	DATE
CHIROPRACTOR NAME	SIGNATURE	DATE
NATUROPATH NAME	SIGNATURE	DATE
REGISTERED MASSAGE THERAPIST NAME	SIGNATURE	DATE