Integrated Health Clinic™
Cancer Care Centre FORT LANGLEY, BC

NEW Cancer PATIENT INTAKE FORM – **ADULT**

We respectfully ask that you complete this form prior to arriving for your scheduled appointment time.

Today's Date: _____ /_____ /_______ (MM / DD / YYYY)

Personal Information

Patient Name: ____ (First) (Middle) (Last)

Date of Birth: _____ /_____ /_______ (MM / DD / YYYY)

Age: ____ Gender: ____ Wt: ______ Ht: ______ Marital status:___________ # Children & ages: __________________

Care Card #: ____________________________

Home Address: __________________________________ City: __________________ Prov/State: ________________

Country: ____________________ Postal Code: ____________ Email: _______________________________________

Phone Numbers: Home: __________________ Work: __________________ Cell: _________________________

Emergency contact: Name: ___________________________ Relationship: ____________ Phone: ________________

Family Doctor: _______________________________ Specialists: ____

Other Health Care Provider(s): ____

Medical Information

Allergies, if known (medical, environmental, foods):____

Dietary Restrictions, if any (religious/vegetarian/vegan):____

Current Medication/s & dosage: ____

(Prescription, over-the-counter, vitamins) ____

____

Past prescription medications: ____

____

Past serious conditions, illnesses, injuries and/or hospitalizations & dates:

____

____

Family Health History: Has a close relative (parent, grandparent, sibling) had any of the following?

- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Cancer / Type(s) ____
- ☐ Eczema
- ☐ Endometriosis
- ☐ Gallstones
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ PMS
- ☐ Skin disease
- ☐ Stroke
- ☐ Tuberculosis

Other medical conditions? ____

Your general state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list your health concerns, in order of importance to you:

1. ______________________________________ 3. ______________________________________

2. ______________________________________ 4. ______________________________________

2nd Floor - 23242 Mavis Avenue | P.O. Box 39 | Fort Langley, BC, V1M 2R4 | phone: 604.888.8325 | fax: 604.888.8365
email: info@integratedhealthclinic.com | www.integratedhealthclinic.com

General Health Information

Do you use any of the following? List the type and frequency if applicable:

Alcohol: ______________________________ Cigarettes: ____
Antacids: ______________________________ Recreational drugs: _________________________________
Caffeine: _____________________________ Tylenol/Aspirin/Advil: ______________________________
Laxatives: _____________________________

Number of antibiotic treatments in last 5 yrs: ___________
History of adverse reactions to immunizations: ☐ Yes ☐ No If Yes, please describe: ________________
____

Are you currently pregnant? ☐ Yes ☐ No
Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) ☐ Yes ☐ No
If Yes, please describe:
____

Have you ever had an abnormal pap, if applicable? ☐ Yes ☐ No

Typical diet, very generally:

Breakfast:____ Snacks:____
Lunch:____ Beverages (Type & Amount):_______________________
Dinner: ____ ____

Occupation: _______________________________________ Spiritual beliefs/Religion: _______________________________

Hobbies ____

Do you exercise regularly? ☐ Yes ☐ No Type:___________________________________ Frequency:_________________

Are you regularly, or have you ever been exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.
____
____

How would you describe the emotional climate of your home? (Indicate levels of stress if applicable)
____
____

How stressful is your work, or other aspects of your life? How do you manage stress?
____
____

Is there anything that you feel may be important for us to know?
____
____
____

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Cancer Specific Information

Please identify in detail any symptoms you are currently experiencing (pain, nausea, diarrhea, headaches, etc.)

____

____

____

____

____

____

If you are currently undergoing any conventional cancer treatment, please identify below:

Chemotherapy: ____

Radiation Therapy: ____

Surgery: ____

Other: ____

If you are currently engaged in a form of alternative cancer treatment, please identify below:

____

____

____

____

Please assess the level of pain you may be experiencing and provided a rating based on the scale below __________.

Pain scale: provide a number between 1 & 10, 1 - being no pain, 10 – being extreme pain

Please assess your overall Quality of Life (QOL) and provide a rating based on the scale below ______________.

Karnofsky QOL Scale

100	Normal no complaints; no evidence of disease.
90	Able to carry on normal activity; minor signs or symptoms of disease.
80	Normal activity with effort; some signs or symptoms of disease.
70	Cares for self; unable to carry on normal activity or to do active work.
60	Requires occasional assistance, but is able to care for most of his personal needs.
50	Requires considerable assistance and frequent medical care.
40	Disabled; requires special care and assistance.
30	Severely disabled; hospital admission is indicated although death not imminent.
20	Very sick; hospital admission necessary; active supportive treatment necessary.
10	Moribund; fatal processes progressing rapidly.
0	Unresponsive

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Informed Consent to Treatment

1. **I understand that the practitioners at this health centre are Naturopathic Physicians, and will use only natural, non-invasive methods of assessment and treatment.**
2. **I understand that any advice given to me as a patient at Integrated Health Clinic is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.**
3. **I understand that I am at liberty to seek, or to continue medical care from another qualified health care provider.**
4. **I understand that the Naturopathic Physician reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.**
5. **I understand that I am accepting or rejecting this care by my own free will.**
6. **I understand that no employee or physician at Integrated Health Clinic is suggesting to me to refrain from seeking the advice of another health care provider.**
7. **I understand that the services offered here are not covered by MSP, and that fees are payable at the time of appointment, including fees for services, prescriptions, and laboratory tests.**
8. **I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the payment of a cancellation fee.**
9. **I understand that any therapies recommended will be explained to me in full by the physician, and that I will give consent to treatment based on informed consent.**

I, ____ have read, understood and agree to the above statements.

Signature: ____ Date:__________________________

Thank you for taking the time to complete this intake form. We look forward to working with you to optimize your health and well being.

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