Welcome to the Integrated Health Clinic Cancer Care Centre!

To help your doctor prepare for your upcoming visit, please complete the following documents:

1. **New Patient Intake form:** The intake captures your pertinent personal and medical information. Please complete to the best of your ability.
2. **Release of Records form:** This document provides authorization to request your medical history documentation from your other providers (family physician, specialists, etc.).

Once you finished the intake form and have signed the consent, Please return if to us via email to: cancercare@integratedhealthclinic.com. We also ask that you please send us pertinent **medical history documentation** as identified below. These documents are critical for your IHC cancer care doctor to prepare for your initial visit. Documentation we request includes:

1. Most recent diagnostic imaging reports (CT scan, MRI, PET scan, etc.).
2. Pathology report (Including the original biopsy report confirming cancer diagnosis).
3. Most recent lab tests (blood work from past 3-6 months).
4. Most recent consultation notes from your oncologists and other relevant specialists.
5. Surgical operative reports (since the cancer diagnosis).

Personal Information

Today's Date: _____ /_____ /_____ **Date of Birth:** _____ /_____ /_____
MM DD YYYY MM DD YYYY

PHN / Care Card #: _____

Patient Name: _____ _____ _____
(First) (Middle Initial) (Last)

Preferred Name: _____

Age: _____ **Gender:** _____ **Wt:** _____ **Ht**: _____

Marital status: _____**Partner's name (if applicable)** _____

# of Children & ages: _____

Home Address: _____

City: _____ **Prov/State:** _____

Country: _____ **Postal Code:** _____

Email: _____

Cell Phone: _____ **Alternate Phone:** _____

Emergency contact: Name: _____ **Relationship:** _____ **Phone:** _____

Family Doctor/Clinic: _____

Specialists/Location: _____

Other Health Care Provider(s): _____

How did you hear about us? _____

_____

Medical Information

Allergies: _____

(medical, environmental, foods, etc.)

Current Medication/s & dosage: (Prescription, over-the-counter, vitamins)

Medication/ Supplement	Dose	Medication/ Supplement	Dose

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

Date	Condition/ Illness/ Hospitalization

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. _____
2. _____
3. _____

General Health Information

Do you use any of the following? ☐ Yes ☐ No

If yes, list the type and frequency if applicable:

Alcohol: _____ Cigarettes: _____

Antacids: _____ Recreational drugs: _____

Caffeine: _____ Tylenol/Aspirin/Advil: _____

Laxatives: _____

Number of antibiotic treatments in the past 5 years: _____

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:

_____

Do you have any dietary restrictions, or are following any formal dietary plan? _____

Typical diet, very generally:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (Type & Amount): _____

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? Identify the main stressors in your life.

_____

_____

_____

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: _____

Immunotherapy: _____

Other: _____

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

_____

_____

_____

_____

_____

Pain:
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

Quality of Life (QOL):
Please assess your overall QOL and provide a rating based on the QOL 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

Clinic Information

Suite #101 – 13585 16th Avenue | Surrey, BC, V4A 1P6
phone: 604.888.8325 | fax: 604.888.8365
email: cancercare@integratedhealthclinic.com | www.integratedhealthclinic.com

Informed Consent

Consent to Email Communication

Risks of Email Communication

Email is a widely used form of communication and can be convenient for patients to exchange information with a healthcare practitioner. However, using email to share medical information poses risks and the patient should be made aware, understand and accept such risks including, but not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Emails can be used to introduce viruses into computer systems.
- Emails are easy to forge, easy to forward (sometimes accidentally) and may exist indefinitely.

Conditions of Using Email

The Integrated Health Clinic doctors and staff will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, Integrated Health Clinic cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information. Therefore, the patient must consent to the use of email for patient information. Consent to the use of email includes agreement to the following conditions:

- Emails to and from the patient concerning diagnosis or treatment may be uploaded and placed into the patient's medical chart.
- The doctors may forward emails internally to the IHC staff and to those involved, as necessary, for diagnosis, treatment, healthcare operations, and other handling.
- The Integrated Health Clinic is not responsible for information loss due to technical malfunctions.
- The patient should not use email for emergencies or other time-sensitive matters.
- The patient is responsible for updating email addresses and informing the Integrated Health Clinic of any information that the patient does not want sent by email.

I, _____ have read, understood and agreed to the above statements.

Signature: _____ Date: _____

Informed Consent to Treatment

1. 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.
2. I understand that I am at liberty to seek, or to continue medical care from another qualified health care provider.
3. I authorize my Naturopathic Doctor to discuss and share my file with any or all of the Integrated Health Clinic Practitioners, if pertinent to my health care.
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 consultations, services, prescriptions, and laboratory tests.
8. I understand that a minimum of **24 hours notice is required for appointment cancellations**, otherwise I will be responsible for payment of a cancellation fee billed at 100% of the service 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 agreed to the above statements.

Signature: _____ Date: _____

Newsletter and Clinic Notices

I choose to receive communications from Integrated Health Clinic, including a monthly newsletter, educational updates, and clinic announcements that may include information about upcoming free webinars, health news, nutritious recipes, updates on the latest lab testing options, and other important health-related topics designed to support my wellbeing. I understand that newsletters are sent no more than once per month, and I may opt out of receiving communications at any time.

☐ **OPT IN** ☐ **OPT OUT**

Signature: _____ Date: _____

Integrated Health Clinic
Suite 101 - 13585 16th Ave, Surrey, BC, V1A 1P6
Phone: 604.888.8325 | Fax: 604.888.8365
email: cancercare@integratedhealthclinic.com

Release of Records Authorization for:

Patient's full name: _____

Date of Birth: _____ PHN: _____

Requesting Doctor: _____

Requested Records Release Authority:

Fax to: Doctor _____ Fax #_____

Faxed to: Facility _____Fax #_____

I authorize the receiving Doctor or Facility to fax a copy of my complete medical records to the Integrated Health Clinic at fax #: 604.888.8365. I release you from any and all legal responsibility or liability that may arise from this authorization.

Requested Records include the past _____ months for:

_____Lab Results _____Imaging Results

_____Consultation Letters _____Other records

Specifics: _____

_____

_____

Send To:

Fax: 604.888.8365
Integrated Health Clinic
Suite 101 - 13585 16th Ave, Surrey, BC, V1A 1P6
Phone: 604.888.8325

Date Requested: _____ Signature: _____