Integrated Health Clinic™
working together for your health FORT LANGLEY, BC

NEW PATIENT INTAKE FORM – **ADULT**

Today's Date: _______ /_______ /________ (MM / DD / YYYY)   Date of Birth: _______ /_______ /_________ (MM / DD / YYYY)

Patient Name: ____ (First) (Middle Initial) (Last)   Preferred Name: __________________

Age: ____ Gender: ____ Wt: ______ Ht: ______ Marital status:____________ # Children & ages: ___________________

Home Address: ____________________________________ City: ___________________ Country: __________________

Postal Code/ZIP: __________________ Phone Numbers: Home: ___________________ Work: ____________________

Cell: __________________ Email: ____ Care Card #: _____________________

Emergency contact: Name: ____________________________ Relationship: _____________ Phone: _________________

Family Doctor: ________________________________ Specialists: ____

Other Health Care Provider(s): ____

How did you hear about us? ____

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

____

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: Y N
Are you currently pregnant? Y N
Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) Y N
Have you ever had an abnormal pap, if applicable: Y N

Typical diet, very generally:

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

Occupation: ____________________________________ Spiritual beliefs/Religion: ________________________

Hobbies ____

Do you exercise regularly? Y N 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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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:______________________________

Integrated Health Clinic™
Cancer Care Centre FORT LANGLEY, BC

Informed Consent for Communication

We value our relationship with you and would like to send you information electronically relating to Integrated Health Clinic. In order to do this, we are collecting your consent to receive electronic messages from us in the form of *appointment reminders*, newsletters, upcoming events and other clinic information. Please take a moment to select either "OPT IN" or "OPT OUT". Opting in will provide Integrated Health Clinic consent to communicate with you electronically. Opting out will indicate that you do not wish to receive any electronic communication from us.

OPT IN **OPT OUT**

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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