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

NEW PATIENT INTAKE FORM – **ADULT**

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

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

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
- ☐ 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: _____
Antacids: _____
Caffeine: _____
Laxatives: _____

Cigarettes: _____
Recreational drugs: _____
Tylenol/aspirin/Advil: _____

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:_____
Lunch:_____
Dinner: _____

Snacks:_____
Beverages (Type & Amount):_____
_____

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 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 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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