

Today's Date: ____/____/____
MM DD YYYY

Date of Birth: ____/____/____
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 | Eczema | Kidney disease | Skin disease |
| Asthma | Endometriosis | Mental illness | Stroke |
| Diabetes | Gallstones | Multiple sclerosis | Tuberculosis |
| Cancer / Type(s) | Heart Disease | Osteoporosis | |
| | 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. _____

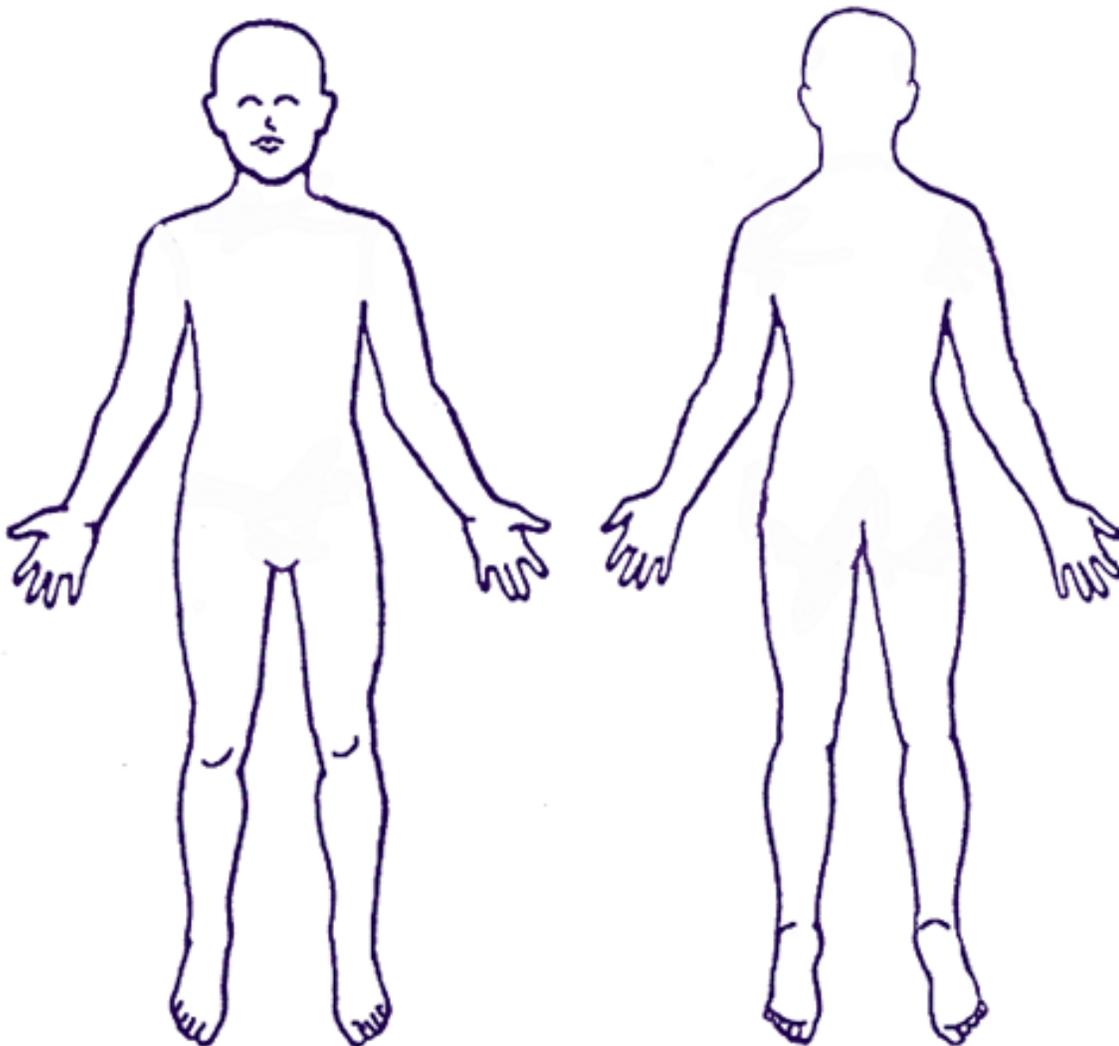
2. _____ 4. _____

General Health Information

Have you had previous surgery? If yes, please provide details: _____

Is your present condition a result of an accident? If yes, please provide details: _____

Please indicate areas of discomfort or pain on the diagram below



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 of 50% of the service fee. **No-Shows** will be 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: _____

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.