Lakeside Natural Health
CENTRE

Adult Intake Form

Today's date: _____

Name:_____ Age:_____ Birth date:_____ M F

Address: _____ City: _____ Postal: _____

Home Phone #:_____(_____)_____Work #: (____)_____

E-mail: _____ Preferred method of contact: Home # Work # Email

Emergency Contact name, phone #, and relationship to you: _____

Occupation:_____

Names of other Healthcare providers:

1._____ Phone #: (___)_____

2._____ Phone #: (___)_____

How did you hear about this clinic? _____

What are your chief concerns? (Please list them in order of importance to you)

1. _____
2. _____
3. _____

Previous Treatments and results? _____

Your Medical History

How would you describe your general state of health?

Excellent Good Fair Poor

Please check the following that apply to you:

Cancer	Diabetes	Surgeries	Depression
High blood pressure	Seizures	Other major illness	Asthma
Heart disease	Hepatitis	Venereal disease	Allergies
Rheumatic fever	Thyroid Disease	Arthritis	Alcoholism
Significant trauma (auto accidents, falls, other)		HIV	Other

Family Medical History (please write the family member beside checked category, eg/ "mother")

Cancer _____
Asthma _____
Diabetes _____
Allergies _____
Seizures _____
Alcoholism _____
Arthritis _____

High Blood pressure _____
Depression _____
Heart Disease _____
Thyroid disease_____
Stroke _____
Kidney disease _____
Other _____

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Medical and Lifestyle Information

Date of last physical exam:_____ Weight _____ Height_____Weight 1 year ago _____

Date of last dental check up: _____ Do you have any mercury fillings? Y N If yes, how many? _____

Energy level (1-10, 10 being the best energy you've ever experienced) _____

Do you wake up feeling refreshed? Y N How many hours of sleep do you get a night? _____

Do you wake during the night? Y N If so, at what time(s)? _____

Reason for waking during the night? _____ Do you drink coffee? Y N #cups/day_____

Have you/do you use recreational drugs? Y N Do you drink alcohol? Y N #drinks/week_____

Do you smoke? Y N #cigarettes/day_____How long have you smoked?_____

Do you drink pop? Y N How much/day? _____ Do you use artificial sweeteners? Y N

Describe your weekly exercise (# of times/week and description of exercise): _____

_____

What do you value in your life? _____

Please circle the number that Indicates your level of stress
(0= no stress, 5= moderate stress, 10= extremely stressful)

Financial	0	1	2	3	4	5	6	7	8	9	10
Job Related	0	1	2	3	4	5	6	7	8	9	10
Relationship	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10
Family Members	0	1	2	3	4	5	6	7	8	9	10
Spiritual	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

List all your current prescription medications

_____

_____

How many times have you been treated with antibiotics in the last 5 years? _____

List all your over-the-counter medications that you take (for example: aspirin, Tums, Tylenol) and include dose and frequency:

_____

List all vitamins, minerals, herbs, Asian medicines, or homeopathic supplements you are taking and include dosage: _____

_____

_____

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Do you have any known allergies (environmental, medicines)? Y N If yes, what are they?

Are you on a restricted diet? Y N Have you ever been on a restricted diet? Y N
If yes to either question please describe the type of diet.

Do you have any food allergies or intolerances? Please list.

Do you get regular screening tests done by another doctor? Y N
(Pap smear, breast, prostate, blood tests, etc.)

Check off any of the following if they are a CURRENT or RECURRING symptom.

General

Change in appetite	Night sweats	Weight gain
Poor sleep	Sweat easily	Weight loss
Fatigue	Sudden decrease in energy	Peculiar tastes or smells
Chills	Cravings	Bleed or bruise easily
Fevers	Strong thirst	

Skin and Hair

Rashes	Change in hair or skin texture	
Eczema	Loss of hair	Dryness
Itching	Dandruff	Ulcerations
Pimples	Recent moles	Skin Cancer

Head, Eyes, Ears, Nose, and Throat (HEENT)

Headaches	Color blindness	Nose bleeds
Head or neck problems	Blurry vision	Teeth problems
Concussions	Cataracts	Jaw clicks
Eye strain	Earaches	Gums bleed easily
Glasses	Poor hearing	Facial pain
Night blindness	Ringing in ears	Recurrent sore throats
Eye pain	Sinus problems	Sores on lips, tongue or mouth

Respiratory

Difficulty breathing	Asthma	Coughing blood
Cough	Pain with a deep breath	Pneumonia
Bronchitis	Production of mucus	Other

Cardiovascular

High blood pressure	Fainting	Cold hands or feet
Low blood pressure	Chest pain	Swelling of hands
Irregular Heartbeat	Varicose veins	Swelling of ankles/feet
Dizziness	Blood clots	

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Gastrointestinal

Indigestion	Abdominal pain or cramps	Rectal pain
Gas	Nausea	Hemorrhoids
Bad breath	Vomiting	Blood in stool
Constipation	Laxative use	Diarrhea

Genito-urinary

Frequent urination	Unable to hold urine	Impotency
Urgency to urinate	Decrease in flow	Sores on genitals
Pain on urination	Blood in urine	Frequent urinary tract infections
Wake at night to urinate	Kidney stones	Other

Gynecology and Pregnancy

Are you pregnant? Y N What is the first day of your last period? _____
Age of first period_____How long does your period last?_____
Date of last PAP_____ Normal cells Abnormal cells

Regular periods	Live pregnancies #_____
Irregular periods	Miscarriage #_____
Painful periods	Abortion #_____
Vaginal discharge	Birth control used. If yes, what type? _____
Vaginal sores	How many years have you been on the birth control pill? _____
Clots	

Changes in body or emotions prior to menstruation. Please describe. _____
Heavy flow Light flow

Musculoskeletal

Neck pain	Knee Pain	Muscle pain
Back pain	Foot / ankle pain	Muscle weakness
Hand/wrist pain	Hip Pain	
Shoulder pain	Other joint or bone problems?	

Neuropsychological

Loss of balance	Depression	Concussion
Quick temper	Susceptible to stress	Seizures
Poor memory	Dizziness	Areas of numbness
Anxiety	Lack of coordination	

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FEE SCHEDULE, CANCELLATION POLICY & PAYMENT OPTIONS

PATIENT COPY

Fee Schedule	Visit Type	Adult	Child (under 12)/ Senior (Over 65)
	Initial Consultation	190.00	160.00
	Follow up Consult - 15 min	45.00	40.00
	30 min	80.00	70.00
	45 min	110.00	100.00
	60 min	140.00	130.00

Telephone Consults	Charged according to above rates
Email Consults	Charged according to above rates for any new concerns (emails regarding treatment plans already prescribed are free of charge)

***** All fees include HST
***** Any Prescribed supplements/botanicals/homeopathics and /or appliances are not included in the above fees

Cancellation Policy

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours advance notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with this clinic policy.

Payment Options

At Lakeside we are pleased to be able to accept the following method of payments for your convenience:
Cash, Cheque, Debit, Visa and MasterCard

CANCELLATION POLICY & PAYMENT OPTIONS
CLINIC COPY

Cancellation Policy
Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours advance notice are subjected to a charge of 100% of the fee for the service scheduled. The clinic will retain a record of your credit card only to process missed appointment fees and a receipt will be promptly issued for any missed appointment fees. We appreciate your cooperation with this clinic policy.

Credit Card Information
Card # _____ Exp. _____ 3 Digit Code _____

Payment Options
At Lakeside we are pleased to be able to accept the following method of payments for your convenience:
Cash, Cheque, Debit, Visa and MasterCard

Patient Confirmation
By signing this form you have agreed to the conditions of our cancellation policy and acknowledge our fee schedule and payment options.

I _____ have reviewed the above information and understand that if I do not provide 48 hours notice to cancel my appointments I will be sent an invoice by mail that will be due 15 days from invoiced date.

Signature _____ Date _____

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PATIENT CONSENT FORM

INFORMED CONSENT

We would like to take this opportunity to welcome you to Lakeside Natural Health Clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means. Your practitioner will conduct a thorough case history. If you are working with a naturopathic doctor a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up.

Statement of Acknowledgement

As a patient of this clinic I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I understand that my treatment will be based in naturopathic medicine, which has a proven clinical foundation, yet may not be accepted practice by standard allopathic medicine. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture. I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

PRIVACY POLICY

Privacy of your personal information is an important part of providing you with quality naturopathic care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. The privacy policy outlines what the centre is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

The centre will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care and to advise you of treatment options
- To Establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners Act
- To invoice for goods and services and to process credit card payments
- To collect unpaid accounts
- To comply generally with the law

PATIENT CONSENT

By signing the consent section of this Patient Consent Form, you have reviewed, understood and agree that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above, and give written informed consent to the statements above regarding Naturopathic Care.

Signature	Print Name
Date	Signature of Witness

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Jessica Liu, ND, Jen Newell, ND

Naturopathic Doctor
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AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL TO LAKESIDE HEALTH CENTRE

(Please send a copy of this form back with records)

Section 1:

(Patient to complete Section 1 and 3 of this form)

To: Dr.(MD): _____ **From: Patient:** _____
(please print) (please print)

Fax No#: _____ **Date of Birth:** _____

Address: _____ **Address:** _____

_____ _____

_____ _____

Telephone: _____ **Telephone:** _____

Section 2:

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _____

Laboratory Results ***most recent blood and physical work-up**

Imaging Results _____

Other _____

Section 3:

I _____ **give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.**

Signature of patient: _____ **Date:** _____