Confidential Patient Intake Form

WELCOME TO INTEGRATIVE FORT LANGLEY

On behalf of the entire team, welcome to Integrative Naturopathic Medical Centre Fort Langley. To get you better prepared for your initial visit, please ensure to read and complete this entire package as it contains information required by your Naturopathic Doctor and important patient policies. We like to be upfront to avoid any possible confusion or inconvenience, and to ensure you have the best experience possible.

INCLUDED IN THESE FORMS

☐ Patient Intake Information

☐ Consents and Missed Appointment Policy

Our Location
23242 Mavis Avenue
Fort Langley, BC V1M 2R4

Office Hours
Mon-Fri 9:00am – 5:00pm
Sat 9:00am – 5:00pm

Running Late?
Please contact the front desk to inform us.

Contact Us
Phone: (778) 308-0101
Email: fortreception@integrative.ca

Cancellation Policy
2-business days
Monday through Friday

Phone Hours
Mon-Fri 9:00am – 4:30pm
Sat 9:00am – 4:30pm

Parking?
Parking in Fort Langley is limited and mostly street parking. To ensure you don't feel rushed, please plan to arrive 30 minutes early to allow time to find a spot.

All questions in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date: ____________________

PERSONAL INFORMATION			
Full Name: ____________________		Preferred Name: ____________________	
Date of Birth: __________	Age: ______	Gender: __________	Preferred Pronouns: ______
Marital Status: __________	How Many Children: ______	Care Card Number: ____________________	
Home Address: ____________________	City/Province: __________	Postal Code: ______	
Mobile Phone: __________	Home Phone: __________	Work Phone: __________	
Other Phone: __________	Email Address: ____________________		

Family Doctor – Name: ____________________	Contact: ____________________
Other Health Care Provider(s): ____________________	

Emergency Contact – Name: ____________________	Relationship: __________	Contact: __________

How Did You Hear About Us?				
☐ Google Search	☐ Google Ads	☐ Social Media	☐ Website	☐ Word of Mouth
☐ Event/Workshop	☐ Newsletter / Email	☐ Referral (specify): ____________________		

COMMUNICATION PREFERENCES	
How would you like to receive reminders for your upcoming appointments (select one): ☐ Email ☐ Text	
Email for reminders: ____________________	Phone for text reminders: ____________________
Would you like to receive emails that include newsletters, health tips, and upcoming events: ☐ Yes ☐ No	

PRIMARY HEALTH CONCERNS		
List your top 3 health concerns, in order of priority:		
Health Concern	**When did this begin?**	**How does it affect your life?**

CURRENT SYMPTOMS		
Check all that apply:		
☐ Fatigue / Low energy	☐ Digestive concerns (bloating, reflux, constipation	☐ Hormonal concerns
☐ Mood / stress / anxiety	☐ Sleep issues	☐ Pain or inflammation
☐ Weight concerns	☐ Immune concerns	☐ Other ______________________

MEDICAL HISTORY
Current medical diagnoses (if any):
Surgeries or hospitalizations (please include the dates):
Significant past illnesses or injuries:

MEDICATIONS & SUPPLEMENTS		
List all current medications and supplements:		
Name	**Dosage**	**Reason**

ALLERGIES OR SENSITIVITIES
☐ None
☐ Food: ______________________
☐ Medication: ______________________
☐ Environmental: ______________________

LIFESTYLE OVERVIEW		
Typical Energy Level: ☐ Low ☐ Moderate ☐ High	Stress Level: ☐ Low ☐ Moderate ☐ High	Sleep Quality: ☐ Good ☐ Fair ☐ Poor
Exercise Type & Frequency (if any): ______________________		
Dietary approach (if any): ______________________		

PREVIOUS TREATMENTS
Have you tried any treatments for your current concerns? ☐ Yes ☐ No
If yes, please briefly describe what you've tried and what helped or didn't help:

YOUR GOALS FOR CARE
What would you like to achieve through this visit or ongoing care?

ADDITIONAL NOTES
Is there anything else you feel your practitioner should know before your appointment?

Consent to Use Email Communications

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 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 healthcare practitioner/and or Integrative staff will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the healthcare practitioner/and or Integrative staff 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 printed and placed into the patient's physical chart
- The healthcare practitioner may forward emails internally to the Integrative staff and to those involved, as necessary, for diagnosis, treatment, healthcare operations, and other handling
- The healthcare practitioner and/or Integrative staff 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 healthcare practitioner and/or Integrative staff of any information that the patient does not want sent by email

Acknowledgement and Consent

Signature (Patient, Parent, or Guardian)	**Date**

Social Media Informed Consent

Integrative Naturopathic Medical Centre is pleased to participate in Social Media outlets such as Instagram. Through these venues, we share staff and patient pictures, office updates, giveaways, and other fun and helpful information that may benefit our patients. With the expressed permission of our patients, we are pleased to share posts during an office visit, lab treatment, events, etc.

- ☐ I give my consent to allow Integrative Naturopathic Medical Centre to post photographs/videos of me on social media
- ☐ I do not give consent to my information/photographs/videos being shared on social media

Signature (Patient, Parent, or Guardian)	Date

Important Information

Missed Appointments and Cancellations
Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48-hours (2-business days) notice, otherwise it may be necessary to charge for the time lost. Please note, late cancellations and no-shows are equivalent to a full appointment fee.

Fees
All visit charges are expected to be paid at the time service is rendered.

BC Medical Coverage
Generally, BC Medical Services Plan (MSP) will not cover any Chiropractic, Naturopathic or Massage Therapy visits. Patients who qualify for Premium Assistance are eligible for a total of 10 visits per calendar year. You will pay our normal fee and MSP will reimburse you directly. Please let the front desk know if you are on Premium Assistance.

Extended Medical
Your medical insurance policy is a contract between you and your insurance company. This office does not collect payment from any insurance company nor guarantee reimbursement. We can provide receipts that can be submitted to your extended medical plan.

Declaration and Informed Consent to Treat

This declaration is to acknowledge that I have been informed and understand that:

1. I am not limited to exclusive treatment from a Naturopathic Doctor. I may also continue to seek treatment and continue medical care from a medical doctor or other licensed health care provider.
2. I understand that video and listening devices are not permitted during a treatment/visit unless consent is given by my practitioner.
3. I authorize my Naturopathic Doctor to discuss and share my file with any or all of the Integrative Practitioners, if pertinent to my health care.
4. I understand that I will receive explanation of the treatments performed and foreseeable side effects of services that I will receive from my Naturopathic Doctor.
5. I hereby authorize and consent to Naturopathic treatment including dietary and lifestyle modification, botanical medicines, acupuncture, homeopathic medicines, and spinal manipulation.
6. I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during intake of case.
7. I agree to pay my account in full at the time of each visit or treatment unless otherwise arranged. This includes fee for Naturopathic services, cost of supplements and remedies, cost of laboratory tests and other fees.
8. I understand Integrative's **Missed Appointment Policy** of **2 full business days** of notice of an appointment cancellation and that failure to give appropriate notice will result in a missed appointment charge up to the full charge of my appointment.

Please Sign and Date
I have read and understand the above declaration. No guarantee of successful treatment has been implied. I understand that I am entitled to a copy of this consent form upon request and that I may withdraw this consent upon request in writing at any time.

Patient Signature *(Parent, Legal Guardian or Relative)*	Date

Physician Declaration
I have explained the contents of this document to the patient and have answered all the patient's questions, and to the best of my knowledge, the patient has been adequately informed and has consented.

Practitioner Signature	Date