Confidential Patient Intake Form

WELCOME TO INTEGRATIVE

Thank you for choosing Integrative Naturopathic Medical Centre to be part of your healthcare team. Please complete this health intake form to the best of your ability and in as much detail as possible. **Ensure to bring it with you to your initial consultation.**

In addition to this health intake form, **please bring any pertinent health records** that you feel may be important to your health care. These can include lab or diagnostic test results, MRI reports, X-Ray results, etc. and can be obtained by you, from your healthcare practitioner, or can be requested by our office during your initial visit.

In order to provide you with the best individualized care possible, your Naturopathic Doctor will assess your overall health which may include, but are not limited to current symptoms, health history, diet, lifestyle, physical and emotional well-being, genetics, environmental exposure (toxic load), and stress levels. **These factors are reviewed thoroughly to identify the root of your concern**s and to determine which naturopathic approach will be most beneficial.

To get you better prepared for your initial visit, please review the following:

Checklist
☐ Patient Intake Forms
☐ Medical Records

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

Our Location

1285 W. Broadway, Vancouver
Suite #730 (7th Floor)

Office Hours

Mon-Fri 8:00am – 6:00pm
Sat 8:00am – 4:00pm

Running Late?

Please contact the front desk to inform us!

Contact Us

(604)738-1012, ext.1
reception@integrative.ca

Cancellation Policy

2-business days
***closed Sundays*

Parking?

FREE 2H parking, metered, underground paid parking

Phone Hours

Mon-Fri 8:00am – 5:00pm
Sat 8:00am – 3:00pm

For more information on our services:

Please visit our website – **integrative.ca**
or give us a call – we'd be happy to answer your questions!

Integrative

Biomeridian Assessment

Part of our patient intake is a Biomeridian Test – it is used to conduct a comprehensive evaluation of your energetic organ health. The theory behind the technology comes from both ancient Chinese Medicine as well as European research.

History

Research by German Physician, Dr. Voll, in the 1950's, identified that meridian points had a lower electrical resistance or increased conductivity compared to other points not associated with meridian channels. His research led to a system of testing conductivity of specific meridian points (primarily on the fingers and toes) to assess whether the conductivity reading was within range or out-of-range. Through such assessment, it is possible to evaluate the energy of meridians, and thereby, assess the energetic health of organs and body systems.

Integrative Approach to Biomeridian Testing

We use a system for meridian testing that was developed in the US and is FDA approved. This system is called the **BioScan: Meridian Stress Assessment System**. It is a computerized program for testing and recording meridian data.

What to Expect	
→	This test is non-invasive and will take 60 minutes to complete
→	The types of tests* will be determined during your initial consultation
→	One of our Naturopathic Doctor Assistants will conduct the test and will be using specific points on your hands and feet
→	Results will be reviewed at a follow-up visit with your Naturopathic Doctor

*Types of Tests

Based on your health concerns, your Naturopathic Doctor may suggest to complete any of the following tests during a Naturopathic Assessment:

- → Vitals
- → Biomeridian Organ Scan
- → Biomeridian Food Sensitivity Test
- → Biomeridian Cellular Screen
- → Body Composition
- → Nerve Express Test
- → Liquid Mineral Test
- → Physical Assessment

Prep for Your Test

Preparing for your Naturopathic Assessment is easy:

- ✓ No lotion or cream on hands and feet
- ✓ Drinks lots of water

NOTES

Today's Date

How did you hear about Integrative?			
Full Name:		Middle Name:	
Health Card # (PHN):			
Date of Birth:		Gender:	
Address:			
City:	Province:	Postal Code:	Country:
Mobile No.:		Home Phone:	
Work Phone:		Occupation:	
Email:			

Medical Doctor:	Contact No.:
Other Health Care Provider:	Contact No.:

IN CASE OF EMERGENCY, NOTIFY:	
Relation:	Contact No.:

Allergies	**Medications**

Would you like to receive emails that include newsletters, health tips, and upcoming events?	Y	N

How would you like to receive reminders for your upcoming appointments? **(select one)**
☐ Email:
☐ Text:

Office Policy
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.

Would you like to discuss ACORN Biolabs Cell Preservation during your consult?			
What is your primary health concern?			
What are your goals for your health at this time?			
When did this condition first begin?			
Is this a recurring problem? ☐ Yes ☐ No	Is this getting better or worse?	☐ Better ☐ Worse	
What do you feel is the cause of the problem?			
What does it feel like?			
What aggravates your symptoms?			
What alleviates your symptoms?			
Are there any other related symptoms?			
Are you receiving treatment for this? ☐ Yes ☐ No If YES – what kind?			
Have you ever received any of the following? **(select ALL that applies)** ☐ Naturopathic Treatment ☐ Chiropractic Treatment ☐ Acupuncture Treatment			
Have you had a personal injury or accident this past year? ☐ Yes ☐ No			
Have you had an ICBC or WCB claim? ☐ Yes ☐ No			
Past 5 years?	Over 5 years?		
Please describe:			
Other health concerns? **(please list)**			

Have you ever been treated for a serious or infections disease? (pneumonia, tuberculosis, Lyme, etc.)
☐ Yes ☐ No If YES – what kind?

List any prescribed medication, over-the-counter drugs, vitamins and nutritional supplements

Medication	Age Started	Length of Use	Dose	Side Effects

List any birth control use or hormone replacement therapy (oral, injection, IUD):

Medication	Age Started	Length of Use	Dose	Side Effects

Family Health History	Describe	Family Member
Allergies/Asthma		
Alzheimer's/Parkinson's		
Anxiety/Depression		
Autoimmune Disease		
Cancer		
Diabetes		
Gastrointestinal Disease		
Heart Attack/Disease		
Liver Disease		
Lung Disease		
Overweight/Obese		
Prostate Disease		
Stroke		
Thyroid Disease		
Other:		

More info:	

Lifestyle & Health Habits				
Exercise	☐ No exercise			
	☐ Mild exercise *(ie. Climb stairs, walk 3 blocks, golf)*			
	☐ Occasional, vigorous exercise *(ie. Workout/recreational, less than 4 times per week for less than 30 minutes, yoga/pilates)*			
	☐ Regular, vigorous exercise *(4 or more times per week for 30 minutes)*			
	☐ Other(please describe):			
Diet	Are you dieting?	☐ Yes/How:		☐ No
	Avoiding anything?		# of meals in a day?	
	Indicate below your intake of meals per day			
	High sugar intake	☐ Most meals	☐ About ½	☐ Few meals
	High salt intake	☐ Most meals	☐ About ½	☐ Few meals
	High fat intake	☐ Most meals	☐ About ½	☐ Few meals
Caffeine	Number of cups/can per day/per week:			
	☐ Pop/Soda	☐ Coffee	☐ Tea	☐ None
Alcohol	Do you drink alcohol? ☐ Yes ☐ No			
	If yes, what kind?			
	How many drinks per week?		How many drinks per month?	
Tobacco	Do you use tobacco? ☐ Yes ☐ No			
	If yes, in what form (cigarettes, chew, pipe, vape etc.)?			
	Frequency of use per day:			
	Age started:	How many years?	Year you quit:	
Substance Abuse *(optional)*	Do you use any recreational drugs? ☐ Yes ☐ No			
	If yes, please describe:			
	Do you use any other drugs or substances no listed already? ☐ Yes ☐ No			
	If yes, please describe:			
Sexual Health	Are you currently, sexually active? ☐ Yes ☐ No			
Environmental Exposure	Do you have mercury or silver amalgam fillings? ☐ Yes ☐ No			
	Have you had any root canals? ☐ Yes ☐ No			
	Do you use hair dyes?		Frequency:	
	Do you use pesticides or herbicides?		Frequency:	

	Are you frequently exposed to any chemicals? (paints, solvents, cleaning solutions, plastics, etc.)
	Other toxins (mold, asbestos, radiation, etc.):

Check and briefly explain if you have, or in the past have had, any symptoms in the following areas:	
☐ Skin (ie. Eczema, rashes, hives)	☐ Heartburn/Indigestion/Acid Reflux
☐ Hair loss/growth	☐ Gas/bloating
☐ Head/Neck	☐ Bowels (constipation, loose stools)
☐ Ears, Nose/Sinuses	☐ Bladder/Urination
☐ Throat	☐ Back/Spine
☐ Lungs/Asthma	☐ Reproductive/Libido
☐ Chest/Heart	☐ Gynecological/Periods
☐ Immune System (Ie. Colds/infections)	☐ Hormones
☐ Circulation	☐ Emotional
Any recent changes with the following? Please describe.	
☐ Appetite/Thirst	☐ Weight
☐ Focus/Concentration	☐ Energy Level
☐ Memory	☐ Ability to sleep (ie. Falling/staying asleep)
☐ Mood (ie. Anxiety, low mood)	☐ Temperature

Other pain/discomfort:	
Are there any significant life events or stressors that contribute to your over health? Is there anything else that you feel is important about your health or lifestyle? Please describe.	

Please complete the following in chronological order, from birth to present, using the approximate age of occurrence		
Surgery		**Age**
Serious Infections/Diseases *(pneumonia, mono, TB, cancer, heart attack, chronic bronchitis, colitis, etc.)*		**Age**
Dental Intervention *(Root canals/extractions, 1st silver amalgam filling, braces, retainer, etc.)*		**Age**
Injuries/Accidents	**With Stitches?** *(Y/N)*	**Age**

Additional Information

Please use this page to add more information about medications/supplements, family health history, lifestyle and health habits, diet, symptoms, and anything else about your health that you feel is important

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 Facebook and 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