WELCOME TO INTEGRATIVE

Integrative
Naturopathic Medical Centre

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 along with you to your initial consultation with your Naturopathic Physician.**

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 reports, 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 Physician 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 concerns** 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

OFFICE HOURS

Monday - Friday 8:00am - 6:00pm
Saturday 8:00am - 4:00pm

OUR LOCATION

Suite #730, 1285 W. Broadway
Vancouver, BC V6H 3X8
(7th floor)

CONTACT US

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

PHONE HOURS

Monday - Friday 8:00am - 5:00pm
Saturday 8:00am - 3:00pm

CANCELLATION POLICY

**We require 2-business days notice. (M-F; excl. weekends, stat holidays) ***Please note - we are closed on Sundays.

PARKING

FREE 2HR street parking, metered street parking, underground paid parking.

RUNNING LATE?

Please contact the front desk to inform us!

FOR MORE INFORMATION ON OUR SERVICES

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

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E: reception@integrative.ca
W: integrative.ca

Confidential Naturopathic Patient Intake Form

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

How did you hear about us?

☐ Google Search ☐ Website ☐ Referral: _____
☐ Google Ads ☐ Word of Mouth ☐ Newsletter/Email
☐ Social Media ☐ Event/Workshop

Today's Date:	**Initial Visit Date:**

Personal Contact Information			
First Name:	Middle Initial:	Last Name:	
Sex assigned at birth: ☐ M ☐ F	Gender Identity (if different than birth sex):		
Date of Birth:	Health Care Card # (PHN):		
Address:			
City:	Province:	Postal Code:	Country:
Mobile Phone #:		Work Phone #:	
Home Phone #:		Occupation:	

Other Health Care Providers	
Medical Doctor:	Contact #:
Other:	Contact #:

Emergency Contact Information	
First Name:	Last Name:
Relation:	Contact #:

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

Would you like to receive emails that include newsletters, health tips, and upcoming events?	☐ Yes ☐ No

Your appointment time is reserved for you.
If you are unable to keep your appointment, we will require 2-business days notice (Monday-Friday; excluding weekends and statutory holidays), otherwise, a missed appointment fee will apply as per our missed appointment policy.

Health Questionnaire	
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 received any of the following? (select all that apply) ☐Naturopathic Treatment ☐Chiropractic Treatment ☐Acupuncture Treatment ☐Other: _____	Have you had a personal injury or accident this past year? ☐Yes ☐No Have you had an ICBC or WCB claim? ☐Yes ☐Past 5 years ☐No ☐Over 5 years Please describe injury or accident (if answer is yes):
Other health concerns? (please list)	
Have you ever been treated for any infectious and/or serious diseases? (pneumonia, tuberculosis, Lyme, etc) ☐Yes ☐No	If yes – when and what kind?

List any prescribed medications, over-the-counter drugs, vitamins and nutritional supplements you've taken

PRESCRIBED MEDICATIONS

Medication	Age Started	Length of Use	Dose	Side Effects

OVER-THE-COUNTER DRUGS

Medication	Age Started	Length of Use	Dose	Side Effects

VITAMINS/NUTRITIONAL SUPPLEMENTS

Medication	Age Started	Length of Use	Dose	Side Effects

List any birth control use or hormone replacement therapy

BIRTH CONTROL

Medication	Age Started	Length of Use	Dose	Side Effects

HORMONE REPLACEMENT THERAPY

Medication	Age Started	Length of Use	Dose	Side Effects

Family Health History / Blood relative Health History		
	Describe	Family Member / Blood Relative
Allergies/Asthma		
Alzheimer's/Parkinson's		
Anxiety/Depression		

Family Health History / Blood relative Health History (Cont'd)		
	Describe	Family Member / Blood Relative
Diabetes		
Gastrointestinal Disease		
Heart Attack or Heart Disease		
Liver Disease		
Lung Disease		
Overweight/Obese		
Prostate Disease		
Stroke		
Thyroid Disease		
Other:		
More Information:		

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 30 minutes or less, yoga/pilates) ☐ Regular, vigorous exercise (ie. 4 or more times per week for more than 30 minutes) Other (please describe):
Diet	Are you dieting? If yes, please describe: Are you avoiding anything? Number of meals per day: **Indicate, below, your intake of meals per day** High-sugar intake ☐ Most meals ☐ About half ☐ Few meals High-salt intake ☐ Most meals ☐ About half ☐ Few meals High-fat intake ☐ Most meals ☐ About half ☐ Few meals
Caffeine	**Indicate number of cups or cans per day/per week** ☐ Pop/Soda: ☐ Coffee: ☐ Tea: ☐ None

Lifestyle & Health Habits Cont'd		
Alcohol	Do you drink alcohol? ☐ Yes ☐ No If yes, what kind?	
	How many drinks per week/per month?	
Tobacco	Do you use tobacco? ☐ Yes ☐ No If yes, in what form? (cigarette, vape, etc)	
	Frequency of use per day?	Age started?
	How many years?	Year you quit?
Substance Use (optional)	Do you use any recreational drugs? ☐ Yes ☐ No If yes, please describe:	
	Do you use any other drugs or substances not listed already? If yes, please describe:	
Sexual Health	Are you currently sexually active? ☐ Yes ☐ No	
	Do you think of yourself as: ☐ Heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual ☐ Other ☐ Choose not to disclose ☐ Don't Know	
	How many partners have you had in the past year?	
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? ☐ Yes ☐ No Frequency:	
	Do you use pesticides/herbicides? ☐ Yes ☐ No Frequency:	
	Are you frequently exposed to chemicals? (paints, solvents, cleaning solutions, plastics, etc.) ☐ Yes ☐ No If yes, please describe:	
	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

Check and briefly explain if you have, or in the past have had, any symptoms in the following areas	
☐ 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 overall health? Is there anything else about your health or lifestyle that you feel is important? Please discribe.	

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 interventions (root canals/extractions, 1st silver amalgam filling, braces, retainer, etc.)	Age

Injuries/Accidents	With stitches?	Age
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	
	☐ Yes ☐ No	

Consent to Use Email Communications

RISKS OF EMAIL COMMUNICATIONS

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 must consent to the use of email for patient information. Consent to the use of email includes agreement to the following conditions:

- Emails to/from the patient concerning diagnosis or treatment may be printed and placed into the patient's physical medical 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

Informed Consent for Social Media Sharing

Integrative Naturopathic Medical Centre is pleased to participate in social media such as Facebook and Instagram.. Through these venues, we share staff and patient photos, 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 photos/videos of me on social media

☐ I do not give consent to my information/photos/videos being shared on social media

ACKNOWLEDGEMENT AND CONSENT

_____ _____

Signature
(Patient, Parent or Guardian)

Date

Important Information

MISSED APPOINTMENTS AND CANCELLATION POLICY

Your appointment time is reserved for you. If you are unable to keep the appointment, we require **2-business days notice (Monday-Friday; excluding weekends and statutory holidays)**, otherwise, it may be necessary to charge for the time lost. There is a range of valid reasons for canceling, however, in order be consistent with all clients, cancellation fees will only be waived in the event of a medical emergency requiring urgent professional treatment, a death in the family or a natural disaster. We do offer appointment reminders, but these are a courtesy only and patients are ultimately responsible for noting and attending appointments as scheduled.

FEES

All visits 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 COVERAGE

Your medical health insurance policy is a contract between you and your insurance company. Should you require information regarding your plan, please contact them directly. **We are pleased to offer direct billing for select health insurance providers** through TelusHealth eclaims. You may view the full list here: www.telus.com/en/health/health-professionals/allied-healthcare-professionals/eclaims.

Should you be eligible for extended benefits - we will collect your policy number, division number, and health care card number (PHN). Depending on your specific insurance plan, we may collect the full or remaining amount. Reimbursement for fully paid visits are rendered by your insurance provider.

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 Physician. I may also continue to see treatment and continue medical care from a medical doctor or other licensed healthcare provider.
2. I authorize my Naturopathic Physician to discuss and share my file with any or all of the Integrative practitioners, if pertinent to my care.
3. I understand that I will receive explanation of the treatments performed and foreseeable side effects of services that I will receive from my Naturopathic Physician.
4. I hereby authorize and consent to Naturopathic treatment including dietary and lifestyle modifications, botanical medicines, acupuncture, homeopathic medicines, and spinal manipulation.
5. I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during intake of my case or during a scheduled telephone consultation.
6. I agree to pay my account in full at the time of each visit or treatment unless otherwise arranged. This includes fees for Naturopathic services, cost of supplements and remedies, cost of laboratory tests and other fees.
7. I understand Integrative's Missed Appointment Policy of 2 full business days of notice (Monday-Friday, excluding weekends and statutory holidays) 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.

ACKNOWLEDGEMENT AND CONSENT

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.

Signature (Patient, Parent or Guardian)	Date