Today's Date		Health Card #	

Full Name:		Middle Name:	
Date of Birth:		Gender:	
Address:			
City:	Province:	Postal Code:	Country:
Mobile No.:		Home Phone:	
Work Phone:		Occupation:	
Email:		Weight:	Height:

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

Would you like to receive emails that include newsletters, health tips, and upcoming events?	Y	N
How Did You Hear About Us?		

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

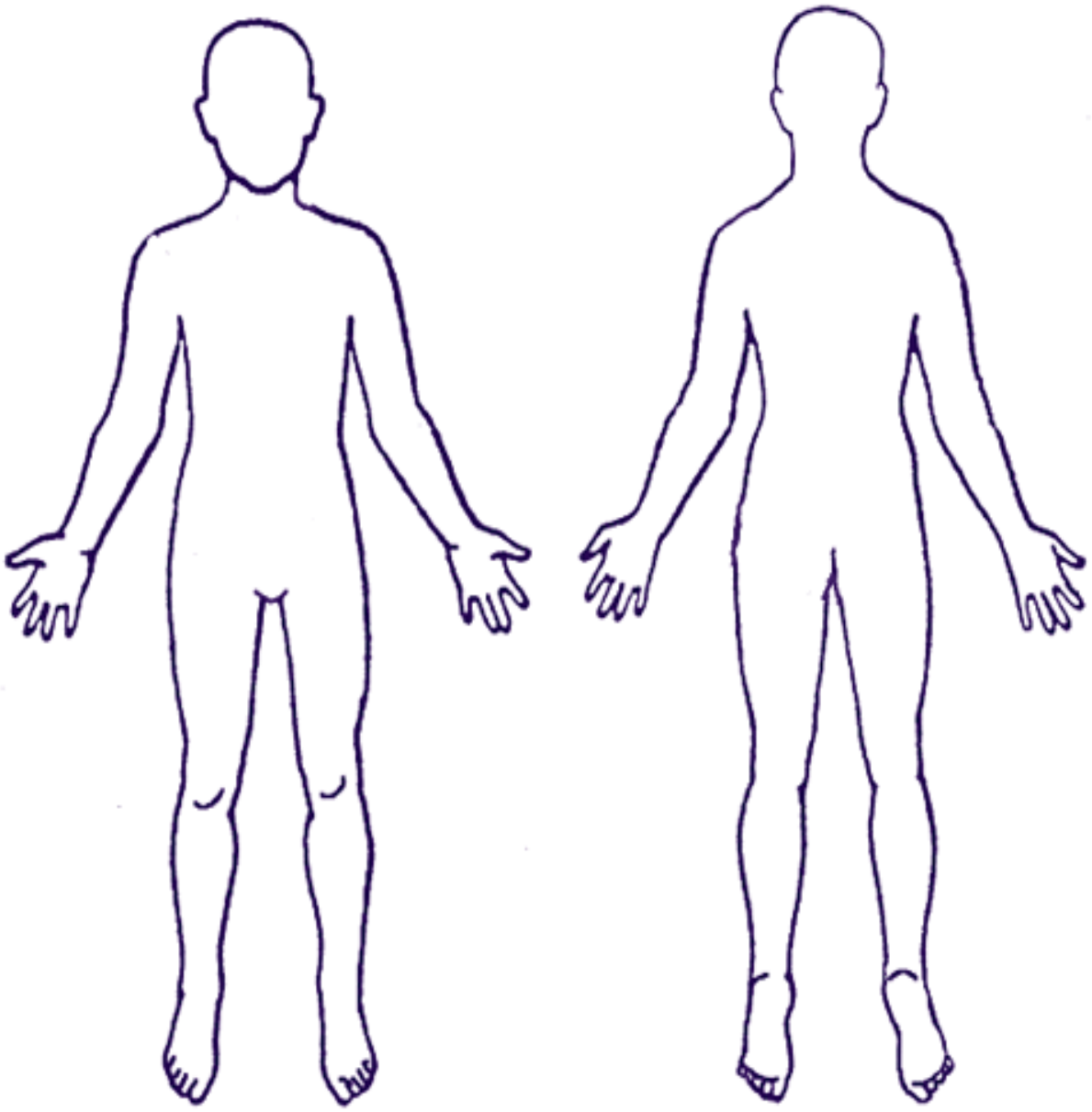
Office Policy
Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48-hours (2-business days) notice, otherwise it may be necessary to charge for the time lost.

Personal Health History				
Have you had any motor vehicle accidents, surgery, or other illnesses?	☐ Yes	☐ No		
Please list:				
Are you seeing another practitioner?	☐ Chiropractor	☐ MD	☐ RMT	☐ Physiotherapist
Other:				

About your current, presenting condition *(the reason you're seeking treatment)*
When and how did this condition begin?
What aggravates it?
What alleviates your symptoms?
Does the pain affect your daily activities? ☐ Yes ☐ No
Explain:
Have you had previous treatment? ☐ Yes ☐ No If YES – what kind?
What do you do to maintain or improve your health?
Is the condition/pain getting: ☐ Progressively worse ☐ Better ☐ Stays the same
Other symptoms felt: ☐ Numbness ☐ Grinding ☐ Popping ☐ Dizziness ☐ Weakness ☐ Nausea ☐ Vomiting
Has this condition occurred before? ☐ Yes ☐ No
Was it resolved? ☐ Yes ☐ No

Other health concerns? **(please select all that apply)**		
☐ Allergies	☐ Gout	
☐ Bruise easily	☐ Head injuries	☐ Osteoarthritis
☐ Cancer	☐ Headaches	☐ Painful menstruation
☐ Colon problems	☐ Heart condition	☐ Poor circulation
☐ Contagious conditions	☐ Hemophilia	☐ Pregnancy
☐ Diabetes	☐ Infections	☐ Respiratory conditions
☐ Digestive problems	☐ Insomnia	☐ Rheumatoid arthritis
☐ Dislocations	☐ Jaw pain	☐ Seizures/convulsions
☐ Enlarged glands	☐ Kidney condition	☐ Epilepsy
☐ Excessive thirst/urination	☐ Multiple sclerosis	☐ Sinus infections
☐ Fainting	☐ Neurological Conditions	☐ Spinal injury
☐ Fever	☐ Numbness/tingling/pain in hands, arms or legs	☐ Tuberculosis
☐ Fractures		☐ Varicose veins
☐ Frequent Colds/Flu	☐ High/Low blood pressure	

If you can, show in the diagrams, areas of concern, discomfort or pain:



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

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 or no-shows are equivalent to a full appointment charge.

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

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 the RMT. I may also continue to seek treatment and continue medical care from a medical doctor or other licensed health care provider.
2. I authorize my RMT to discuss and share my file with any or all of the Integrative Practitioners, if pertinent to my health 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 RMT.
4. I hereby authorize and consent to massage therapy and rolfing.
5. I agree to pay my account in full at the time of each visit or treatment unless otherwise arranged.
6. 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