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 TCM 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!

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 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.

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?

Personal Health History		
List any other prescribed medication, over-the-counter drugs, vitamins and nutritional supplements		
Medication	Dose	Frequency Taken
List any birth control use or hormone replacement therapy (oral, injection, IUD)		
Medication	Dose	Frequency Taken

Family Health History					
	Describe	Family Member		Describe	Family Member
Allergies/ Asthma			Heart Attack or Heart Disease		
Alzheimer's/ Parkinson's Disease			Liver Disease		
Anxiety/ Depression			Lung Disease		
Autoimmune Disease			Overweight/ Obese		
Cancer			Male Issues		
Diabetes			Stroke		

Gastrointestinal Disease			Thyroid Disease		
Other family history:					

Lifestyle & Health Habits				
Exercise	☐ No exercise			
	☐ Mild exercise *(climb stairs, walk 3 blocks, golf)*			
	☐ Occasional vigorous exercise *(workout/recreational, less than 4 times per week for less than 30 minutes, yoga or pilates)*			
	☐ Regular vigorous exercise *(4 or more times per week for 30 + minutes)*			
	☐ Other (please describe):			
Diet	Are you dieting? ☐ Yes ☐ No			
	If yes, how so?			
	# of meals you eat in an average day?			
	Daily sugar intake	☐ Hi	☐ Med	☐ Low
	Daily salt intake	☐ Hi	☐ Med	☐ Low
	Daily fat intake	☐ Hi	☐ Med	☐ Low
Caffeine	# of cups/cans per day/week:			
	☐ Pop/soda ☐ Coffee ☐ Tea ☐ None			
Alcohol	Do you drink alcohol? ☐ Yes ☐ No			
	If yes, what kind?			
	How many drinks per week?			
Tobacco	Do you use tobacco?			
	If yes, in what form (cigarettes, chew, pipe, etc.):			
	Frequency of use per day (cigarettes per day):			
	Age you started:	How many years:	Year you quit:	
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.)*
	Please list any other important environmental exposures you may have:

GENERAL HEALTH	
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain:	
☐ Skin	☐ Stomach/Intestines
☐ Head/Neck	☐ Bladder
☐ Ears	☐ Bowel
☐ Nose	☐ Circulation
☐ Throat	☐ Stress
☐ Lungs	Recent changes in:
☐ Chest/Heart	☐ Weight
☐ Back	☐ Energy Level
☐ Hair loss/growth	☐ Ability to sleep
☐ Other pain/discomfort	☐ Temperature
Is there anything else that you feel is important pertaining your health or lifestyle? (please describe)	

Surgery/Injuries/Infections/Dental History
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	Age

Injuries/Accidents	Stitches?	Age

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 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.

Treatment
The most common minor ill effects of acupuncture, if they occur, are mild bruising or mild local pain, temporary aggravation of symptoms, a feeling of faintness or drowsiness. Only single-use, sterilized needles are used. Joint infections, nerve damage and lung punctures are very rare complications of acupuncture. Precautions are always observed to avoid complications.

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 Dr. Karen Lam. 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 TCM 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 TCM Doctor.
5. I hereby authorize and consent to TCM 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 TCM 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.

I, also, consent to the following indicated treatments with Dr. Karen Lam: *(please select all that apply)*

- ☐ Acupuncture for induction of labour
- ☐ Cosmetic Acupuncture *(I understand that minor facial bruising may occur)*
- ☐ Traditional Acupuncture, rolling or cupping, tuina massage

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