INTEGRATIVE
Naturopathic Medical Centre

Health History Questionnaire

Dear New Patient:

On behalf of the entire team, welcome to Integrative! We are excited to have you join us and look forward to assisting you with all your scheduling needs.

Here are a few policies we feel are important for you to know. We like to be upfront to avoid any possible confusion or inconvenience, and to ensure you have the best experience possible.

- **Need to cancel or change an appointment?** No problem! We accept **2-business days** *(48 hours)* notice for any cancellations or rescheduling. Since we are closed on Sunday, this means any cancellations or changes for a Monday appointment need to be made on, or before, the preceding Friday. Cancellations made outside of this time frame (i.e. the morning of, or 47 hours or less before, etc.) are subject to a missed appointment charge, equivalent to a full appointment fee.

- **Wondering if the Doctor is on time?** Feel free to call us before your appointment. We will do our very best to give you an accurate update.

- **Running late?** Please give us a call and let us know. It is important to remember the lateness may cut into your appointment time and, while we will do our very best to accommodate, sometimes we will need to rebook your appointment if you arrive too late.

- Text or Email? **Choose your own reminder!** At Integrative we offer reminders via text message or email. These reminders are a courtesy and patients are expected to remember their scheduled appointments.

- Attached to this email are your new patient forms, please fill them out and bring them with you to your first visit. If you cannot print them out, please arrive 15 minutes before your scheduled appointment time so we can provide you a copy and have you fill them out at the clinic.

- **Online booking** is also available. If you have not received your email log-in information, please feel free to ask us to resend your details.

Now that we have our policies out of the way, we are excited to have you as part of the Integrative community! If you have any questions or concerns, you can always count on the front desk team to assist you.

Sincerely,

The Front Desk Team

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

Personal Information		
Name:		Date:
Birth date (mm/dd/yy):		Gender:
Care Card #:	Height:	Weight:
Address:		City:
Province:		Postal Code:
Cell Phone:		Home Phone:
Occupation:		Work Phone:
Marital status: Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐		
Emergency Contact Name:		
Relationship:		Phone:

How did you hear about our clinic?

Appointment reminders	
How would you like to receive reminders of your upcoming appointments? (**choose one option**)	
☐ Email	Email Address:
☐ Text	Cell phone number:
Would you like to receive emails that include newsletters, health tips, and upcoming events? Yes ☐ No ☐	

Personal Health History	
Medical Doctor:	Phone:
Other Health Care Provider:	Phone:

List any allergies or sensitivities (medications, foods, environmental, etc.):	
Allergen	**Reaction**

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Personal Health History	
What are your goals for your health at this time?	
What is your primary health concern?	
When did this condition first begin?	
Is this a reoccurring problem? Yes ☐ No ☐	Is this getting better or worse? Better ☐ Worse ☐
What do you feel is the cause of this 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 Naturopathic Treatment? Yes ☐ No ☐	
Have you ever received Chiropractic Treatment? Yes ☐ No ☐	
Have you ever received Acupuncture Treatment? Yes ☐ No ☐	
Have you had a personal injury or accident in the past year? Yes ☐ No ☐	
Have you had an ICBC or WCB claim? ICBC ☐ WCB ☐	
Past 5 years?	
Over 5 years?	
Please describe:	
Other health concerns? (Please list):	
Have you ever been treated for a serious or infectious disease (pneumonia, tuberculosis, Lyme etc)? Yes ☐ No ☐	

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Personal Health History				
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**		**Describe**	**Family member**
Allergies/Asthma			Heart Attack/Disease		
Alzheimer's/Parkinson's			Liver Disease		
Anxiety/Depression			Lung Disease		
Autoimmune Disease			Overweight/Obese		
Cancer *(please see below)*			Prostate Disease		
Diabetes			Stroke		
Gastrointestinal Disease			Thyroid Disease		
Other relevant family history:					

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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?		
	Avoiding anything?	# of meals you eat per day:		
	Indicate below your intake of meals per day:			
	High sugar intake	☐ Most meals	☐ About ½ my meals	☐ Few meals
	High salt intake	☐ Most meals	☐ About ½ my meals	☐ Few meals
	High fat intake	☐ Most meals	☐ About ½ my meals	☐ Few meals
Caffeine	Number 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?	How many drinks per month?		
Tobacco	Do you use tobacco? ☐ Yes ☐ No			
	If yes, in what form (cigarettes, chew, pipe, etc.)?			
	Frequency of use per day:			
	Age you 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? ☐ 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.) ☐ At work ☐ At home ☐ None			
	Other toxins (mold, asbestos, radiation, etc.):			

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General Health			
Check and briefly explain if you have or in the past have had any symptoms in the following areas:			
☐	Skin (e.g. 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 (e.g. colds/infections)	☐	Hormones
☐	Circulation	☐	Emotional

Recent changes in:

☐	Appetite/Thirst	☐	Weight
☐	Focus/Concentration	☐	Energy level
☐	Memory	☐	Ability to sleep (e.g. falling/staying asleep)
☐	Mood (e.g. 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 that you feel is important about your health or lifestyle? (please describe)

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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, first silver amalgam filling, braces, retainer, etc.	Age

Injuries/Accidents	With stiches? Y/N	Age

Declaration and Informed Consent to Treat

Fees

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

Patients who qualify for **Premium Assistance** throught Medical Services Plan of British Columbia (MSP) are eligible for a total of **10 visits** per calendar year. The 10 visits are in conjunction with any other services you may already be utilizing with other practitioners outside of Integrative i.e. massage, chiropractic medicine, acupuncture, etc. for a combined total of 10. You will pay our normal fee and MSP will reimburse you $23 directly. Please let the front desk know if you are on Preminum Assistance.

Extended Medical

We do not bill directly to insurance companies. You will receive a complete receipt that you can submit to your insurance provider.

Declaration

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

1. I am not limited to exclusive treatment from a Naturopath. 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 I will receive explanation of the treatments performed and foreseable side effects of services that I will receive from my Naturopathic Doctor.
3. I hereby authorize and consent to Naturopathic treatment including dietary and lifestyle modification, botanical medicines, acupuncture, homeopathic medicines, and spinal manipulation.
4. I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during intake of case.
5. 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.
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.

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.

_____ _____

Date Patient Signature
(Parent, Legal Guardian or Relative)

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.

_____ _____

Date Practitioner Signature