Dr. Karen Lam, TCM, R.Ac
Doctor of Traditional Chinese Medicine
Registered Acupuncturist

Confidential

New Patient Consultation Form

Dear New Patient,

Welcome and thank you for choosing Integrative Naturopathic Medical Centre. Enclosed in this package are several forms for you to complete before your initial visit. Please complete them in as much detail as possible as they will provide valuable information about your health and any potential areas of concern.

In addition to the new patient consultation forms, please bring with you copies of any recent laboratory or diagnostic test results as well as any other information you feel is important. These can be obtained, by you, from your medical professional or can be requisitioned by our office during your initial visit.

Each person has a unique set of factors that contribute to their overall health and well-being. These include, but are not limited to, the following: diet, lifestyle, genetics, and environmental exposure, and stress, physical and emotional well-being. My goal as a Doctor of Traditional Chinese Medicine is to take these factors into consideration in order to provide you with the best individualized treatment possible.

During our initial consultation, we will review your symptoms and health history in as much detail as possible in order to identify the root of your concerns and determine which approach will be most beneficial.

In the meantime, please refer to our website www.integrative.ca, for more information on the many services offered at Integrative Naturopathic Medical Centre. If you have any questions or concerns, please feel free to contact the clinic at any time.

I look forward to meeting you in person and working together to achieve your health goals.

Sincerely,

Dr. Karen Lam

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 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

INTEGRATIVE
Naturopathic Medical Centre

Health History Questionnaire

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:
☐ Telephone	Daytime phone number:
☐ Text	Cell phone number:
Would you like to receive emails that include newsletters, health tips, and upcoming events? Yes ☐ No ☐	
Email Address (if not indicated above):	

Personal Health History	
Medical Doctor:	Phone:
Other Health Care Provider:	Phone:
List any allergies or sensitivities (medications, foods, environmental, etc.):	
Allergen	**Reaction**

INTEGRATIVE
Naturopathic Medical Centre

Health History Questionnaire

Personal Health History		
Pregnancies (if applicable)	Have you ever been pregnant? ☐ Yes ☐ No	
# Pregnancies _____	# of Miscarriages _____	# of Terminations _____
Please describe details:		

What is your primary health concern?	
Describe what it feels like:	
Are there any other related symptoms?	
What aggravates or alleviates your symptoms?	
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?	
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?	
Have you ever been treated for a serious or infectious disease (pneumonia, tuberculosis, Lyme etc)? Yes ☐ No ☐	

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	**Age Started/Length of Use**	**Side Effects**

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					

INTEGRATIVE
Naturopathic Medical Centre

Health History Questionnaire

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? ☐ Yes ☐ No			
	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.)			☐ Yes ☐ No
	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	Recent changes in:	
☐	Lungs	☐	Weight
☐	Chest/Heart	☐	Energy level
☐	Back	☐	Ability to sleep
☐	Hair loss/growth	☐	Temperature
☐	Other pain/discomfort:	Stress:	

Is there anything else that you feel is important about your health or lifestyle? (please describe)

Health History Questionnaire

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 Root canals & extractions, first silver amalgam filling, braces, retainer, etc.	Age

Injuries/Accidents	Stiches?	Age

INTEGRATIVE
Naturopathic Medical Centre

Health History Questionnaire

Dr. Karen Lam, TCM., R.Ac.

Declaration and Informed Consent to Treat

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 or guarantee reimbursement. We will provide receipts that can be submitted to your extended medical plan.

Declaration

This 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 I will receive explanation of the treatments performed and foreseable side effects of services that I will receive from Dr. Karen Lam.
3. I hereby authorize and consent to treatment including dietary and lifestyle modification, botanical medicines, acupuncture, homeopathic medicines, and spinal manipulation by Dr.Karen Lam.
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 Dr. Lam's 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 also consent to the following indicated treatment with Dr. Karen Lam: (Please select all that apply)

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

Please sign and date:

I have read and understand the above declaration. Dr. Lam has explained the procedure(s) to me so that I fully understand. 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 Dr. Karen Lam TCM.,R.Ac