525 BROOKER RIDGE, UNIT #109 NEWMARKET ON L3X 2M2 T: 905.953.1008 / F: 905.235.5308

WELCOME…

Dear Patient:

Thank you for choosing Align Health Centre for your Health Care needs. By choosing our clinic, we assure you that are choosing the highest quality of health care. In order to best help you, we need to know about your medical history. Please take a few moments to fill in the enclosed intake form before your first appointment.

Your initial visit will be a two-part visit scheduled 1 week apart. The first part is 60 minutes, and includes an in-depth history taking and physical exam. The second part is also 60 minutes and includes a review of systems and a personalized treatment plan. Subsequent visits are 30-45 minutes in length. Please refer to the table below for fee breakdown.

During the first part of the initial visit, an in-depth health history is taken in order to understand all the factors that may be affecting your health. The visit will also include a complaint oriented physical exam, and may include diagnostic tests such as urine analysis and Chinese tongue and pulse taking. Additional laboratory testing may be discussed and performed if indicated. All this information will assist me in making a thorough assessment of your condition. For the second part of the initial visit, a personalized treatment plan will be designed and discussed. Follow up visits may vary in frequency and length based on your individual needs as well as the nature of your health concerns.

All information will remain completely confidential. We will not be contacting your other health providers unless a written authorization from you is provided.

Fee Breakdown

Initial Visit – Part 1 – History taking and Physical Exam (1 Hour)	$87.00 + HST
Initial Visit – Part 2 – Review of Systems and Treatment (1 Hour)	$87.00 + HST
Follow-Up Visit (45 minutes)	$84.00 + HST
Follow-Up Visit (30 minutes)	$67.00 + HST
Phone Consultation (15 Minutes)	$35.00 + HST
Acupuncture – (30 minutes) Traditional Chinese Medicine	$67.00 + HST
Facial Rejuvenation Acupuncture	$111.00 + HST

If possible, please arrange, bring, mail or fax all medical test results (blood, urine, ultrasound, MRI's, surgical reports) pertaining to your health from your physician's office.

Please remember that it takes time to feel better when using naturopathic medicine. You may be someone who has spent many years with a chronic problem unsolved by conventional medicine; or you may be feeling well and want to make adjustments in order to improve your general health. No matter what your reasons are for coming, remember that some patients need to be patient! The more you are able to participate in your own care, the easier it will be to address your health concerns.

1. This is to acknowledge that I have read the above information and understood its contents.
2. I agree to pay my full account at the time of each visit or treatment, including fees for services, laboratory tests or any supplements or remedies I wish to purchase,

__________________________ __________________________

Patient Signature Date

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INTAKE FORM

PERSONAL INFORMATION			
Name:			Date of 1st Visit:
Date of Birth:	Age:		Gender: M F
Address:			
City:	Prov:		Postal Code:
Phone (home):			Phone (work):
Phone (cell):			Email:
Occupation:			Hours worked per week:
Can a message be left regarding your visit? ☐ Home ☐ Work ☐ Cell ☐ Please don't leave a message regarding visit			
Martial Status: ☐ Single ☐ Common-Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed			
Live with (check all that apply): ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone			
Number of Children:			
If you are female, are you currently pregnant? ☐ Y ☐ N			

OTHER HEALTH CARE PROVIDERS	
1.	2.
Occupation:	Occupation:
Phone:	Phone:
Fax:	Fax:

EMERGENCY CONTACT	
Name:	Relationship:
Phone (home):	Phone (work / cell):

HOW DID YOU HEAR ABOUT OUR CLINIC? ______________________

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INTAKE FORM

MAIN HEALTH CONCERNS

Rank Your Health Concerns in order of importance	When did it begin?
1.	
2.	
3.	
4.	
5.	

What type of therapies have you tried in the past for this concern(s)?

☐ Diet Modification ☐ Vitamins / Minerals ☐ Fasting ☐ Herbs ☐ Homeopathy ☐ Chiropractic
☐ Acupuncture ☐ Pharmaceuticals ☐ Other ______________________

What was the outcome? ____

GENERAL INFORMATION

How would you describe your current state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Circle the level of current stress you are experiencing on a scale of 1 to 10 (1 being the least):

1 2 3 4 5 6 7 8 9 10

Please identify your major cause of stress (financial, job, family, etc): ______________________

Do you consider yourself: Overweight Underweight Just right Current weight ________ Maximum weight ________

Have you experienced any unintentional weight loss of 10 lbs or more over the last 3 months? ☐ Yes ☐ No

What do you usually eat and drink for:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

Do you have any food allergies or intolerances? ____

Do you have any dietary restrictions? (religious, vegan, vegetarian, etc.) ______________________

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INTAKE FORM

List any medications / supplements that you have or are currently taking (P = past / C = current):

YEAR	P / C	NAME OF MEDICATION / SUPPLEMENT	ILLNESS	ADVERSE REACTIONS

Do you take any of the following frequently:

☐ Asprin ☐ Tylenol ☐ Ibuprofen ☐ Laxatives ☐ Cough remedies ☐ Antacids ☐ Diet pills ☐ Birth Control

Major Hospitalizations, Surgeries and Injuries: please indicate dates and complications (if any)

YEAR	ILLNESS, SURGERY, INJURY

If known, please list the immunizations that you have received:

☐ DPT (diphteria, pertussis, tetanus) ☐ H. influenza B ☐ Hepatitis A ☐ Hepatitis B ☐ Polio

☐ Tetanus booster ☐ “flu shot” ☐ Small Pox ☐ MMR (measles, mumps, rubella)

Have you ever had a reaction to a vaccine? ☐ Yes ☐ No

Are you exposed to any harmful chemicals (e.g. renovations, pesticides)? ☐ Yes ☐ No

If so, please explain: ______________________________

____

Please check all that apply to the following questions:

Any changes in your ability to: ☐ See ☐ Hear ☐ Taste ☐ Smell ☐ Feel sensations

Strong like for any of the following tastes: ☐ Sour ☐ Bitter ☐ Sweet ☐ Salty ☐ Rich / Fatty ☐ Spicy / Pungent

Strong dislike for any of the following tastes: ☐ Sour ☐ Bitter ☐ Sweet ☐ Salty ☐ Rich / Fatty ☐ Spicy / Pungent

Do you prefer: ☐ Warmth (e.g. drinks, weather) ☐ Cold (e.g. drinks, weather) ☐ No Preference

What is your best time of day: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

What is your worst time of day: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night

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INTAKE FORM

REVIEW OF SYSTEMS (Y = Yes, Currently / P =In the Past/ N = No Never)

SKIN	Y	P	N	EYES	Y	P	N	MEN'S HEALTH	Y	P	N
ACNE, BOILS				CATARACTS				PAIN IN TESTICLES			
PSORIASIS				GLAUCOMA				CHANGES IN SCROTUM			
ECZEMA / RASH				PAIN				DISCHARGE			
NIGHT SWEATS				REDNESS				SORES			
CHANGE IN MOLE				BLURRED VISION				SEXUALLY TRANSMITTED INFECTION			
COLOUR / TEXTURE CHANGE				CHANGES IN VISION				SEXUAL DIFFICULTIES			
THINNING HAIR				FLOATERS (SPOTS IN VISION)				HERNIA			
TEMPERATURE CHANGES				DOUBLE VISION				BREAST CHANGES			
DRYNESS				BOTHERED BY SUN				**WOMEN'S HEALTH**			
EXCESSIVE SWEATING				GLASSES / CONTACTS				MENSTRUAL CRAMPS			
LUMPS				DISCHARGE / TEARING				PMS			
EASILY BRUISE / SLOW HEALING				**HEAD**				PERIODS REGULAR			
NAIL CHANGES				HEADACHE				HEAVY FLOW			
ITCHING				DIZZINESS				PAIN DURING INTERCOURSE			
NOSE				HEAD INJURY				VAGINAL DISCHARGE			
DISCHARGE				**NECK**				VAGINAL ITCHINESS			
POLYPS				ENLARGED GLANDS				YEAST INFECTION			
ITCHY				THYROID ISSUES				SEXUAL DIFFICULTIES			
SINUS INFECTION				PAIN /STIFFNESS				SEXUALLY TRANSMITTED INFECTIONS			
POST NASAL DRIP				**EARS**				BREAST SELF-EXAM			
FREQUENT COLDS				CHANGES IN HEARING				UTERINE FIBROIDS			
NOSE BLEEDS				HEARING AID				BREAST TENDERNESS			
HAY FEVER				EARACHES				NIPPLE DISCHARGE			
STUFFINESS				EAR INFECTION				BREAST LUMPS			
THROAT & MOUTH				**RESPIRATORY**				AGE OF FIRST MENSES			
SORE THROAT				FREQUENT INFECTIONS				LENGTH OF CYCLE			
DIFFICULTY SWALLOWING				PNEUMONIA				LENGTH OF PERIOD			
BAD BREATH				COUGH				AGE OF MENOPAUSE			
CAVITIES				YELLOW / GREEN PHLEGM				**URINARY**			
CHANGES IN TASTE				WHEEZING				BLOOD IN URINE			
SORE TONGUE				ASTHMA				URINARY TRACT INFECTION			
TIMES / DAY BRUSHING TEETH				SPITTING UP BLOOD				URGENCY			
LAST VISIT TO DENTIST				SHORTNESS OF BREATH				INCONTINENCE			
				BRONCHITIS				KIDNEY STONES			
				TUBERCULOSIS EXPOSURE				FREQUENT AT NIGHT			
				PAIN				DIFFICULTY URINATING			
				LAST CHEST X-RAY				CHANGE IN FREQUENCY			

CONTINUED ON NEXT PAGE...

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INTAKE FORM

MUSCLES & SKELETON	Y	P	N	ENDOCRINE	Y	P	N	CARDIOVASCULAR	Y	P	N
BACK PAIN				DIABETES				HIGH BLOOD PRESSUE			
JOINT PAIN / STIFFNESS				EXCESSIVE THIRST				PALPITATIONS			
ARTHRITIS				EXCESSIVE HUNGER				IRREGULAR HEARTBEAT			
BROKEN BONES				EXCESSIVE SWEATING				CORONARY ARTERY DISEASE			
WEAKNESS				FATIGUE				FATIGUE WITH EXERTION			
SPASMS / CRAMPS				LOW BLOOD SUGAR				MURMUR			
JOINT SWELLING				HEAT / COLD INTOLERANCE				CONGENITAL HEART CONDITION			
GASTROINTESTINAL				HORMONE THERAPY				CHEST PAIN			
FLATULENCE				**PERIPHERALVASCULAR**				**EMOTIONAL**			
BURPING				VARICOSE VEINS				ANXIETY			
BLOATING				COLD EXTREMITIES				LOW MOOD			
DIARRHEA				SWELLING IN HANDS / LEGS				DEPRESSION			
CONSTIPATION				ACHING LEG				PANIC ATTACKS			
BLOOD IN STOOL/BLK STOOL				NUMBNESS				INSOMNIA			
GREY STOOL				ULCERS ON EXTREMITIES				RAGE			
STOMACHACHE								MOOD SWINGS			
ABDOMINAL CRAMPING								PHOBIAS / FEARS			
CHANGES IN APPETITE								NIGHTMARES			
LACK OF APPETITE											
# OF BOWEL MOVEMENTS / DAY											
VOMITING											
NAUSEA											
HEARTBURN											
SOUR TASTE IN MOUTH											
FOOD INTOLERANCES / ALLERGIES											
GALL BLADDER REMOVED											
HEMMORHOIDS											
CHANGES IN BOWEL HABITS											
INDIGESTION											

FAMILY HISTORY

HEALTH PROBLEMS	RELATIONSHIP TO PATIENT	AGE OF ONSET
ARTHRITIS		
ASTHMA		
ALZHEIMER'S DISEASE		
AUTOIMMUNE (MS, LUPUS)		
CANCER		
DEPRESSION		
DIABETES		
HYPERTENSION		
ALLERGIES		
HEART PROBLEMS		
OTHER		

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INTAKE FORM

HEALTH HABITS - PLEASE CHECK ALL THAT APPLY

EXERCISE		LIFESTYLE		FOOD FREQUENCY		SLEEP	
5-7 DAYS PER WEEK		SMOKE CIGARETTES		SKIP BREAKFAST		WAKE FEELING RESTED	
3-4 DAYS PER WEEK		YEAR: ________ PACKS / DAY: ________		ONE MEAL PER DAY		WAKE FEELING TIRED	
1-2 DAYS PER WEEK		EXPOSED TO 2ND HAND SMOKE		TWO MEALS PER DAY		8-10 HOURS PER NIGHT	
45 MINUTES OR MORE DURATION / WORKOUT		DRINK WATER		THREE MEALS PER DAY		6-8 HOURS PER NIGHT	
30-45 MINUTES DURATION / WORKOUT		GLASSES / DAY ______		GRAZE (SMALL FREQUENT MEALS)		LESS THAN 6 HOURS PER NIGHT	
LESS THAN 30 MINUTES DURATION / WORKOUT		DRINK COFFEE OR TEA		EAT CONSTANTLY WHETHER HUNGRY OR NOT		SLEEP THROUGHOUT THE NIGHT	
WALK		CUPS / DAY _______		EAT ON THE RUN		DIFFICULT FALLING ASLEEP	
RUN, JOG, JUMP ROPE		DRINK ALCOHOL		ADD SALT TO FOOD		DIFFICULTY STAYING ASLEEP	
WEIGHT TRAIN		DRINKS / WEEK _______					
YOGA		USE RECREATIONAL DRUGS					
SWIM		WHICH ONES: ______________					
OTHER: ____________________							

Do you get regular screening tests from another doctor? (Pap, physical, blood work) ☐ Yes ☐ No

Date of last physical exam ____

If you are sexually active, what form of contraception do you use: ☐ Birth Control Pill ☐ Condom ☐ Diaphragm IUD
☐ Sponge ☐ Cervical Cap ☐ Other: ______________________

PERSONAL OVERVIEW

Reversing illness by treating the underlying cause of disease, and effectively managing health care *does not happen overnight*. It requires a commitment to lifestyle change, and following therapeutic protocols.

How would you describe your present level of commitment to making changes in your health? Please circle one of the following.

(%) 0 10 20 30 40 50 60 70 80 90 100

What are your expectations of Naturopathic Medicine?

____

____

____

Is there anything that you feel is important that has not been covered here?

____

____

____

Patient Signature (or Guardian) : ____________________________________

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INFORMED CONSENT NATUROPATHIC TREATMENT

****PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR FIRST APPOINTMENT****

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle non-invasive techniques are generally used in order to stimulate the body's innate healing capacity. The Naturoapthic Doctor will take a thorough case history; perform a physical exam including breast exam, and take blood and urine samples (if required).

It is important that you inform the Naturopathic Doctor immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight risks associated with naturopathic medicine.

These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. The duration is usually short.
- An allergic reaction may occur to the supplements and/or herbs that are taken. Please, advise your Naturopathic Doctor of any allergies that you have.
- Pain, bruising or injury from venipuncture or acupuncture.
- Fainting or puncturing of an organ are extremely rare; however, you should be aware of the risk.
- Naturopathic Doctors are trained to handle emergencies should they occur

I understand:

- The clinic does not guarantee treatment results
- The Naturopathic Doctor will explain the exact nature of any treatment provided and will answer any questions that I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.

Patient's Name: (Please print): ______________________________

Signature of Patient or Guardian: ______________________________

Signature of Naturopathic Doctor: ______________________________

Date: ______________________________