New Patient Intake Form

Date_____

Name_____

Address_____ Phone #_____

City, Province_____ Postal Code_____

Date of Birth (M/D/Y) _____ Email Address _____

Sex: M or F Age: _____ Marital Status S M D W

Occupation_____

Address_____

City_____
Phone #_____

Provincial Health Card Number_____

Prior Naturopathic

Name_____ Phone#_____

Medical Doctor:

Name_____ Phone#_____

Address_____

How did you hear about our office:_____

Medications/ Supplements

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medications	Dosage	How long?	Medications	Dosage	How long?
1.			**4.**		
2.			**5.**		
3.			**6.**		

Please list all current vitamins/minerals, herbs, or homeopathies, the daily dose and how long you have taken it.

Supplements	Dosage	How long?	Supplements	Dosage	How long?
1.			**5.**		
2.			**6.**		
3.			**7.**		
4.			**8.**		

Allergies (Please list all known)

Allergies	Items	Reactions
Medications		
Foods		
Environment		
Animals		

Consent to Treatment

1. That you understand that the methods utilized in this practice have a proven clinical Foundation yet may not be accepted practice by standard (allopathic) medicine.

2. That you understand that treatment and/or referral to other health practitioners is based upon the assessment of your health revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation.

3. That you understand that the practitioner reserves the right to determine which cases fall outside their scope of practice, in which event an appropriate referral will be recommended.

4. That you are not an agent of any private or governmental agency attempting to gather information without so stating your intentions.

5. That you are accepting or rejecting this care of your own free will.

6. That you understand that the ultimate responsibility for your health care is your own, and that we are here to support you in this. We reserve the right to discontinue our services where it is apparent that your expectations and what we provide are not in agreement.

7. That you understand that fees are payable at the time of the appointment by the patient or guardian. There is a fee for completion of any insurance forms. 24 hours notice is required for appointment cancellation, otherwise you will be responsible for the full fee. Any special financial agreement may be made with your practitioner.

I, _____ have read, understood and acknowledge the above.

(Print name)

Signature: _____ Date: _____

(Signature of Client or Guardian) (To be signed at the office during your first visit)

Supplements

Name of Supplements	Dose	Date