King West Chiropractic Health Centre
145 King Street West, Concourse Level, Toronto, ON, M5H 1J8
Tel: 416.815.9595   Fax: 416.815.9009

ADULT INTAKE FORM

Date: ___________________________

First Name: _____________________________________

Last Name: _____________________________________

Date of Birth: ___________________________________ Sex: M F
Day / Month / Year

Address: ____

City: ____ Postal Code: ______________

Phone: [home]___________________________________
[work] __________________________x______
[other] __________________________________
Email Address: _________________________________

May we leave messages at any of these numbers?
Y N

Emergency Contact: Name: ______________________ Relation: _________________
Phone: ______________________

Who is your insurance provider? ____

How did you find out about the clinic / referred by? __________________________________

Other health care providers: Please list name, address, phone number

1.	2.	3.

Please list your health concerns, in order of importance to you

1.
2.
3.
4.

MEDICAL HISTORY

How would you describe your state of health? Excellent Good Fair Poor
(please circle one)

Please list any past and current medical condition, injuries, illnesses, and hospitalizations, including approximate dates:

Past Prescription Medications:

Current Prescription Medications:

Current Supplements:

Do you suffer from allergies (environmental, food, or medical?) Please List

How many times have you been treated with antibiotics? __________

Do you currently use any of the following? (please circle)

Aspirin Antacids Laxatives Diet pills
Birth Control pills/implants/injections Cortisone Sedatives

Alcohol---how much/day or week _________________________

Tobacco---how much/day or week _________________________
Caffeine (coffee, tea, cola) – how much/day or week _____________________

Recreational drugs---what and how often ______________________________

Please indicate which vaccinations you have had?

* DPT (diphtheria, perussis, tetanus)
* Haemophilus influenza B
* Polio
* Hepatitis B
* Other

*MMR (measles, mumps, rubella)
*'Flu' vaccine
*Hepatitis A
*Tetanus – date _________________

____

Please list any adverse reactions

____

Do you have regular screening tests done by another doctor? (Pap test, blood tests, prostate etc) Y_______ N_______

DIET

Do you have any food allergies or intolerances? Please list

____
____
____
____

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

____
____

Please describe a typical day's diet:

Breakfast

____

Lunch

____

Dinner

____

Snacks

____

Beverages (and quantity)

____

FAMILY HISTORY

Please indicate if anyone in your family has had any of the following:

Allergies		Cancer	
Asthma		Heart Disease	
High Blood Pressure		Diabetes	
Stroke		Kidney Disease	
Depression		Other mental illness	
Drug abuse/alcoholism		Neurological disorders	
Autoimmune Diseases		Other	

- I don't know my family medical history

FEMALE:

*Do you conduct regular (monthly) self-breast examinations?
*Are you currently pregnant?
*If you are menstruating, what was the first day of your last menstrual period?
*At what age did your menses begin?
*What is the length of your cycle?
*If your menses has changed or ceased, when did this start?
*Have you been pregnant?
*How many times have you carried to full term?

MALE:

*If you are 40 or older, do you get regular prostate screening exams/tests?
    *If yes, when was your last exam?
*Have you ever been diagnosed with prostate problems? (please provide details)

*Do you conduct monthly self-testicular examinations?

LIFESTYLE

Occupation:

____

Do you exercise regularly? What form and how often?

____

Are you regularly exposed to toxins or other hazards (work, home etc)? Please describe.

____

____

How would you describe the emotional environment of your home?

____

____

How stressful is your life (including work and home)? How do you handle these stressors?

____

____

Is there anything that you feel is important that has not been covered in this form?

____

____

Thank You

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Dear Patient: Welcome to Naturopathic Medicine!
Please take a few moments to read over our office policy. We will be happy to answer any questions you may have regarding this policy or procedures employed in the clinic.

OFFICE POLICY

<u>*Fee Schedule:</u>

Initial Visit (60-90 min)	$175.00
Follow-up Visit (45 min)	$85.00
Subsequent Visit (30 min)	$70.00
Acute Visit (20 min)	$45.00

<u>*Acupuncture Packages</u>

Package of 6 Treatments	$360.00
Package of 12 Treatments	$660.00

Packages are encouraged to be utilized within 3-6 months to optimize treatment outcome

****All prices are subject to change and do not include GST**

Missed Appointments

At least 24 hours notice is required when canceling or rescheduling any appointments. Patients are responsible for the full fee of any missed appointments without 24 hour notice.

Insurance

Many benefit plans cover some or all Naturopathic services to some extent. While the Naturopathic Services at KWC do not deal directly with insurance companies, we do issue official receipts that may be submitted for reimbursement.

Privacy Policy

The personal information collected is for limited and confidential use by the clinic. The information will not be released to others unless so directed by the patient themselves unless law requires it. We reserve the right to contact you on occasion for the following purposes: confirming appointments, clarifying your prescriptions and protocols, clarifying your account and clinic updates/promotions.

Patient Signature: ___________________________________ Date: ________________

PATIENT INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Naturopathic Doctors are highly trained in physical clinical diagnosis, much the same as general practitioner MDs. Diagnostic procedures include, but are not limited to, a complete medical, social and environmental history of the individual and a screening physical examination, which may include a breast exam, laboratory and orthopedic testing as well as possible referral to another practitioner.

Once a clinical diagnosis has been reached, there are a number of different possible treatment approaches that may be used, and a unique treatment plan will be developed for each individual. The majority of treatments used by Naturopathic Doctors fall under one or more of the following categories: clinical nutrition and nutraceuticals, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine, naturopathic bodywork / manipulations and counseling. Although naturopathic treatments are considered gentle and safe when administered correctly, they are not without risks and/or side effects in specific health conditions or if used incorrectly. Your attending Naturopathic Doctor will discuss any specific risk factors of your treatment with you.

If you are on any medications, pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

Slight health risks to treatment by naturopathic medicine include but are not limited to:

Aggravation of pre-existing symptoms.

Allergic reactions to supplements or herbs.

Pain, bruising or injury from venipuncture or acupuncture.

Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.

Muscle strains and sprains, disc injures from spinal manipulation and the potential for stroke is a concern in neck manipulation. Clinical research has shown that stroke-like occurrences are rare – approximately 1 in 1.5 million manipulations.

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PATIENT INFORMED CONSENT

I, ___________________________________ the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic and therapeutic procedures and have discussed, to my satisfaction, this and any requests for related information from the Naturopathic Doctor. I further acknowledge and confirm that I have been informed of and understand the therapeutic procedures with respect to the financial costs, expected benefits, potential risks and side effects of specific treatments, the likely consequences of not having / following the procedures, and what alternative course(s) of action are available to me. I intend this consent form to cover the entire course of treatment for my present condition.

I understand that the results are not guaranteed. I do not expect the Naturopath Doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

As a result, I do hereby voluntarily CONSENT for the recommended diagnostic and therapeutic procedures as specified by my attending Naturopathic Doctor. I also understand that I may change the status of my voluntary informed consent at any time.

Signature of Patient or Lawful Representative　　　　Date Signed (dd/mm/yyyy)

______________________________________　　　　________________________

Signature of Attending ND　　　　Date Signed (dd/mm/yyyy)

______________________________________　　　　________________________

CHANGE TO INFORMED CONSENT

I do hereby CONSENT / WITHHOLD / WITHDRAW MY INFORMED CONSENT for the recommended diagnostic and therapeutic procedures / plan as specified by my attending Naturopathic Doctor. I also understand that I may change the status of my voluntary informed consent at any time.

Signature of Patient of Lawful Representative   Date Signed (dd/mm/yyyy)

_______________________________________   ________________________

Signature of Attending ND   Date Signed (dd/mm/yyyy)

_______________________________________   ________________________

____