

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: _____ <small>Day / Month / Year</small>		Sex: M F	
Address: _____			
City: _____		Postal Code: _____	
Phone: [home] _____		May we leave messages at any of these numbers? Y N	
[work] _____ x _____			
[other] _____			
Email Address: _____			
Emergency Contact: Name: _____		Relation: _____	
Phone: _____			
Who is your insurance provider? _____			
How did you find out about the clinic / referred by? _____			
Would you like to receive our King West Newsletter? Y _____ N _____			

Other health care providers: Please list name, address, phone AND fax numbers

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

Please list any past and/or current medical conditions, injuries, illness' and hospitalizations, including approximate dates:

Past prescription medications:

Current prescription medications:

Current supplements and time of day taken:

Do you suffer from allergies (environmental, food, 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	Birth Control Pills
Cortisone	Sedatives	Diet Pills	

Alcohol→ how much per day/week _____

Tobacco→ how much per day/week _____

Caffeine Intake (including coffee, tea, cola) → how much per day/week _____

Recreational Drugs → what and how often? _____

Please indicate which vaccinations you have had?

- DPT (diphtheria, pertussis, tetanus)
- Haemophilus influenza B
- Polio
- Hepatitis A
- Hepatitis B
- MMR (measles, mumps, rubella)
- 'Flu' shot
- Tetanus – Date _____
- Other _____

Please list any adverse reactions _____

Do you get regular screening tests done by another doctor? (Pap test, blood work, 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 (list type)	
Asthma		Diabetes	
High Blood Pressure		Kidney Disease	
Heart Disease		Other Mental Illness	
Depression		Neurological Disorders	
Drug/Alcohol Abuse		Thyroid Imbalances	
Stroke		Autoimmune Disease	

- I don't know my family medical history

FEMALE:

Do you conduct monthly self-breast examinations?

Are you currently pregnant?

If you are menstruating, what was the first day of your last 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? _____ If yes, how many times have you carried to term?

MALE:

Do you conduct regular self testicular examinations?

If you are 40 or older, do you receive regular prostate screening exams/tests?

If yes, when was your last exam?

Have you ever been diagnosed with prostate problems? (if yes, please provide details)

Lifestyle

Occupation:

Do you exercise regularly? What form and how often?

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

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 else that you feel is important that hasn't 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

***Fee Schedule:**

Initial Visit (60-90 min)	\$178.00
Follow-up Visit (45 min)	\$88.00
Subsequent Visit (60 min)	\$130.00
Subsequent Visit (30 min)	\$73.00
Acute Visit (20 min)	\$45.00

***Acupuncture Packages**

10% discount offered on packages of 6 or more acupuncture treatments (30 min sessions). Please speak with Dr. Smith for details. Packages are encouraged to be utilized within 3-6 months to optimize treatment outcome

****All prices are subject to an annual 3-5% increase and do not include HST**

Missed Appointments and Late Cancellations

We require advanced notice of 24 hours for cancelled appointments in order to notify, in a reasonable amount of time, other patients who may be waiting for an appointment, that an opening has become available. A flat fee of \$40.00 will be charged for missed appointments or appointments cancelled with less than 24 hours

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

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)
