Chiropractic
Acupuncture
Massage Therapy
Foot Orthotics
Naturopathic Medicine

KING WEST CHIROPRACTIC HEALTH CENTRE
145 King St. West, Concourse Level M5H 1J8 Tel: 416-815-9595 Fax: 416-815-9009
Email: kwc@bellnet.ca www.kingwestchiropractic.com

NATUROPATHIC ADULT INTAKE FORM

Date: _____
(mm/dd/yy)

Personal Information

Prefix: Dr Mr Mrs Ms Miss

Last Name First Name Initial(s)

Address City Province Postal Code

( ) - ( ) - ( ) -
Home Phone Number Work Phone Number Mobile Phone Number

May we leave messages? Y / N
Email Address

/ /
Date of Birth (mm/dd/yy) Occupation Insurance Provider

Who referred you? _____
Would you like to receive our King West Newsletter? Y / N

Emergency Contact

( ) - ( ) -
Name Relationship Daytime Phone Evening Phone

Information

What are your health concerns and goals, in order of importance to you?:

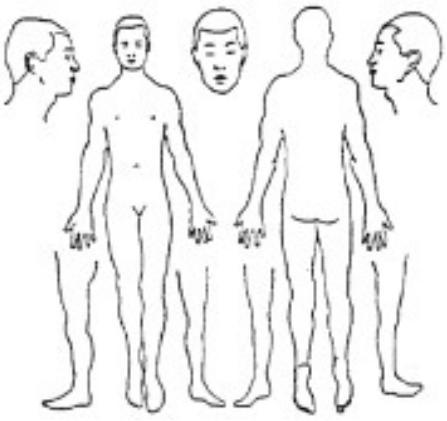
1
2
3
4

Please list your health care providers, including their name, address, phone AND fax numbers:

1	2	3

1. How would you describe your state of health? Excellent Good Fair Poor

2. Indicate any painful or distressed areas:



3. What behaviors/habits do you currently engage in that you believe *support* your health?:

4. Do you currently engage in any behavior/habits that you believe contribute *negatively* to your health?:

5. What potential obstacles can you foresee in adhering to treatment?:

6. How committed are you in adhering to treatment: Very / Somewhat / Minimally

Medical History

7. Approximately when was your last physical exam?:
8. Please indicate any serious conditions, illnesses or injuries, and any hospitalizations with approximate dates:

9. Have you had any special testing done (e.g. MRI, XRAY, Colonoscopy, Biopsy, etc.). If so, please list (what/when):

10. Do you have any allergies (medicines, environmental, etc)?: Yes / No
    If so, please list:

13. How many times have you been treated with antibiotics?:
14. Do you currently use any of the following? (Please circle):

Asprin Antacids Birth Control Pills Cortisone Diet Pills Laxatives Sedatives

15. Please list all current medications and natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.) and time of day taken:

16. Please list past prescription medications and natural health products:

17. Please list if and how much per day/week you use the following:
Alcohol: _____ Caffeine: _____
Tobacco: _____ Recreational Drugs (what kind): _____

18. Is there anything that you feel is important that has not been covered?:

Family History

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

Allergies		Diabetes		Neurological Disorders	
Asthma		Drug/Alcohol Abuse		Stroke	
Autoimmune Disease		Heart Disease		Thyroid Imbalances	
Cancer (list type)		High Blood Pressure		Mental Illness (list type)	
Depression		Kidney Disease			

☐ I don't know my family medical history

Female

Do you conduct monthly self-breast examinations?: Y / N
Are you currently pregnant?: Y / N
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? Y / N If so, how many times have you carried to term?: _____

Male

Do you conduct regular self-testicular examinations? Y / N
If you are 40 or older, do you receive regular prostate screening exams/tests? Y / N
If yes, when was your last exam?: _____
Have you ever been diagnosed with prostate problems? Y / N
If yes, please provide details: _____

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: _____ Date: _____
(mm/dd/yy)

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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)	$200.00
Follow-Up Visit (45 min)	$150.00
Subsequent Visit (60 min)	$110.00
Subsequent Visit (30 min)	$85.00

Acupuncture Packages*

10% discount is offered on packages of 6 or more acupuncture treatments (30 min sessions). Please speak with the Naturopathic Doctors 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 $45.00 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 King West Chiropractic Health Centre 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.

Signature: _____ Date: _____
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INFORMED CONSENT TO NATUROPATHIC TREATMENT

I, _____ the undersigned, do hereby understand and 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 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.
- the results are not guaranteed. I do not expect the Naturopathic 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.
- I am at liberty to seek or continue with medical care from a medical doctor or another Ontario licensed healthcare provider.
- I consent to the collection, use and/or disclosure of my personal information or medical history by the Naturopathic Doctor at King West Chiropractic Health Centre listed below as outlined by the privacy legislation and the Board of Drugless Therapy – Naturopathy (PIPEDA) (BDDT-N).

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.

I, _____, acknowledge that I have discussed or have had the opportunity to discuss with the Naturpathic Doctor at King West Chiropractic Health Centre, the nature and purpose of my treatment in general and my treatment in particular, as well as the contents of this Consent.

I consent to the treatments offered or recommended to me by the Naturopathic Doctor listed below. I intend this Consent to apply to my present and future Naturopathic care.

Date: _____
(mm/dd/yy)

_____ _____
Patient Signature Patient Name

_____ _____
Naturopathic Doctor Signature Naturopathic Doctor