vital health
NATUROPATHIC CLINIC
www.vitalhealthclinic.ca

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tel 780.449.4047 fax 780.449.0454
dispensary 780.417.8835

Date: _____

Name: _____ _____ Gender: M F

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____

May we leave messages related to your appointments? Y N If so, which number: HOME CELL WORK

Age: _____ Birthdate: _____

Address: _____

_____ _____

Email Address: _____

Please check to receive: ☐ Appointment Reminders & Confirmations ☐ Bi-Monthly Newsletter

Occupation: _____ Spouse's Occupation: _____

Living Situation: alone / with spouse / with partner / with family / with friend(s) / other

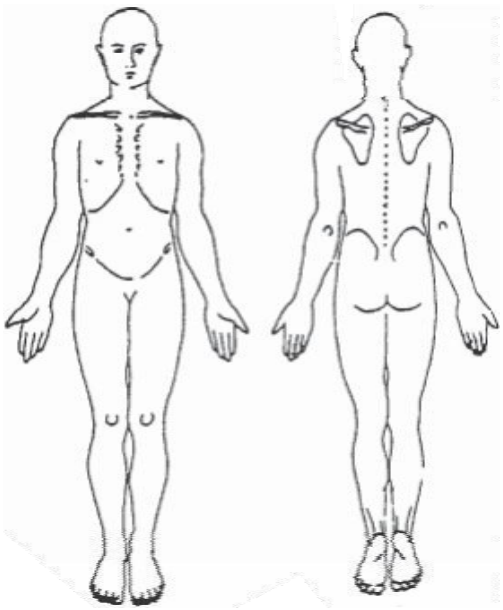
Health Professionals you visit: _____

_____

How did you hear about our clinic: word of mouth / Facebook / magazine / newspaper / radio

other (please specify) _____

Please circle any areas affecting you.



Briefly outline the reason for your visit today:

INFORMED CONSENT

Naturopathic Medicine promotes health, prevention and treatment of disease by natural means. Naturopathic Doctors (NDs) favor gentle, non-invasive techniques to stimulate the body's inherent healing capacity. A number of different therapies are used to address physical symptoms and the mental, emotional, and spiritual aspects of your health. These therapies include nutrition and vitamin supplements, herbal medicine, homeopathic medicine, Traditional Chinese Medicine & acupuncture, physical medicine (hydrotherapy, massage, adjustments, exercises and stretches), and counseling including lifestyle changes.

During your initial visit, your ND will take a thorough case history and perform a relevant physical examination. Your ND may request previous lab work already performed or order blood and urine samples for further testing.

Extra caution is taken with pregnancy and lactation, very young children, people with diabetes, heart, liver or kidney impairment and/or people taking multiple medications. It is very important that you inform your Naturopathic Doctor immediately of any illness(es) from which you are suffering and any medications (prescription and over-the counter) and/or supplements that you are currently taking. Please advise your ND immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

Even the gentlest therapies may cause complications in certain physiological conditions. These risks include, but are not limited to:

- Aggravation of pre-existing symptoms during the healing process
- Allergic reactions or side effects from supplements or herbs
- Pain, bruising, fainting or injury from intramuscular injections, acupuncture, or IV therapy

As a patient you will receive information about your diagnosis, treatment options, relevant costs, expected benefits, possible risks and side effects. Your ND will answer any questions that you may have to the best of his/her ability.
Naturopathic health care is a joint responsibility between the ND and the patient. Improving one's lifestyle and complying with treatment recommendations is just as important as the in-office treatment being provided, and results cannot be guaranteed. The ND is not necessarily expected to be able to anticipate and explain all the risks and complications for treatment. The patient chooses to rely on the ND to exercise professional judgment when deciding which treatment will be in the patient's best interest based on the facts known at the time. Naturopathic Medicine and Conventional Medicine are not mutually exclusive and therefore, the patient is free to and encouraged to seek or continue medical care from a qualified physician.

Patient records will be kept confidential and will not be released to others without consent from both the ND and the patient, unless required by law. Your ND may share pertinent information with other NDs at the clinic with the purpose of discussing the best course of treatment and to deliver safe and efficient care. Your personal information may be used to establish and maintain contact, communicate with other treating health-care providers, and to allow for efficient follow-up with treatment, billing and processing of payments.

As the patient, I understand that I am responsible for the total charges incurred for each visit, which I agree to pay at the conclusion of each visit. If I have coverage for Naturopathic Medicine through my Extended Health Coverage, I am responsible for billing my own insurance company.

In the event you do need to cancel or reschedule with less than 24 hours notice, you are welcome to have a friend or family member take your appointment to avoid paying 50% of the service's full fee. When booking an appointment at Vital Health we ask that you respect we are reserving staff member's time for your appointment. Our cancellation policy is being implemented to ensure staff member's do not suffer a loss of income when we are unable to fill an appointment cancelled with short notice.

I have read and understood the information and policies presented. I intend this consent form to cover the entire course of my treatment. I understand that I am free to withdraw this consent and discontinue participation at any time.

With this knowledge, I _____ (Name of Patient) voluntarily consent to treatment by the Naturopathic Doctors at Vital Health Naturopathic Clinic Inc. I ACKNOWLEDGE and DECLARE that I am aware and agree to all of the above and I thereby authorize Naturopathic Assessment, Examination & Treatment:

Patient Name: _____ (please print) Date: _____

Signature of Patient/Guardian: _____ If a minor, Guardian's name: _____

BODY SYSTEM	EXPLAIN ANY DIFFICULTIES YOU MAY EXPERIENCE
Head	
Neck	
Face	
Eyes/Ears	
Nose	
Mouth	
Throat	
Stomach	
Abdomen / Intestines	
Colon / Rectum	
Bowel Movements	
Liver / Gallbladder	
Kidneys	
Urination	
Chest	
Breasts	
Lungs	
Heart	
Circulation	
Blood	
Back	
Hands / Arms	
Feet / Legs	
Joints	
Skin	
Glands / Hormones	
Male / Female Organs	
Sexual Function	
Sleep	
Energy Level	
Mental Function	
Nervous Function	
Emotions	
Weight	

(OVER)

HAVE YOU EVER HAD:	YES If applicable	HAVE YOU EVER HAD:	YES If applicable
Alcohol Problems		Heart Problems	
Anemia		High Blood Pressure	
Arthritis/Gout		Hypoglycemia	
Back Problems		Kidney Troubles/Nephritis	
Broken Bones		Immune Diseases (HIV/AIDS)	
Blood Disorders		Liver, Cirrhosis, Hepatitis	
Cancer		Lung Diseases (TB, Pneumonia)	
Concussion/Head Injury		Mental Problems	
Diabetes		Migraine Headaches	
Eczema/Psoriasis/Hives		Multiple Sclerosis	
Epilepsy		Nervous Problems	
Frequent Colds		Polio/Meningitis	
Frequent Infections		Rheumatic Fever	
Food/Chemical/Drug Poisoning		Sexually Transmitted Diseases	
Gallbladder Troubles/Stones		Stroke	
Glandular or Hormonal Problems		Ulcers, Diarrhea, Colitis	

LIST ANY HOSPITALIZATIONS/SURGERIES
DATE/REASON:
DATE/REASON:
LIST ANY ALLERGIES
LIST MEDICATIONS/SUPPLEMENTS

DAILY HABITS	YES / NO	DAILY HABITS	YES / NO
Physical Exercise: Hours/week ____		Fresh Air & Relaxation	
Smoking: Cigarettes/day_____		Coffee/Tea: cups/day_____	
Alcohol: Drinks/day _____		Soft Drinks: glasses/day _____	
Drugs:		OTHER	