VITAL HEALTH
naturopathic clinic

#100 - 895 Pembina Rd.
Sherwood Park, AB T8H 3A5
Tel: 780-449-4047
Fax: 780-449-0454
www.vitalhealthclinic.ca

Date: _____ Birthdate (D/M/Y): _____ Age:_____

Name: _____ Gender: M F X

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

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

Email Address: _____

Please check if you would like to receive appointment reminders and confirmations via ☐ TEXT ☐ EMAIL ☐ BOTH

If you would like to receive our quarterly newsletter, please check here ☐

Emergency Contact Name:_____ Relation:_____ Phone Number:_____

How did you hear about our clinic: Word of Mouth / Google or Website / Facebook / Instagram

Home Address: _____

_____

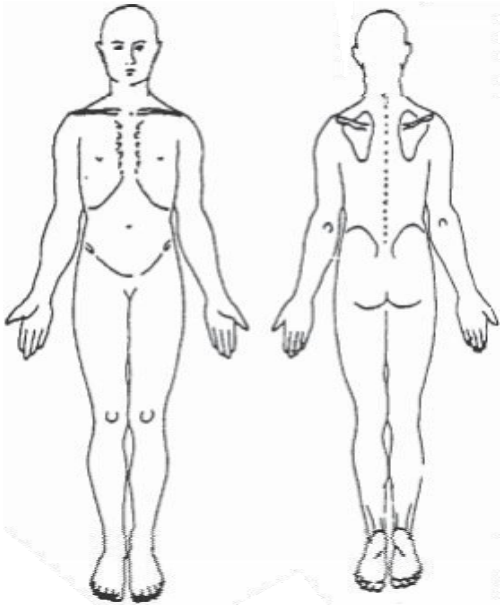
Living Situation: alone / with spouse / with partner / with family / with friend(s) / other:_____

Occupation: _____ Spouse's Occupation *(if applicable):* _____

Health Professionals you visit: _____

_____

Please circle any areas affecting you.



Briefly outline the reason for your visit today:

»

»

»

»

Please list any allergies:_____

_____

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 (adjustments, exercises, 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. It is very important that you inform your ND immediately of any illness(es) from which you are suffering, any medications (prescription and over-the counter), and/or supplements that you are currently taking. Vital Health is a scent reduced facility, please avoid from wearing any strong scents into the clinic.

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, or acupuncture

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. Please advise your ND immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis, treatment options, relevant costs, expected benefits, possible risks and side effects. Your Naturopathic Doctor (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 Naturopathic Doctor (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.

When booking an appointment at Vital Health we ask that you respect reserving the Doctors time for your appointment. 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 consultation fee. To book an appointment, we ask that patients please fill out the credit card authorization form attached. Our cancellation policy is being implemented to ensure the Doctors do not suffer a loss of income when we are unable to fill an appointment cancelled within short notice.

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. 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 the above and I thereby authorize Naturopathic Assessment, Examination & Treatment:

Patient Name (please print): _____
Date: _____

Signature of Patient, and/or Guardian: _____

If a minor, Guardian's name (please print): _____

Please check off any areas you are experiencing difficulties with:

- ☐ Head/ Neck
- ☐ Back
- ☐ Arms/ Hands
- ☐ Legs/ Feet
- ☐ Joints/ Arthritis
- ☐ Cognitive Function
- ☐ Eyes
- ☐ Ears
- ☐ Mouth/ Nose/ Throat
- ☐ Chest/ Lungs
- ☐ Heart
- ☐ Blood Circulation
- ☐ Breasts
- ☐ Hormones/ Libido
- ☐ Reproductive Organs/ Fertility
- ☐ Skin
- ☐ Sleep/ Energy
- ☐ Mental Health; Anxiety/ Depression/ Emotions
- ☐ Stomach/ Abdomen/ Bowel Movements
- ☐ Rectum/ Colon
- ☐ Liver/ Gallbladder
- ☐ Kidneys/ Urination
- ☐ Weight
- ☐ Other:_____

Have you ever had problems with:

- ☐ Alcohol/ Drugs
- ☐ Autoimmune Diseases
- ☐ Broken Bones
- ☐ Blood Disorders
- ☐ Blood Pressure/ Cholesterol
- ☐ Cancer
- ☐ Colitis/ Ulcers/ Constipation/ Diarrhea
- ☐ Concussions/ Head Trauma
- ☐ Frequent Colds / Infections
- ☐ Heartburn/ Acid Reflux
- ☐ Immune Diseases (HIV/AIDS)
- ☐ Kidney/ Gallbladder Stones
- ☐ Liver Diseases (Cirrhosis, Hepatitis etc.)
- ☐ Low Blood Sugars/ Diabetes
- ☐ Low Iron
- ☐ Lung Diseases
- ☐ Mental/ Nervous Disorders
- ☐ Migraine Headaches
- ☐ Poisoning (food, chemical, drug)
- ☐ Seizures
- ☐ Sexually Transmitted Infections
- ☐ Stroke
- ☐ Thyroid
- ☐ Other:_____

What are your daily habits? (approximately):

- ☐ Cigarettes, how many do you smoke per day?:_____
- ☐ Cannabis, how much do you consume per day?: _____
- ☐ Fresh Air & Relaxation, how many hours per week?: _____
- ☐ Physical Exercise, how many hours per week?: _____
- ☐ Screen time, how many hours per day?_____
- ☐ Other:_____

Does your family have any of the medical history below:

- ☐ Autoimmune Diseases
- ☐ Cancer
- ☐ Diabetes
- ☐ Dementia/ Alzheimer's
- ☐ High Blood Pressure/ Cholesterol
- ☐ Mental Illness/ Depression/ Anxiety
- ☐ Stroke/ Heart Attack
- ☐ Other:_____

Please list any prescription, over the counter medications, or supplements you are currently taking:

Please list any hospitalizations or surgeries below:

Please provide us an example of what you typically eat in a day:

- Breakfast

- Lunch

- Dinner

- Snacks

Please check off any liquids you drink daily, and how many cups of each:

- ☐ Water _____
- ☐ Pop _____
- ☐ Coffee _____
- ☐ Tea_____
- ☐ Milk_____
- ☐ Juice _____
- ☐ Alcohol; *include what kind* _____

Credit Card Authorization Form

When booking an appointment at Vital Health Naturopathic Clinic Inc., we ask that you respect reserving the Naturopathic Doctors' time for your appointment.

In the event a patient needs to cancel or reschedule with **less than 24 hours' notice, you will be charged 50% of the consultation fee**. Our cancellation policy is being implemented to avoid last-minute cancellations/ no shows. This ensures the Doctors do not suffer a loss of income when we are unable to fill an appointment cancelled within short notice. You are welcome to have a friend or family member take your appointment to avoid paying the cancellation fee.

Credit Card Information
Card Type: ☐ MasterCard ☐VISA
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy):
Cardholder Postal Code/ Street Address associated with card:

I _____, authorize Vital Health Naturopathic Clinic Inc. to charge my credit card 50% of the consultation fee if I am to cancel within 24 hours' notice of an appointment with no back up patient to fill the spot. I understand that my information will be saved on file.

_____ _____

Patient Signature Date