evolve*
CHIROPRACTIC & WELLNESS CENTRE

☐ **Evolve 5th Avenue**

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Naturopathic Patient Intake

* denotes R Macdonald Professional Corporation

First Name _____ Last Name _____ Emergency Contact Name and Number _____

Address _____ City _____ Postal Code _____

Cell Phone _____ Work Phone _____ Email (for appointment reminders) _____

Birthdate (dd/mm/yr) _____ Gender _____ Marital Status _____ Occupation _____

Family Doctor _____ ~~Last Physical Exam~~ _____ Alberta Health Care Number _____

For your convenience, we can keep a credit card on file:

Number: _____ - _____ - _____ - _____ Expiry: ____ / ____ CCV: _____

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name _____ Group ID/Policy Number _____ Member Number _____

Relationship to Cardholder (self, spouse, child) _____ Name of Cardholder _____

HEALTH INFORMATION

Health Priorities/ Chief Concerns:

List your main health concerns in order of importance:

1. _____
   _____
2. _____
   _____
3. _____
   _____

Describe your overall health: ☐ Poor ☐ Fair ☐ Good ☐ Excellent

MEDICAL HISTORY

Please indicate any serious illnesses, conditions, or reasons for hospitalization.

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose per day	How long?
1.		
2.		
3.		
4.		
5.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement/Brand	Dose per day	How long?
1.		
2.		
3.		
4.		
5.		

Please indicate any allergies and/or food sensitivities.

Allergy/Food Sensitivity	Symptoms

How many courses of antibiotics have you had in the past 5 years? _____

Were you frequently given antibiotics as a child?_____ If so, for what?_____

Have you had an adverse reactions from any vaccinations? _____

Do you use any of the following?

Type	Check one	How much/How often/Form
Alcohol	☐ Yes ☐ No	
Tobacco	☐ Yes ☐ No	
Caffeine	☐ Yes ☐ No	
Recreational Drugs	☐ Yes ☐ No	
Laxatives	☐ Yes ☐ No	
Antacids	☐ Yes ☐ No	
Diet Pills	☐ Yes ☐ No	
Pain Medication/ Pain Killers	☐ Yes ☐ No	
Birth Control	☐ Yes ☐ No	

Please indicate which of the following screening tests you receive.

Test	Check one	How often/ Most recent date
CBC (complete blood count)	☐ Yes ☐ No ☐ Never	
Breast Exam	☐ Yes ☐ No ☐ Never	
Mammogram	☐ Yes ☐ No ☐ Never	
DEXA Scan	☐ Yes ☐ No ☐ Never	
PAP Test (women)	☐ Yes ☐ No ☐ Never	
Digital Rectal Exam (Men)	☐ Yes ☐ No ☐ Never	
Testicular Exam (Men)	☐ Yes ☐ No ☐ Never	
PSA (Men)	☐ Yes ☐ No ☐ Never	
Cholesterol	☐ Yes ☐ No ☐ Never	
Blood Glucose	☐ Yes ☐ No ☐ Never	
Other (x-ray, ultrasound, EEG, ECG, CT scan, MRI, ect.)	☐ Yes ☐ No ☐ Never	

FAMILY HISTORY

Please indicate whether **you or your immediate family members** have or had the following:

Condition	Who?	Condition	Who?	Condition	Who?
Alchoholism		Cancer Type:		Depression	
Allergies				Osteoporosis	
Alzeimers		Drug Addiction		Parkinsons	
Arthritis Type:		Diabetes Type:		Seizure/Epilepsy	
				Stroke/Aneurysm	
Asthma		Eczema/Psoriasis		Thyroid Condition Type:	
Autoimmune Disease Type:		Heart Disease			
		Kidney Disease		Tuberculosis	
HIV/AIDS		Liver Disease		Other	

LIFESTYLE

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Glasses of water per day? _____

Cups/ glasses per day? Coffee ____ Black tea ____ Herbal tea ___ Pop ____ Other _____

Do you exercise? ☐ Yes ☐ No What type, how often? _____

Have you recently gained or lost weight? ☐ Yes ☐ No Weight gained/lost_____

Rate your stress level: (low) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 (high)

Which factors most contribute to your stress? ☐Health ☐Work ☐Money ☐Family ☐Marriage ☐Relationship ☐Other

Hobbies _____

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

_____

_____

How did you hear about us?_____

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Dr. Janelle Albas BSc, ND
Dr. Courtney Babcock BSc, ND
Doctors of Naturopathic Medicine
T: 403.474.7792

Declaration and Consent to Treatment

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications.

It is important that you inform your Naturopathic Doctor immediately of:

- Any disease process from which you currently suffer
- If you are on any medications either prescribed or over-the-counter
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently breast feeding
-

There are some health risks associated with treatment by Naturopathic Medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture
- Accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, and disc injuries from spinal manipulation.
- The very small potential for stroke is a concern in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that results are not guaranteed. I do not expect the ND to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise judgment during the course of my treatment which she feels is in my best interest based on the facts which are known**.**

I also understand that pharmaceutical grade supplements and herbal medicines prescribed and sold by my naturopathic doctor may be a part of my treatment protocol. This is to ensure that the appropriate dose and quality of medicine is administered and immediately available, in order to provide the most effective treatment possible. I also understand that there may be an additional cost for certain diagnostic procedures.

With this knowledge I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I intend for this consent to cover the course of my treatment. I am free to withdraw my consent and discontinue treatment at any time. I also testify that I am able to give legal consent or there is a parent or guardian able to sign on my behalf.

If I am unable to make a scheduled appointment I will provide 24 hours advance notice to avoid being charged a missed appointment fee of 100%. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as any other applicable fees. I understand that all supplements, labs and naturopathic fees are non-refundable.

Dated this_____ day of_____, 20_____.

Name: _____ **Signature: _____**

(please print) **(patient or legal guardian)**

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Consent for Collection, Use, and Disclosure of Personal Information

Your Naturopathic Doctor understands the importance of protecting your personal information.

To help you understand how she does that, here is an outline of how your Naturopathic Doctor may use and disclose this information:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To inform you of change of location/moving
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other health-care providers i.e. MDs, NDs, Osteopaths
- To allow your Naturopathic Doctor to efficiently follow-up for treatment, care and billing
- To invoice for goods and services
- To process payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others
- To be used for research purposes.

Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

I have reviewed the above information that explains how my Naturopathic Doctor will use my personal information, and the steps that she is taking to protect my information.

I agree that my Naturopathic Doctor can collect, use and disclose personal information about me as set out above in the information about my Naturopathic Doctor's privacy policies.

Dated this_____ day of_____, 20_____.

Name: _____ **Signature: _____**

(please print) **(patient or legal guardian)**