



ARGYLE NATURAL HEALTH CENTRE
NATUROPATHIC INTAKE FORM

Full Name: _____
(First) (Middle) (Last)

Date of Birth: ____/____/____ Age: _____ Sex: F M
dd mm yy

Marital Status: Single Married Common-law Divorced Widowed

Street Address: _____

City: _____ Postal Code: _____

Tel (home): _____ Tel (work): _____ Tel (cell): _____

Occupation/Employer: _____ Referred By: _____

Emergency Contact - Name: _____ Tel: _____

Health card number: _____

Medical Doctor(s): _____

Email address: _____

(EMAIL ADDRESSES ARE USED FOR CONFIRMATION OF APPOINTMENTS AND APPOINTMENT REMINDERS)

What are your major health concern? Please list them in order of importance:

Circle any of the following conditions you have or may have had:

- | | | | | | |
|-------------|----------------|--------------------|---------------------|------------------------|----------------|
| abcess | diabetes | hepatitis | multiple sclerosis | rheumatic fever | tuberculosis |
| abortion | emphysema | HIV | mumps | rubella/German measles | typhoid fever |
| alcoholism | epilepsy | influenza | parasites | scarlet fever | venereal warts |
| anemia | frequent colds | kidney disease | peritonitis | sexual abuse | warts |
| arthritis | gallstones | leukemia | pelvic inflam. dis. | skin diseases | whooping cough |
| asthma | genital herpes | low/high blood pr. | pleurisy | sinusitis | worms |
| cancer | gonorrhea | malaria | pneumonia | stroke | yellow fever |
| chicken pox | gout | measles | PMS | strep throat | others: |
| cold sores | hayfever | miscarriages | prostatitis | syphilis | _____ |
| depression | heart disease | mononucleosis | psychiatric illness | tonsilitis | _____ |

Have any of your family members suffered from any of the conditions listed above? If so, please indicate their condition(s), their relation to you and their age at the time of their illness or death (e.g. high blood pressure - mother - 76) _____

For each of the following family members, please indicate present age and health status, or age at the time of death and cause of death:

Mother: _____

Father: _____

Mother's mother: _____

Mother's father: _____

Father's mother: _____

Father's father: _____

Children: _____

Sister(s)/brother(s): _____

What immunizations have you had, and did you react badly to any of them?

	Immunizations	Reaction, if any
<input type="radio"/>	Measles, Mumps, Rubella (MMR)	_____
<input type="radio"/>	Smallpox	_____
<input type="radio"/>	Diphtheria, Pertussis, Tetanus (DPT)	_____
<input type="radio"/>	Hepatitis	_____
<input type="radio"/>	Polio	_____
<input type="radio"/>	Others _____	_____
<input type="radio"/>	Others _____	_____

What surgeries or major injuries have you had? _____

Have you ever been hospitalized? If so, why and when? _____

What medications, if any, are you currently on? _____

What natural supplements (vitamins, minerals, herbs, ...) are you currently on? _____

Do you have any known allergies or intolerances? If so, what are they? _____

Have you ever seen a naturopath or other complementary alternative health professional? If so, what were they? _____

Have you ever suffered any serious trauma in your life that you feel is still affecting you? _____

What is a typical day's diet for you?

Breakfast: _____

Lunch: _____

Supper: _____

Snacks: _____

Drinks: _____

Indicate if any of the statements below apply to you (please elaborate):

- Diet often _____
- Eat out often _____
- No regular exercise _____
- Consume caffeine _____
- Exposed to chemicals or environmental hazards _____
- Exposed to tobacco _____
- Consume alcohol _____
- Use recreational drugs _____

What is your:

Weight now? _____ Minimum adult weight? _____ Maximum weight? _____

Ideal weight? _____ Height? _____

How much leisure time do you usually have? _____

What are your typical leisure activities? _____

Do you enjoy your job/school? Why or why not? _____

Do you enjoy your relationships with your family and friends? Why or why not? _____

What is your general outlook on life? _____

How committed are you to making changes in your life in order to improve your health? _____

Thank you for filling this out.

The information you provide will assist in providing you with quality naturopathic health care.

The Naturopathic Physician's primary purpose is to prevent disease, to promote health, and to restore, maintain and optimize health and well-being through individualized patient care and public education



ARGYLE NATURAL HEALTH CENTRE

"your natural choice for health care"

3643 Sherwood Drive, Regina SK S4R 4A7

Tel: (306) 352-4242 Fax (306) 352-1573

Dr. Katherine Cheah, N.D.

Dr. Kathleen Fyffe, N.D.

I, the undersigned, hereby give my consent to naturopathic care and treatment from the Naturopathic Physician. Naturopathic care and treatment may include, but are not limited to, a physical examination, naturopathic diagnosis, nutritional and dietary counselling, botanical medicine, homeopathy, acupuncture, and lifestyle counselling.

I understand that I am entitled to a full description and explanation of any procedure before it is performed, and that I have the right to refuse treatment should I choose to do so.

I have read and understood the above.

Patient name (please print)

Patient signature

Date

Witness signature

Argyle Natural Health Centre Naturopathic FEE SCHEDULE

I understand that the fees of the Argyle Natural Health Centre are as follows:

VISIT	FEE
Initial Visit (approximately 2 hours)	\$150.00 + GST
Follow up visit (approximately 1 hour)	\$80.00 + GST
Initial acupuncture visit Dr. Fyffe (approximately 1 hour)	\$100.00 + GST
Follow up acupuncture visit Dr. Fyffe (approximately 30 mins)	\$55.00 + GST

The patient will be made aware of any additional costs for other procedures/test.

Please note that there is a 24-hour cancellation policy. If 24 hours notice is not given, a \$25.00 missed appointment fee will be charged.

I acknowledge that I may purchase products/supplements prescribed from the N.D. or any health food store.

I, the undersigned do acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/treatments and have discussed these to my satisfaction. I further acknowledge and confirm that I have been informed of and understand the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having/following the procedures/treatment and what alternative course(s) of action are available to me.

I do hereby voluntarily give my informed consent for the recommended therapeutic procedures/treatments as prescribed by the N.D. and for any future modifications of the procedures/treatments. I also understand that I may change the status of my voluntary consent at any time. I intend this consent to apply to all my present and future naturopathic care.

SIGNATURE OF PATIENT

DATE

NAME OF PATIENT PRINTED

DOCTOR'S SIGNATURE