A New Leaf
Naturopathic Clinic

A New Leaf Naturopathic Clinic
#102 - 5171 221A Street
Langley, B.C. V2Y 0A2

CONFIDENTIAL PATIENT HEALTH FORM

Today's Date: ______________________________
Full Name: ______________________________ Preferred Name: ______________
Care Card Number: ______________________________
Age: __________ **Date Of Birth:** ______________________________
Gender: ______________ **I Identify As:** ______________________

Address: ______________________________
City: ____________ **Province:** __________ **Postal Code:** ______________
Home Phone: ______________ **Mobile Phone:** ______________________
Email Address: ______________________________
Occupation: ______________________________
How Did You Hear About Us? ______________________________

Emergency Contact:
Name: ______________________________ Relationship: ______________
Phone Number: ______________________________

Medical Doctor:
Name: ______________________ Clinic Name: ______________________
Phone Number: ______________________ Fax Number: ______________________

Preferred Pharmacy:
Name: ______________________________
Phone Number: ______________________ Fax Number: ______________________

Other Health Care Providers Seen: (ie: Chiropractor, Massage Therapist) ______________________

Extended Medical Coverage Company: ______________________________

Main Health Concerns In Order Of Importance:
1) ______________________________
2) ______________________________
3) ______________________________

What Are Your Expectations For This Visit:
____
____

Vaccinations: ______________________________
Did You Experience Any Adverse Reactions?
____

Allergies/Sensitivities:
Medications: ______________________________
Foods: ______________________________
Environmental, Chemical, Other: ______________________________

Current Medications & Supplements:
1) ______________________________
2) ______________________________
3) ______________________________

All information contained in this intake form is confidential.

A New Leaf Naturopathic Clinic
#102 - 5171 221A Street
Langley, B.C. V2Y 0A2

Lifestyle - Please list usage as daily, weekly, monthly, or never:
Tobacco: ____ Alcohol: ____
Recreational Drugs: ________________________________ Coffee/Caffeine: __________________________________
Sugar/Sweets: ____________________________________ Soda: ____
Artificial Sweeteners: ____

General Health History:
Height: _______________________ Weight: _____________________ Weight 1 Year Ago: _______________________
At what time is your energy generally the highest? __________________ Lowest? _______________________________
Current Stress Level (1-10) __________________ Main Causes: ____
Do You Exercise? (Y or N) ___________________ If yes, what kind and how often? _____________________________

Review Of Symptoms - Please highlight or circle the following symptoms if they apply to you:

Addiction
Allergies
Alzheimer's
Anemia
Anxiety
Arthritis (Type): __________
Asthma
Autoimmune Disease
Breast Lumps
Breast Pain/Tenderness
Cancer (Type): __________
Celiac Disease
Chest Pain
Chronic Cough
Constipation
Depression
Diabetes (Type): __________
Dizziness
Ear Infection
Eczema
Emotional Outbursts
Epilepsy/Seizures
Excess Hunger/Thirst
Excess Sweating
Fainting
Fatigue
Fever/Chills
Glaucoma
Hair Loss
Headaches
Hearing Loss
Heart Disease
High Blood Pressure
Irregular Periods/Spotting
Kidney Disease
Liver Disease
Loss Of Balance
Lupus
Menopause
Mental Illness
Multiple Sclerosis
Neck Pain/Stiffness
Nausea
Osteoporosis
Pain During Urination
Poor Concentration
Pregnancy
Rapid Weight Change
Rectal Pain
Sinus Problems
Sleep Disturbances
Sore Throat
Stress
Stroke
Thyroid Disease/Problems
Vaginal Discharge
Other: __________
Other: __________
Other: __________
Other: __________

Family Medical History - Please highlight or circle if anyone in your family has a history of the following:
Addiction
Allergies
Alzheimer's
Anemia
Arthritis (Type): __________
Asthma
Autoimmune Disease
Cancer (Type): __________
Celiac Disease
Depression
Diabetes (Type): __________
Epilepsy/Seizures
Glaucoma
Heart Disease
High Blood Pressure
Kidney Disease
Liver Disease
Lupus
Mental Illness
Multiple Sclerosis
Osteoporosis
Stroke
Thyroid Disease
Other: __________

A New Leaf Naturopathic Clinic

A New Leaf Naturopathic Clinic
#102 - 5171 221A Street
Langley, B.C. V2Y 0A2

CONSENT TO NATUROPATHIC TREATMENTS

I, ____, hereby authorize A New Leaf Naturopathic Clinic to perform specific procedures as deemed necessary to facilitate my diagnosis and treatment. I understand that I am free to withdraw my consent and discontinue at any time. I consent to my examination and treatment by the doctor and/or any doctor serving as back-up to him/her.

I understand that my treatment plan may include, but may not be limited to, any or all of the following core modalities and procedures to assess, treat, or otherwise address my specific health concerns.

- **Therapeutic Nutrition:** Prescribing of nutritional supplements including intramuscular or subcutaneous vitamin injections
- **Acupuncture & Oriental Medicine:** Insertion of thin, sterile needles at specific points of the body, application of ear seeds, cupping, and prescribing of traditional oriental herbal formulas
- **Botanical Medicine:** Prescribing of botanicals such as teas, tinctures, solid extracts, powders, creams, suppositories, etc
- **Physical Medicine:** Soft tissue massage, stretching traction, or ultrasound
- **Homeopathy:** Prescribing of minute doses of natural substances such as plants, animals, and minerals to stimulate healing
- **Lifestyle Counseling:** Recommendations on diet, exercise, sleep, hygiene, and stress reduction
- **Naturopathic Manipulation:** Physical manipulation to correct the musculoskeletal structure
- **Hydrotherapy:** Use of water treatments including hot, cold, and sauna
- **Diagnostic Procedures:** Including but not limited to venipuncture, PAP smears, laboratory evaluations of blood, saliva, and urine, ECG, spirometry, physical exams, neurological exams, and musculoskeletal assessments
- **Prescribed Medications:** Pharmaceuticals that are within the scope of Naturopathic Medicine in British Columbia

Potential Risks: Pain, discomfort, bruising, blistering, itching, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies, allergic reactions to prescribed herbs, supplements, or medications, soft tissue or bone injury from physical manipulations, and aggravation of pre-existing conditions.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and other symptoms of disease, assistance in disease and injury recovery, and prevention of disease or its progression.

Notice For Pregnant Women: All female patients must alert their doctor if they know or suspect that they are pregnant, as some treatments could present a risk to the pregnancy.

I recognize that even the gentlest therapies potentially have their complications in certain conditions, on very young children, the elderly, or those on multiple medications. I acknowledge that the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy and all medications, including over the counter drugs and supplements.

I understand that the doctor is not able to anticipate or explain all of the risks and complications of treatment, and therefore rely on him/her to exercise their judgement during the course of the procedure based on known facts. I acknowledge that no guarantees of service have been made to me concerning the results of the treatments offered to me.

Cancellation Policy: ***48 hours notice is mandatory for all cancellations.*** A missed appointment or late cancellation will result in a fee being charged. All payments are due at the time of treatment.

Email Communications: Doctors may give out their email addresses, which are strictly to be used for short questions regarding any current treatments. Emails are not to be used in lieu of an office visit.

Prescription Refills: All prescription refills called in or requested will be looked at within one week. Please be advised that this is carried out at the doctors' discretion and you may be required to make an appointment for a refill.

By signing below, I acknowledge that I have read this form or that it has been read to me. I understand all of the above and give my written consent to evaluation and treatment by the doctor. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I may seek treatment. I hereby acknowledge that the information I have provided is true and complete to the best of my knowledge.

Printed Name Of Patient: ______________________________________ Date: ________________________

Signature Of Patient: ____

All information contained in this intake form is confidential.

A New Leaf Naturopathic Clinic
#102 - 5171 221A Street
Langley, B.C. V2Y 0A2

CONSENT TO NATUROPATHIC TREATMENTS - PATIENT COPY

I, ____, hereby authorize A New Leaf Naturopathic Clinic to perform specific procedures as deemed necessary to facilitate my diagnosis and treatment. I understand that I am free to withdraw my consent and discontinue at any time. I consent to my examination and treatment by the doctor and/or any doctor serving as back-up to him/her.

I understand that my treatment plan may include, but may not be limited to, any or all of the following core modalities and procedures to assess, treat, or otherwise address my specific health concerns.

- **Therapeutic Nutrition:** Prescribing of nutritional supplements including intramuscular or subcutaneous vitamin injections
- **Acupuncture & Oriental Medicine:** Insertion of thin, sterile needles at specific points of the body, application of ear seeds, cupping, and prescribing of traditional oriental herbal formulas
- **Botanical Medicine:** Prescribing of botanicals such as teas, tinctures, solid extracts, powders, creams, suppositories, etc
- **Physical Medicine:** Soft tissue massage, stretching traction, or ultrasound
- **Homeopathy:** Prescribing of minute doses of natural substances such as plants, animals, and minerals to stimulate healing
- **Lifestyle Counseling:** Recommendations on diet, exercise, sleep, hygiene, and stress reduction
- **Naturopathic Manipulation:** Physical manipulation to correct the musculoskeletal structure
- **Hydrotherapy:** Use of water treatments including hot, cold, and sauna
- **Diagnostic Procedures:** Including but not limited to venipuncture, PAP smears, laboratory evaluations of blood, saliva, and urine, ECG, spirometry, physical exams, neurological exams, and musculoskeletal assessments
- **Prescribed Medications:** Pharmaceuticals that are within the scope of Naturopathic Medicine in British Columbia

Potential Risks: Pain, discomfort, bruising, blistering, itching, discolorations, infection, burns, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, hydrotherapies, allergic reactions to prescribed herbs, supplements, or medications, soft tissue or bone injury from physical manipulations, and aggravation of pre-existing conditions.

Potential Benefits: Restoration of health and the body's maximal functional capacity, relief of pain and other symptoms of disease, assistance in disease and injury recovery, and prevention of disease or its progression.

Notice For Pregnant Women: All female patients must alert their doctor if they know or suspect that they are pregnant, as some treatments could present a risk to the pregnancy.

I recognize that even the gentlest therapies potentially have their complications in certain conditions, on very young children, the elderly, or those on multiple medications. I acknowledge that the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy and all medications, including over the counter drugs and supplements.

I understand that the doctor is not able to anticipate or explain all of the risks and complications of treatment, and therefore rely on him/her to exercise their judgement during the course of the procedure based on known facts. I acknowledge that no guarantees of service have been made to me concerning the results of the treatments offered to me.

Cancellation Policy: ***48 hours notice is mandatory for all cancellations.*** A missed appointment or late cancellation will result in a fee being charged. All payments are due at the time of treatment.

Email Communications: Doctors may give out their email addresses, which are strictly to be used for short questions regarding any current treatments. Emails are not to be used in lieu of an office visit.

Prescription Refills: All prescription refills called in or requested will be looked at within one week. Please be advised that this is carried out at the doctors' discretion and you may be required to make an appointment for a refill.

By signing below, I acknowledge that I have read this form or that it has been read to me. I understand all of the above and give my written consent to evaluation and treatment by the doctor. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I may seek treatment. I hereby acknowledge that the information I have provided is true and complete to the best of my knowledge.

Printed Name Of Patient: ____________________________________ Date: ________________________

Signature Of Patient: ____

All information contained in this intake form is confidential.