DOCTORS' CHOICE
INTEGRATIVE
MEDICINE
Passion. Inspiration. Nourishment.

PATIENT INTAKE FORM

Personal Information:

Last Name: _____First Name: _____
Date of Birth: _____Gender: M F (circle one)
Day/Month/Year
Address: _____
City: _____ Province: _____ Postal Code: _____
Tel: Home: _____ Work: _____ Cell: _____
Email address: _____ *I wish to receive email notification of clinic updates and monthly newsletters*: Y N (circle one)

Occupation: _____
Relationship or Marital Status: _____Live with: _____

In case of Emergency:
Contact: _____Relationship:_____Telephone:_____

B.C. Care Card #_____
Name as it appears on card: _____

Do you have extended health care? Y, N, Name of Insurance Co._____
Where and when did you last receive health care? _____
What was the reason?

_____
Who is your primary health care physician? _____
May we contact him/her and if so, what is the telephone number?

_____

How did you find out about our clinic? _____
If you were referred, please indicate whom we may thank: _____

Cancellation Fee

A $50.00 charge will be applied to cancellations with less than 24 hours notice.

Patient Signature: _____ Date: _____

Doctors Choice Integrative
1190 Thurlow Street Vancouver, BC V6E 1X3
Phone: 604-688-1169 *Fax*: 604-688-1176
info@doctorschoiceintegrative.com

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HEALTH HISTORY QUESTIONNAIRE

Present Health Concerns

Please indicate if the condition is acute or chronic.

1. _____
2. _____
3. _____

Allergies

Please list allergies to any drugs, foods, environmental or other known allergens.

_____

_____

Childhood Illnesses

_____

_____

Immunization History

Please list all vaccines received with approximate dates.

_____

_____

_____

Birth History

Were you born vaginally or via c-section? _____ Were there any complications? _____

If yes, please explain_____

_____

Were you breastfed? _____ For how long? _____

Hospitalization/Surgeries

Please indicate the reason and approximate date.

_____

_____

History of serious illnesses/Accidental injuries

Please indicate approximate date.

_____

_____

Family Medical History

For example, Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure…

_____

_____

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Medications

List any prescription drugs, over-the counter medications, vitamins and other natural health products you are currently taking. Please include dosage if known.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you ever used Homeopathic remedies? _____
Which ones? _____

Reproductive History

Female:

Age menses began: _____ Number of days period lasts: _____
Are your cycles regular? _____How many days? ___ Date of last period? _____
Do you have pain or other difficulties with your period? _____
If yes, please describe: _____
_____

If you use birth control, please indicate the type: _____
Number of pregnancies: _____Number of live births: _____
Number of miscarriages: _____Number of abortions: _____
Difficulties conceiving? _____

Date of last pap: _____ Any abnormal results? _____
Have you had a mammogram? ____Results? _____
Do you perform breast self-exam: ____Any tenderness lumps or discharge? _____
Have you received the HPV Vaccine? _____

Have you experienced menopause and/or symptoms?
_____
_____

Male:

History of prostate enlargement?
_____
Difficulties stopping or starting stream of urine? _____
History of testicular masses or pain? _____
Do you perform regular testicular examination on yourself? _____

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Thank you for taking the time to fill out this form. All information contained within is confidential, and will not be released without your permission.

STATEMENT OF ACKNOWLEDGEMENT

Each person seeking care in this clinic should understand that the practitioner is a Naturopathic Doctor, not a Medical Doctor. Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunctions and natural therapeutics for correction. The methods used in this clinic for therapeutics include, but are not limited to: Clinical Nutrition & IV Therapies, Acupuncture and Traditional Chinese Medicine, Homeopathy, Botanical Medicine, Naturopathic spinal manipulation, Physical Medicine, Hydrotherapy and Lifestyle Counselling.

Each patient must sign this document before any treatment is rendered.

My signature acknowledges that:

- I understand that Dr. Martha Reid works within the Naturopathic scope of practice as outlined by the College of Naturopathic Physicians of British Columbia.
- I acknowledge that Dr. Martha Reid is not a Medical Doctor and employs some methods which may not be considered orthodox medical practice.
- I understand that treatments here and/or referral to other health practitioners is based upon an assessment of conditions revealed through personal history and interview, physical examination and laboratory results.
- I understand that any treatment or advice provided to me by Dr. Martha Reid is not being provided in the place of, or to the exclusion of, any other treatment or advice that I may now be receiving or, may in the future receive, from a physician, surgeon, or any other licensed health care provider.
- I confirm that there has been no suggestion to me by Dr. Martha Reid or anyone under her direction or control to refrain from seeking or following conventional medical attention.
- I understand that failure to comply with the recommended treatment programs as prescribed by Dr. Martha Reid may undermine the expected results.
- I understand all fees for service are payable at the time of the appointment and that MSP or Extended Health Plans may only subsidize a portion of the Naturopathic services. As such, I accept full responsibility for any fees incurred during care and treatment. I agree to fully discharge this responsibility at the time of the visit unless prior arrangements have been made.
- I do hereby authorize and consent to treatment by Dr. Martha Reid, ND.

_____ _____

Print patient's name Signature of patient

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