BURNABY HEIGHTS Integrative HEALTHCARE

HEALTH HISTORY INTAKE FORM

Naturopathic health care and preventative medicine are only possible when the physician has a complete and thorough understanding of you, physically mentally, and emotionally. Please complete this questionnaire as thoroughly as possible. All information is *confidential*. Please mark anything you do not understand with a question mark.

PERSONAL INFORMATION

Name: ______________________________________

Home Address: ______________________________________

City: ______________________________________

Postal code: ______________________________________

Home Phone: ______________________________________

E-mail: ______________________________________

Occupation: ______________________________________

Names of other Healthcare Providers:

Chiropractor: ______________________________________

Massage Therapist: ______________________________________

Age: ______________ Sex: M F

Birthday (Mo/Day/Yr): ________/________/____________

Marital Status: ______________________________________

Children (Sex/Age): ______________________________________

Work Phone: ______________________________________

How did you hear about us? □newspaper ad □friend □yellow pages □other ______________________________________

BC Care Card Number: ______________________________________

Medical Doctor: ______________________________________

Specialist: ______________________________________

Email Consent: New legislation requires that we obtain consent prior to sending emails to our patients.
I consent to receiving emails from Burnaby Heights Integrative Health Clinic and/or its staff. Yes No

YOUR MAIN HEALTH CONCERN(S): (please list in order of importance)

1) ______________________________________
2) ______________________________________
3) ______________________________________
4) ______________________________________

When did your problem(s) begin (be specific)? ______________________________________

Have you been given any diagnosis? If so, what? ______________________________________

What measures have you taken to improve your problems(s)? ______________________________________

Have you had any x-rays or special studies (CT, MRI, Echocardiogram), if so please list: ______________________________________

PAST MEDICAL HISTORY (please check and include date)

□ CANCER	□ DIABETES
□ HEART DISEASE	□ HIGH BLOOD PRESSURE
□ HEPATITIS	□ KIDNEY DISEASE
□ RHEUMATIC FEVER	□ THYROID DISEASE
□ VENERAL DISEASE	□ OTHER: ______________________

CHILDHOOD ILLNESSES

□ SCARLET FEVER	□ GERMAN MEASLES
□ MUMPS	□ DIPHTHERIA
□ MEASLES	□ OTHER: ______________________

Surgeries (list date): ______________________________________

Significant Trauma (auto accidents, falls, etc.): ____

Allergies: ____

VACCINATIONS

□ POLIO	□ TETANUS SHOT
□ MEASLES/MUMPS/RUBELLA (MMR)	□ DIPHTHERIA
□ PERTUSSIS	□ OTHER: ____________________

FAMILY MEDICAL HISTORY (please check those that apply)

	FATHER	MOTHER	SIBLING	PATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	MATERNAL GRANDMOTHER
AGE (if living)							
HEALTH(good/bad)							
CANCER (list type)							
DIABETES							
HEART DISEASE							
HIGH BLOOD PRESSURE							
HIGH CHOLESTEROL							
STROKE							
EPILEPSY							
MENTAL ILLNESS							
ASTHMA							
ALLERGIES							
KIDNEY DISEASE							
GLAUCOMA							
ANEMIA							
TUBERCOLOSIS							
RHEUMATOID ARTHRITIS							
AGE (at death)							
CAUSE OF DEATH							
OTHER: _________							

LIFESTYLE

Do you have any occupational stress (chemical, physical, psychological)? ____________________________

Describe your weekly exercise? ____

Current Medications:

Prescriptions/Over the counter drugs: ____

Vitamins/Herbs____

____

Diet

Are you or have you ever been on a restricted diet? If so, what kind? ____________________

Please describe your daily diet.

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________

Drinks: ____________________

How many packs of cigarettes do you smoke per day? ________

Have you ever smoked in your life? ________

How much coffee do you drink per week? ________

How much alcohol do you drink per week? ________

How much tea do you drink per week? ________

How much pop do you drink per week? ________

GENERAL (Please check if any of the following symptoms are currently a problem or are a recurring problem, if in the past, indicate with a P)

Current Weight: ________

Ideal Weight: ________

Weight 1 year ago: ________

□Poor appetite
□Poor sleep
□Fatigue
□Fevers
□Chills
□Night sweats
□Sweat Easily
□Tremors
□Cravings
□Localized weakness
□Poor balance
□Change in appetite
□Bleed or bruise easily
□Weight loss
□Weight gain
□Sudden energy drop (time of day?)
□Strong thirst (hot or cold drinks)
□Peculiar tastes or smells

SKIN AND HAIR

□Rashes
□Ulcerations
□Hives
□Itching
□Eczema
□Pimples
□Dandruff
□Loss of hair
□Recent moles
□Change in hair or skin texture
□Any other hair or skin problems ____________________

GASTROINTESTINAL

□Nausea
□Indigestions
□Black stools
□Vomiting
□Belching
□Blood in stools
□Constipation
□Gas
□Rectal pain
□Diarrhea
□Bad breath
□Hemorrhoids
□Abdominal pain or cramps
□Chronic laxative use
□Any other stomach problems ________

MUSCULOSKELETAL

□Neck pain
□Muscle pain
□Knee pain
□Back pain
□Muscle weakness
□Foot/Ankle pain
□Shoulder pain
□Hand/Wrist pain
□Swelling of joints
□Joint nodules
□Any other joint or bone problems ____________________

RESPIRATORY

□Cough
□Coughing blood
□Pain with deep breath
□Bronchitis
□Pneumonia
□Asthma
□Difficulty breathing lying down
□Production of phlegm (colour?)
□Any other lung problems ________

HEAD/EYES, EARS, NOSE, AND THROAT

□Dizziness	□Concussions	□Migraines
□Glasses	□Eye strain	□Eye pain
□Poor vision	□Night blindness	□Colour blindness
□Cataracts	□Blurry vision	□Earaches
□Ringing in ears	□Poor healing	□Spots in front of eyes
□Sinus problems	□Nosebleeds	□Recurrent sore throats
□Grinding teeth	□Facial pain	□Sores on lips or tongue
□Teeth problems	□Jaw clicks	□Headaches (where/when)

□Any other head or neck problems ____

CARDIOVASCULAR

□High blood pressure	□Low blood pressure	□Fainting
□Irregular heart beat	□Swelling of hands	□Swelling of feet
□Cold hand or feet	□Phlebitis	□Difficulty breathing
□Blood clots	□Chest pain	□Dizziness

□Any other heart or blood vessel problems ____

GENITO-URINARY

□Pain on urination	□Inability to hold urine	□Kidney stones
□Increased frequency in the day	□Increased frequency in the night	□Male: Dribbling
□Frequent infections (bladder/ kidney)	□Male: Prostatitis/ Benign prostatic hypertrophy	□Male: Decreased force of stream

PREGNANCY AND GYNECOLOGY

Age at first menses: ____________	Number of births: ____________	Premature births: ____________
First date of last menses: ________	Abortions: ________________	Miscarriages: ______________
Duration of menses: ____________	Frequency of menses: __________	Birth control: _______________
□Painful menses	□Light menses	□Clots
□Heavy menses	□Irregular menses	□Last PAP/Prostate Exam ________
□Breast lumps	□Vaginal discharge	□Vaginal sores

□Changes in body/psyche prior to menstruation (describe): ______________________________

NEUROPSYCHOLOGICAL

□Seizures	□Dizziness	□Loss of balance
□Areas of numbness	□Lack of coordination	□Blood in stools
□Concussion	□Depression	□Poor memory
□Quick temper/irritable	□Anxiety	□Easily susceptible to stress
□Have you ever been treated for emotional problems?	□Have you ever considered or attempted suicide?	□Any other neurological or psychological problems ________

COMMENTS

Please indicate any other problems you would like to discuss.

____
____
____
____

INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic physicians assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities may include: diet and nutritional supplements, vitamin-mineral injections and intravenous treatments, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, physical medicine and lifestyle counselling.

Individual diets and nutritional supplements are one of the means recommended to address deficiencies, treat disease processes, and to promote health. The benefits may include increased energy, increased gastrointestinal function, improved immunity, and general well-being.

Botanical medicine is plant based medicine that involves the use of herbal teas, tinctures, capsules and other forms of herbal preparations that may assist in recovery from injury and disease.

Homeopathy is a form of medicine that uses minute doses of the very thing that causes symptoms in healthy people. These tiny doses of plant, animal, or mineral origins may be used to stimulate the body's ability to heal itself. Homeopathy can be a powerful tool that effects healing on a physical and emotional level.

Traditional Chinese Medicine and Acupuncture. Eastern herbs and dietary changes may be recommended to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tincture or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medicine theory.

Physical medicine refers to the use of hands-on techniques such as massage therapy as well as various types of electrical stimulation and therapeutic ultrasound for the purposed of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and to stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, your naturopathic physician will perform a thorough case history; conduct a physical examination, and when indicated, take saliva, blood and/or urine samples. Even the safest therapies may cause complications in certain physiological conditions (e.g., pregnancy, breastfeeding, very young children, or those taking multiple medications or with multiple medical conditions). Some therapies must be used in caution; therefore, it is important that you inform us of any medical conditions or change in medical conditions you have as well as any medications or supplements that you are taking. If you are pregnant or if you are breast–feeding, please advise your naturopathic physician immediately.

There may be some slight health risks associated with naturopathic medicine. These include but are not limited to:

Aggravation or pre-existing symptoms
Allergic reactions to supplements, herbs or prescription medication
Pain, bruising or injury from injections, blood draws or acupuncture
Fainting or puncturing of an organ with acupuncture needles

Please initial beside each statement below.

___I understand that a record will be kept of the health services provided to me. This health record will be kept confidential and will not be disclosed or released to others without my consent, unless required by law. I understand that I may look at my medical records at any time and can request a copy of them by paying the appropriate fees.

___I understand that the naturopathic physician will answer any questions that I have to the best of his or her abilities. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions here).

___I understand that charges are to be paid at the times of the visit unless specific arrangements have been made prior to my scheduled appointment. Payment for all dispensary items is due at the time of the visit.

___I understand that missed appointments or late cancellations (less than 24 hour notice) will be subject to a $25 fee.

___I understand that it is my responsibility to comply with the recommendations of the naturopathic physician in terms of treatment schedule and maintaining regular follow up appointments.

__ I have read and understand this document and accept the risks involved with receiving naturopathic treatment.

__ Prescription refills without a Naturopathic Office Visit will be charged $20.00 and Medical Letters will be charged $20.00. These can be claimed on your extended health care plan and may be covered depending on your coverage.

As a patient, you are responsible for the total charges incurred for each visit. We accept cash, debit, visa, or mastercard. If you have extended health coverage for naturopathic physicians, you are responsible for billing your own insurance company. We will provide you with the necessary documentation to do this. If you are on premium assistance with MSP, then you will receive $23 reimbursement for 10 visits per calendar year.

I have read and understand the above-stated policies and information. I understand that I am free to withdraw from treatment and to discontinue further participation in these procedures at any times.

Patient name (please print) ______________________________

Signature of Patient/Guardian: ___________________________ Date: ______________

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For Patients with Extended Health Benefits
Insurance Providers include: Great-West Life, Sun Life, Standard Life, Johnson Inc., Industrial Alliance, Chamber of Commerce, Maximum Benefit, Manulife, Desjardins, and Blue Cross

Benefit Assignment Form

Insurance Company: ____________________________

Patient Name: ________________________________ Date of Birth: ___________

Policy Number: ________________________________

Member ID Number: _____________________________

If you are not the insured member, then please provide insured member name and date of birth.

Insured Member Name: _________________________ Date of Birth: ___________

I hereby assign benefits payable for the eligible claims to the **Burnaby Heights Integrative HealthCare, Inc (the Provider)** responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Credit Card: Visa/Mastercard: _____________________________ Exp:__________

Date: ____________

Signature: ___________________________ Print Name: ______________________

For Patients with Extended Health Benefits
Insurance Providers include: Great-West Life, Sun Life, Standard Life, Johnson Inc., Industrial Alliance, Chamber of Commerce, Maximum Benefit, Manulife, Desjardins, and Blue Cross

ELECTRONIC TRANSMISSION AUTHORIZATION AND CONSENT FORM

Insurance Company: ______________________________

Patient Name: __________________________________ Date of Birth: ___________

Policy Number: __________________________________

Member ID Number: ______________________________

If you are not the insured member, then please provide insured member name and date of birth.

Insured Member Name: __________________________ Date of Birth: ___________

CONSENT TO COLLECT AND EXCHANGE PERSONAL INFORMATION

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and/or plan administrator and their service provider(s) to:

-use my personal information for the above purposes.

-exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.

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-exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.

-exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

ELECTRONIC TRANSMISSION AUTHORIZATION AND CONSENT FORM

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Date: ____________

Signature: __________________________

Print Name: __________________________