Redefined Health

**Patient Intake Form**

Name: _____

Parent contact (if patient is < 18 years of age):_____

Address: _____

City:_____ Prov:_____ Postal code:_____

Date of Birth:_____ Age:_____ Male: _____ Female:_____

Home phone:_____ Cell:_____ Other:_____

Email:_____

Alberta Health Care number*:_____

*please be advised that personal health care numbers are collected in accordance with the Alberta Health Act. Numbers are protected and used solely for the purposes of diagnosis, treatment and referral. Alberta Health Care currently does not make payments for any portion of treatment offered at Redefined Health.

Occupation:_____

Hobbies and Interests:

_____

_____

_____

How did you hear about Redefined Health? Website?_____ Google search?_____Facebook?_____

Referral:_____

Other:_____

Signature:_____ Date:_____

Redefined Health

**Please complete the following questions:**

What are your current health concerns?

Please list them in **order of importance**:

1._____

2._____

3._____

4._____

**Allergies:**

Are you **hypersensitive or allergic** to any of the following:

Drugs:_____

Foods:_____

Environmental allergens:_____

_____

_____

**Current Medications:**

Please list all prescription medications, vitamins or other supplements you are taking and the reason/condition for using them.

1._____

2._____

3._____

4._____

**Typical daily food intake:**

Breakfast:_____

_____

Lunch: _____

_____

Dinner:_____

_____

Snacks:_____

_____

Beverages:_____

_____

**General:**

Weight:_____lbs Height: _____ ft _____in.

Weight 1 year ago: _____lbs

Max weight/when:_____

Please circle yes or no for the following:

| | | |
|---|---|---|
| Do you exercise: | YES | NO |
| Have a supportive relationship: | YES | NO |
| Had any major traumas: | YES | NO |
| Have a history of abuse: | YES | NO |
| Treated for drug dependence: | YES | NO |
| Treated for alcoholism: | YES | NO |
| Do you smoke cigarettes: | YES | NO |
| Do you use recreational drugs: | YES | NO |

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Please ✓ the appropriate answer:
Yes = Yes, a condition you are experiencing ***now***
No = No, a condition you have ***never*** had
Past = A condition you ***have had*** in the past

***Mental/Emotional***

| | |
|---|---|
| Mood Swings | □Yes □No □Past |
| Anxiety or nervousness | □Yes □No □Past |
| Poor concentration | □Yes □No □Past |
| Memory problems | □Yes □No □Past |

***Endocrine***

| | |
|---|---|
| Low thyroid | □Yes □No □Past |
| Heat or cold intolerance | □Yes □No □Past |
| Low blood sugar | □Yes □No □Past |
| Diabetes | □Yes □No □Past |
| Fatigue | □Yes □No □Past |
| Seasonal depression | □Yes □No □Past |

***Immune***

| | |
|---|---|
| Vaccinations | □Yes □No □Past |
| Reactions to vaccinations | □Yes □No □Past |
| Chronic infections | □Yes □No □Past |
| Chronic swollen glands | □Yes □No □Past |
| Mood Swings | □Yes □No □Past |
| Slow wound healing | □Yes □No □Past |

***Skin***

| | |
|---|---|
| Rashes | □Yes □No □Past |
| Eczema, Hives | □Yes □No □Past |
| Acne, Boils | □Yes □No □Past |
| Itching | □Yes □No □Past |

***Head***

| | |
|---|---|
| Headaches | □Yes □No □Past |
| Migraines | □Yes □No □Past |
| Head injury | □Yes □No □Past |

***Ears***

| | |
|---|---|
| Earaches | □Yes □No □Past |
| Ringing in ears | □Yes □No □Past |
| Dizziness | □Yes □No □Past |

***Nose and sinus***

| | |
|---|---|
| Frequent colds | □Yes □No □Past |
| Nosebleeds | □Yes □No □Past |
| Congestion | □Yes □No □Past |
| Seasonal allergies | □Yes □No □Past |
| Sinusitis | □Yes □No □Past |
| Loss of smell | □Yes □No □Past |

***Mouth and throat***

| | |
|---|---|
| Frequent sore throat | □Yes □No □Past |
| Burning tongue | □Yes □No □Past |

***Respiratory***

| | |
|---|---|
| Cough | □Yes □No □Past |
| Wheezing | □Yes □No □Past |
| Asthma | □Yes □No □Past |
| Bronchitis | □Yes □No □Past |

***Cardiovascular***

| | |
|---|---|
| Heart disease | □Yes □No □Past |
| High/low blood pressure | □Yes □No □Past |
| Palpitations | □Yes □No □Past |
| Strokes | □Yes □No □Past |

***Urinary***

| | |
|---|---|
| Increased frequency | □Yes □No □Past |
| Frequency at night | □Yes □No □Past |
| Frequent infections | □Yes □No □Past |

***Gastrointestinal***

| | |
|---|---|
| Heartburn | □Yes □No □Past |
| Passing gas | □Yes □No □Past |
| Belching | □Yes □No □Past |
| Change in thirst | □Yes □No □Past |
| Change in appetite | □Yes □No □Past |
| Constipation | □Yes □No □Past |
| Diarrhea | □Yes □No □Past |

How many bowel movements/day? _____

***Musculoskeletal***

| | |
|---|---|
| Joint pain | □Yes □No □Past |
| Stiffness | □Yes □No □Past |
| Muscle spasms | □Yes □No □Past |
| Arthritis | □Yes □No □Past |

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**Consent to Naturopathic Medical Care**

Patient Name:_____

Date of Birth:_____

I hereby consent to my Naturopathic Doctor (Dr. Leyanna Zubach-Cassano) to treat me for the purposes I have indicated on my Client Intake form. I consent to any assessments, physical examinations and techniques which may be recommended by my Naturopathic Doctor. This can also include acupuncture, as seen fit and mutually agreed upon.

I acknowledge and understand that the Naturopathic Doctor must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Naturopathic Doctor and have disclosed all medical conditions affecting me. It is my responsibility to keep my Naturopathic Doctor updated on my medical history. The medical information I have provided is true and complete to the best of my knowledge. I authorize my Naturopathic Doctor to release or obtain information pertaining to/from my other caregivers or third party payers.

I have read the above noted consent and I have had the opportunity to question the contents of my treatment. By signing this form, I confirm my consent to Naturopathic medical care and intend this consent to cover the treatment discussed, as well as any other treatment proposed by my Naturopathic Doctor. I understand that I may withdraw my consent for future treatment at any time and my treatment will then be discontinued.

Cancellation policy: We appreciate at least **24 hours** notice for cancellation of any appointment. If circumstances are such that an appointment must be missed, please notify us as soon as possible. **Please be advised that no-show appointments will be subject to a fee of 50% of the appointment value.** Redefined health does not offer direct billing to secondary insurance companies on your behalf. It is the responsibility of the patient to confirm and understand the extent of their coverage amounts and restrictions with their individual insurance company. All service payments are due when service is rendered. Payment is accepted in the form of cash, Debit, Visa or Mastercard. I understand that I am responsible for payment of all services or treatments rendered at Redefined Health.

Patient name:_____

Patient signature_____ Date:_____

Witness name:_____

Witness signature:_____ Date:_____