



**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: \_\_\_\_\_



**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



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? \_\_\_\_\_

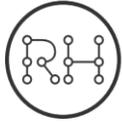
### **Musculoskeletal**

Joint pain Yes No Past

Stiffness Yes No Past

Muscle spasms Yes No Past

Arthritis Yes No Past



### 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: \_\_\_\_\_