Integrative Cancer Care: New Patient Intake Form

Please help me provide you with a complete and thorough evaluation by completing this questionnaire fully.

Your information is kept private and confidential as per the Ontario Privacy Act.

Name: _____ (Full Name) Birthday: _____/_____/_____ (mm dd yyyy) Age: ____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____

Cellular Phone #: _____ Email: _____

(Optional) I Identify as: ☐ Female ☐ Male ☐ Non-Binary ☐ Two Spirit ☐ Other _____

Note: As a courtesy, we do email or text reminders for appointments, and sometimes let our patients know of important clinic updates via email. ☐ I do not wish to receive emails

How did you find out about us? Personal Referral Professional Referral Google/Website Walking By
Other _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

To better understand your life's pressures, stresses, exposures:

Marital Status: ☐ Single ☐ Common-Law ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
# of Children: ___

Are you working currently? Y or N Occupation: _____
On leave? Y or N, for how long? _____

Your Health Care Team:

Medical Doctor: _____ Phone #: _____
Which hospital are you receiving care at? _____
Medical Oncologist: _____ Phone #: _____
Radiologist: _____ Phone #: _____
Surgeon: _____ Phone #: _____
Palliative Care Specialist: _____ Phone #: _____
Nurse: _____ Phone #: _____
Other: _____ Phone #: _____

Date of Last:
Physical Exam: ____/____/____ (mm dd yyyy) Blood Work: ____/____/____ (mm dd yyyy) Last Scan: ____/____/____ (mm dd yyyy)

What to Bring: First Visit Checklist

- □ Complete Intake Form filled out.
- □ Pathology Report for clear communication of current diagnosis and disease location.
- □ Most recent imaging reports: (x-ray, CT, ultrasound, MRI).
- □ Most recent blood work done.
- □ Complete Food Log.
- □ Current medications and therapy schedule – filled out on the forms, or pharmacy print out attached.

What are your current health concerns that you would like addressed?

Concern: When did this begin?

_____
_____
_____
_____
_____
_____

Type of cancer including cell type, stage, grade, receptor status if applicable:

_____
_____
_____

Location or areas affected, metastases:

_____

Is this a □ New Diagnosis or a □ Recurrence?

Have you had any other type of cancer before? Y or N _____

Please list what current treatment you are having or will be having, Include any chemo drugs, immune therapy, targeted therapy drugs, radiation, and combinations with anti-nausea drugs and steroids. Please include frequency and duration.

Chemo/Immunotherapy/Targeted Therapy Drugs	Starting/started When?	Frequency	Number of Total Treatments
Radiation Treatment,	Frequency, for how long?		

Started/Starting When? Where?	

Surgical Procedures	When?

4. Please list **ALL** of your medical diagnoses in a timeline sequence:

Diagnosed Condition	When it began/was diagnosed	Treatment: medication/procedure

Please list other health conditions that you have, in their order of importance.

Concern: Since When?

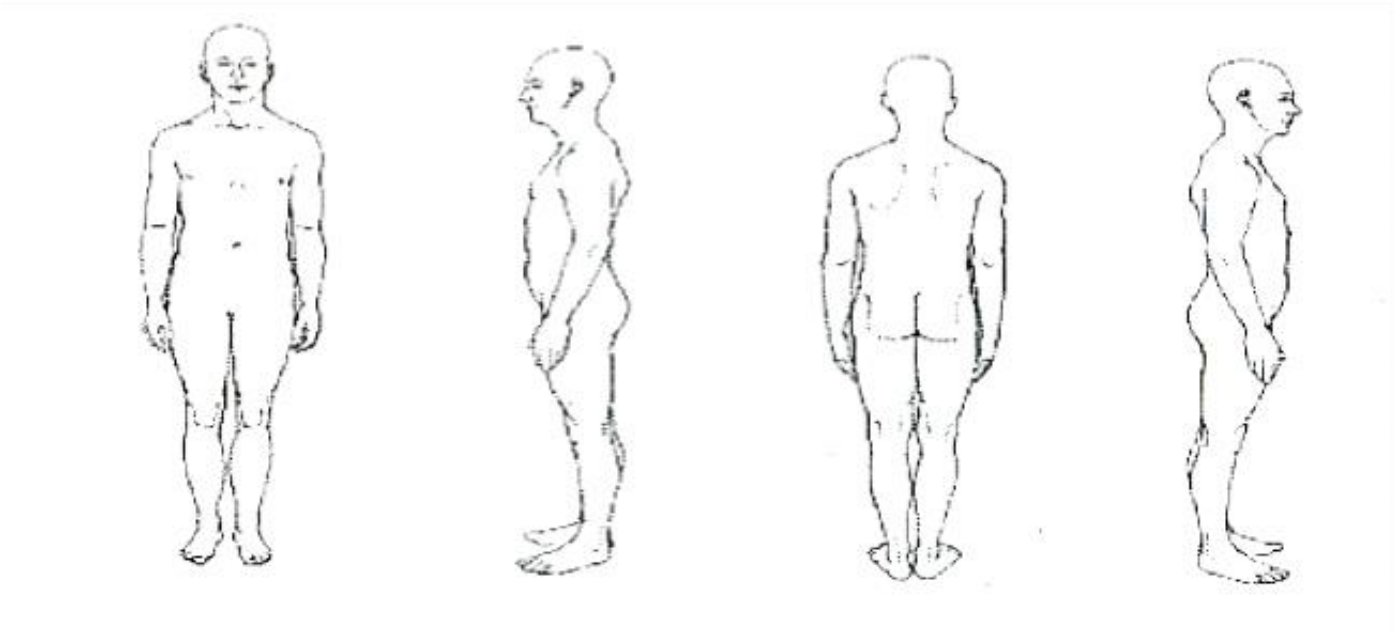
_____
_____
_____
_____
_____
_____

What are your health goals, and goals with Integrative Care?

_____

_____
_____
_____

On the following diagram, mark the areas of physical pain or discomfort.



What other types of treatment are you receiving?

☐ Acupuncture	☐ Homeopathy	☐ Physiotherapy	☐ Psychotherapy
☐ Chiropractic	☐ Massage	☐ Osteopathy	☐ Energy work
☐ Diet change	☐ Pharmaceutical Drugs	☐ Supplements	☐ Other_____
☐ Herbs		☐ Other	

Outcome: _____

List current medications and dose (prescribed or over the counter):

Medication	Dose and frequency	Since when?	Adverse Effects?

Are there medications that you don't tolerate? _____

List all supplements you are currently taking and dosages: (vitamins, minerals, enzymes, homeopathic, herbs, etc.)

Supplement (Brand)	Dose and Frequency	Since When?	Adverse Effects?

Are there supplements that you don't tolerate well? _____

_____

Allergies

Do you have any anaphylactic allergies? _____

Do you have any allergies to: medications, environmental substances (airborne, dust, pollens animals, chemicals) or foods? What reactions to you experience?

_____

_____

Do you have any food sensitivities? What reactions to you experience?

_____

Do you have any food sensitivities? Please list

_____

Hospitalizations (please list):

Year Operation/ Illness/ Injury Outcome

_____

_____

_____

_____

Do you consider yourself: □ Underweight □ Overweight □ Just Right

□ I've noticed unintentional weight loss of 10 lbs. or more in the last 3 months
□ I've noticed unintentional weight gain of 10 lbs. or more in the last 3 months.

Your weight today: _____ Height: _____

Are you now, or have you in the past, been consistently exposed to any of the following:

- □ Electromagnetic frequencies or radiation (cellphone towers, hydro lines, transformers, chronic cell phone use, MRI or X-ray equipment)
- □ Chemicals (solvents, paints, smoke, printers, pesticides, hair dye, film processing, factory work, mechanic work, cosmetics, dyes, fabric industry)
- □ Implants: breast, dental, joint
- □ Particulate matter (construction materials, dust, asbestos, fiberglass, particle board, burning waste etc.)
- □ Farming, tree-planting, landscaping, treated fields/golf courses, cut flower industry
- □ Pesticides, insecticides, weed-killers
- □ Molds, damp basements
- □ Recycled air
- □ Nuclear exposure- Chernobyl area, nuclear plant area, nuclear waste area, X-ray equipment, chemo
- □ Second Hand Smoke
- □ Jet fuel, Car exhaust (for work, or live close to highway), In Airplanes a lot
- □ Metal work
- □ Medications that adversely affect your health, or changed something negatively
- □ Other _____

Temperature

12. Do you prefer Warm drinks or Cold drinks?
13. Do you prefer Warm weather or Cooler weather?
14. Do you tend to feel more: WARM or COLD
15. Are you colder/warmer than others in the same room as you? Y or N

Do you have a taste in your mouth: □ On Waking □ All Day and if yes, is it:

□ Bitter □ Sour □ Other _____
□ Metallic □ Sweet

Energy Level and Patterns

16. Rate your current energy level from 1 to 10 with 10 being the most energy you've had.

1 2 3 4 5 6 7 8 9 10

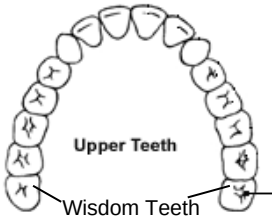
17. When are you most energetic (please circle):
4-6am 7-9am 9-11am 11-1pm 1-3pm 3-5pm 5-7pm 7-9pm 9-11-pm 11-1am 1-4am
18. When are you least energetic (please circle):
19. 4-6am 7-9am 9-11am 11-1pm 1-3pm 3-5pm 5-7pm 7-9pm 9-11-pm 11-1am 1-4am
20. If applicable, when are your symptoms the worst? _____
21. If applicable, when are your symptoms the best? _____

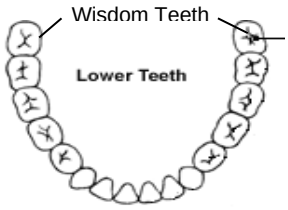
Your Teeth

Oral health has systemic impacts on your immune system. Current research shows links between oral health and various systemic diseases.

Please indicate any teeth which have been:

X Excised (indicate implant if present)
C Capped
F Filled (circle: white or metal amalgams)
R Root canal.





Do you gums bleed with brushing or flossing? Y or N
Do you have gum disease? Y or N
Do you, or have you had any other issues with your teeth, tongue, or mouth?

_____

Lifestyle: Stress, Sleep, Exercise, Nutrition, Vices, Emotions

Stress, Pressures, and Coping and Emotional Health

1. Please circle the level of stress you are experiencing on a scale of 1 to 10, with 1 being the lowest.
   1 2 3 4 5 6 7 8 9 10
2. Please identify the major causes of stress (e.g. job, family, finances, legal, health).
   _____
   _____
3. Are you happy in your life right now? _____
4. Is your life: Satisfactory/Boring/Demanding/Unsatisfactory/Balanced/okay at the moment/Thriving?
5. Do you worry over: Home life/marriage/children/Job/Income/Finances/Extended family/Future
6. Do you **often** feel:

□ Depressed	□ Worried	□ Overwhelm
□ Hopeless	□ On edge/vigilant	□ Emotionally all over
□ Helpless	□ Tense, pressured	□ Sensitive
□ Doomed	□ Impatient	□ Bored
□ Sad	□ Irritable	□ Numb
□ Angry	□ Inferior	□ Content
□ Frustrated	□ Not Good Enough	□ Satisfied
□ Dissatisfied	□ Sense of failure/failing	□ At Peace
□ Anxious	□ Alone	□ Happy
□ Panic	□ Unsupported	□ Joyful
□ Phobic	□ Guilt	□ Manic

7. What do you do to cope with your stresses: e.g. (meditation, time in nature, exercise, talking it out, psychotherapy, smoke, drink, eat, hobby, nothing – push through, sleep)
   _____

8. Do you have any spiritual practices or practices that replenish and nourish you? _____

As human beings, we each require the following; please checkmark any that you feel are not sufficiently present in your life.

- □ Connection
- □ Meaning
- □ Safety
- □ Love
- □ Purpose
- □ Personal Freedom (freedom of the person in going and coming, freedom of opinion and its expression)
- □ Personal Agency (subjective awareness of initiating, executing, controlling one's own volitional actions in the world).

Sleep

9. How many hours do you sleep at night on average? _____
Do you feel rested when you wake up? Y or N Bedtime: _____ Wake-up Time_____
Do you have trouble: □ falling asleep □ Staying asleep? How many times do you wake up? _____

Exercise

10. In your estimation, how physically fit are you?
Unfit Below Average Average Above Average Very fit

9. What do you do for exercise, many times per week and for how long?

_____

Nutrition/Hydration

7. Any foods that you avoid and why? _____
8. Are following a diet plan? (Keto, Paleo, vegetarian, vegan) _____
Since when? _____
9. How many: Cups of water/day? _____
10. Do you cook? Y or N How often do you eat out per week? _____
22. A strong craving for any of the following flavors:

- □ Bitter
- □ Sour
- □ Sweet
- □ Rich/Fatty
- □ Spicy/hot
- □ Salty
- □ Savory

Do you have any strong cravings for particular foods? Which ones? : _____

Substances

11. Alcoholic beverages/week (Please answer honestly)? _____
12. Caffeine: Cups of coffee, tea, pop/day? _____
13. Recreational drugs? Y or N If yes, which? How often? _____
14. Cannabis Use? Y or N What forms? _____
15. Do you smoke? Y or N If "yes" how much per day? _____ Please list past use; how much smoked daily for how long, and number of years quit: _____

Number of bowel movements per day or per week _____

- □ Formed
- □ Loose
- □ Many Pieces
- □ One Solid Piece
- □ Undigested Food Present
- □ Mucus Present
- □ Difficult to pass
- □ Dry
- □ Pellets
- □ Constipation
- □ Diarrhea (liquid)
- □ Painful
- □ Cramps
- □ Odorous

Approximately how many times have you been treated with antibiotics? _____

16. Any conditions/occurrences from which you feel your health has been never the same since?

_____

Medical History

Please check the conditions you have had or continue to experience: **Specify (p) Past or (c) Current.**

- ☐ Abuse
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Angina
- ☐ Hay Fever
- ☐ Alzheimer's
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Appendicitis
- ☐ Asthma
- ☐ Atypical Pap
- ☐ Auto Immune Disease
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Carpal Tunnel
- ☐ Chicken Pox
- ☐ Cholesterol Elevated
- ☐ Circulatory Problems
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular Disease
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Environmental Sensitivity
- ☐ Epilepsy
- ☐ Eyes, Ears, Nose, Throat Problems
- ☐ Gallstones
- ☐ Genetic Disorder
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Valve Problem
- ☐ Hepatitis A B C
- ☐ Herpes: Oral/Genital
- ☐ HIV
- ☐ Hypertension
- ☐ Infection- Chronic
- ☐ Irritable Bowel Syndrome
- ☐ Kidney or Bladder Disease
- ☐ Learning Disability
- ☐ Liver Disease
- ☐ Malaria
- ☐ Measles
- ☐ Mental Illness _____
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Neurological Problems
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Paralysis
- ☐ Parasites
- ☐ Parkinson's
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seasonal Affective Disorder
- ☐ Sleep Apnea
- ☐ STD
- ☐ Stent
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary Tract Infections
- ☐ Varicose Veins
- ☐ Whoop
- ☐ Other _____ _____ _____

What vaccinations have you had? _____

Any complications? _____

Family Medical History (Also indicate which family member)

- ☐ Arthritis
- ☐ Autoimmune Disease _____
- ☐ Asthma
- ☐ Alzheimer's Disease
- ☐ Bleeding Problems
- ☐ Cancer (Type)_____ _____
- ☐ Cardiovascular disease
- ☐ Cholesterol elevated
- ☐ Dementia
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Epilepsy
- ☐ Hay Fever, Allergies
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Mental Health Issues _____
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Stroke
- ☐ Substance Abuse (Which) _____
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other _____

Systems Review: Please check all Current Symptoms

- ☐ Recurrent Infections
- ☐ Swollen Lymph Nodes
- ☐ Sweating at night
- ☐ Sweat Easily
- ☐ Excessive Thirst
- ☐ Thirst but No Desire to Drink
- ☐ Excessive Appetite
- ☐ Recent Change in Appetite
- ☐ Fatigue
- ☐ Poor Sleep
- ☐ Edema (Water Retention)
- ☐ Underweight
- ☐ Overweight
- ☐ Heat Intolerance
- ☐ Cold Intolerance
- ☐ Other _____

Cardiovascular

- ☐ Blood Clots
- ☐ Fainting
- ☐ Chest pain
- ☐ Heart Palpitations
- ☐ Cold Hands/Feet
- ☐ Difficulty Breathing
- ☐ Irregular Heartbeat
- ☐ Swelling in Hands/Feet
- ☐ High/low blood pressure
- ☐ Other _____

Musculoskeletal

- ☐ Neck Ache/Pain
- ☐ Back Ache/Pain
- ☐ Muscle Pains
- ☐ Joint Pain
- ☐ Stiffness
- ☐ Muscle Weakness
- ☐ Orthotics
- ☐ Hernia

Other _____

Behavioral

- ☐ Nervousness
- ☐ Anxiety
- ☐ Depression
- ☐ Easily Stressed
- ☐ Overwhelm
- ☐ Moody
- ☐ Aggressive/Bad Temper
- ☐ Panic Attacks
- ☐ Fear
- ☐ High Pressure Job
- ☐ Other _____

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Gas/Bloating
- ☐ Bad Breath
- ☐ Constipation
- ☐ Use Laxatives
- ☐ Diarrhea
- ☐ Change in Bowel Habits
- ☐ Pain or Cramps
- ☐ Sensitive Abdomen
- ☐ Indigestion/Heartburn
- ☐ Belching
- ☐ Rectal Pain
- ☐ Bloody Stools
- ☐ Mucus in Stools
- ☐ Hemorrhoids
- ☐ Black Stools
- ☐ Other _____

Respiratory

- ☐ Coughing Blood
- ☐ Coughing Phlegm/Mucus
- ☐ Tight Chest
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Postnasal Drip
- ☐ Wheezing
- ☐ Difficulty Breathing When Lying Down
- ☐ Recurrent/Persistent Cough/Cold

Other _____

Neurological

- ☐ Numbness/Tingling
- ☐ Twitching
- ☐ Tremors
- ☐ Loss of Balance/Coordination
- ☐ Nerve Damage
- ☐ Vertigo
- ☐ Other _____

Skin

- ☐ Bleed or Bruise Easily
- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Dry Skin/Scalp
- ☐ Oily Skin/Scalp
- ☐ Loss of Hair
- ☐ Dandruff
- ☐ Ulcerations
- ☐ Pimples/Acne
- ☐ Hives
- ☐ Fungal Infection
- ☐ Recent Moles
- ☐ Change in Colour of Mole
- ☐ Other _____

Head, Eyes, Ears, Nose, Throat

- ☐ Dizziness
- ☐ Concussions
- ☐ Headaches
- ☐ Ringing in Ears
- ☐ Hearing Aid
- ☐ Poor Hearing
- ☐ Draining/Discharge from Ear
- ☐ Teeth Problems
- ☐ Bleeding Gums
- ☐ Dentures
- ☐ Sores on Lips or Tongue
- ☐ Dry Mouth
- ☐ Grinding Teeth
- ☐ Dry Throat/Hoarseness
- ☐ Jaw Clicks
- ☐ Spots in Eyes/Floaters
- ☐ Wear Glasses/Contacts
- ☐ Color Blindness
- ☐ Eye Pain
- ☐ Cataracts
- ☐ Night Blindness, Difficulty
- ☐ Blurry Vison
- ☐ Nose Bleeds

- ☐ Snoring
- ☐ Sinus Problems
- ☐ Mucus in Nose and Throat
- ☐ Other _____

Genito-Urinary

- ☐ Pain on Urination
- ☐ Unable to Hold Urine
- ☐ Urgency to Urinate
- ☐ Frequent Urination
- ☐ Wake up to Urinate
- ☐ Blood in Urine
- ☐ Dribbling Urination
- ☐ Kidney Stones
- ☐ Impotency
- ☐ Other _____

Sexual Orientation (Optional)

- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Transgender
- ☐ Queer
- ☐ Asexual

Male

- ☐ Discharge from Penis
- ☐ Pain in Testicles
- ☐ Lump in Testicles
- ☐ Prostate Abnormalities
- ☐ Vasectomy
- ☐ Change in Sex Drive
- ☐ Infertility
- ☐ Varicocele

Other _____

Female

- ☐ Vaginal Itching or Burning
- ☐ Vaginal Discharge
- ☐ Cervical Dysplasia
- ☐ Painful Menstrual Periods
- ☐ Lumps in Breast
- ☐ Discharge from Nipple
- ☐ Pain with Intercourse
- ☐ PCOS
- ☐ Bleeding Between Periods
- ☐ Fibroids
- ☐ Endometriosis
- ☐ Hysterectomy Full/Partial
- ☐ Ovarian Cysts
- ☐ PMS
- ☐ Perimenopausal
- ☐ Menopausal
- ☐ Midcycle Pains
- ☐ Irregular Cycles
- ☐ Recent Change in Cycle
- ☐ Infertility
- ☐ Insufficient Lactation
- ☐ Tendency to Miscarry
- ☐ Tubal Ligation
- ☐ Change in Sex Drive Low or High
- ☐ Other _____

Last Pap Date: _____

Methods of Birth Control:

_____

_____

Last Mammogram/Thermogram:

_____

Menstruation:

Last Menstrual Period Date:

_____

Cycle Length (e.g. 28 days)

_____

# of days of bleeding: _____

PMS/Menstrual Symptoms

- ☐ Mood Changes (Anger, Irritable, Sad, Sensitive
- ☐ Cravings
- ☐ Water Retention
- ☐ Cramping
- ☐ Breast Tenderness
- ☐ Back Pain
- ☐ Diarrhea/constipation
- ☐ Difficulty sleeping
- ☐ Fatigue
- ☐ To Hot/To Cold
- ☐ Headaches, Migraines
- ☐ Acne/Pimple Flare
- ☐ Other _____

Flow

- ☐ Clots
- ☐ Heavy: #Pads/Day _____
- ☐ Scanty
- ☐ Dark Red
- ☐ Bright Red
- ☐ Better Pressure
- ☐ Worse Pressure
- ☐ Better Heat
- ☐ Other _____

Birth Control Pill History of Use:
# of years? _____
What ages? _____
Tolerance to it? Good bad

Hormone Replacement Therapy? Y or N
How long? _____

Number of Pregnancies_____
Number of Live Births_____
Number of Miscarriages _____
Number or Abortions_____

And finally, would you like to:

- ☐ Have More Energy/Stronger
- ☐ Have More Endurance
- ☐ Increase Your Sex Drive
- ☐ Lose/Gain Weight
- ☐ Be Less Moody
- ☐ Not Be Dependent on Over-The-Counter/Other Meds
- ☐ Be less Indecisive
- ☐ Be More Organized
- ☐ Feel More Motivated
- ☐ Think More Clearly
- ☐ Improve Memory
- ☐ Stop Using Laxatives and Stool Softeners
- ☐ Be More Relaxed
- ☐ Sleep Better
- ☐ Better Breath
- ☐ Better Body Odor
- ☐ Have less Colds and Flus
- ☐ Get Rid of Allergies
- ☐ Reduce risk of Inherited Familial Disease Tendencies
- ☐ Be Free of Pain
- ☐ Be Happier!
- ☐ Other: _____

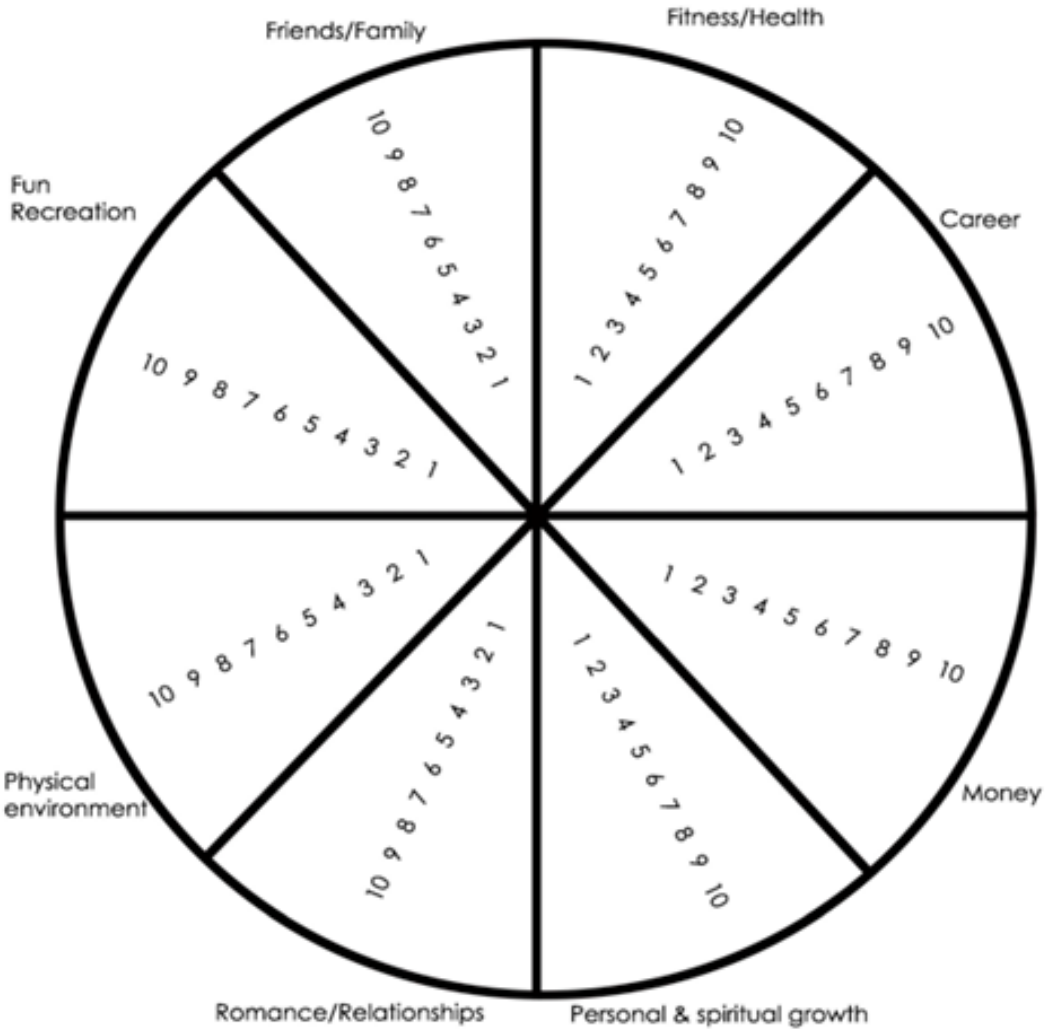
_____

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

Career pertains to career and power
Money pertains to money and financial fitness
Physical Environment pertains to connection to nature
Personal Growth pertains to personal growth and spirituality

For example, if you are extremely happy in your career, shade the entire pie shape for career. Do the same for each area, starting from the center point radiating outwards.



Food Log

Please use this sheet to track your food and mood over a seven-day period.
Be Honest! Include everything you eat and drink in one day, include portions where possible.
There is a section at the bottom where you should mark the number of bowel movements (BMs) you have that day as well as their consistency. Record any other symptoms you experience such as gas, bloating, heartburn, nausea, or headaches.

Start Day:	**Monday**	**Tuesday**	**Wednesday**
Breakfast Mood Energy	Time:	Time:	Time:
Snack (if any) Time:			
Lunch Mood Energy	Time:	Time:	Time
Snack (if any) Time:			
Dinner Mood Energy	Time:	Time:	Time:
Snack (If any before bed) Time:			
BMs Other Symptoms			

Start Day:	**Thursday**	**Friday**	**Saturday**
Breakfast Mood Energy	Time:	Time:	Time:
Snack (if any) Time:			
Lunch Mood Energy	Time:	Time:	Time
Snack (if any) Time:			
Dinner Mood Energy	Time:	Time:	Time:
Snack (If any before bed) Time:			
BMs Other Symptoms			

Sunday	**Breakfast**	**Snack (if any) Time:**	**Lunch**	**Snack (if any) Time**	**Dinner**	**Snack (if any) Time**	**BMs Other Symptoms**
Mood Energy	Time:		Time:		Time:		

Context of Care

1. What does healthy mean for you? (physical wellness, energy, peace of mind, quality of life, good relationships) _____

_____

2. We love what we do and are happy you are choosing to improve your health. We wish to be really clear about your goals and understanding of the care we provide. We want to clarify any questions you may have. Why did you choose to come to this clinic and what do you know about our approach?

_____

_____

3. What 3 expectations do you have of this visit to our clinic?

_____

_____

4. What long- term expectations, personal and health goals do you have of working with our clinic?

_____

_____

Lifestyle changes are a critical aspect of treating root causes of any chronic disease and may be part of your therapeutic protocol. We understand that these changes can be easy for some and quite challenging for others.

My purpose and meaning comes from a real passion to help, and to get you well. We are here to support you, and ensure you reach your goals. Your ability to heal, comes from you. We wish to know more about your motivation level and areas where you may need support.

5. On a scale of 1-10, how committed are you to recovering your health and addressing root causes of your health concerns?

1 2 3 4 5 6 7 8 9 10

6. Are you prepared to make lifestyle changes, invest in laboratory testing, consult fees and nutritional supplements (and or IV/injection therapy)? _____

7. What behaviors or lifestyle habits do you engage in regularly that support your health?

_____

_____

8. What behaviors or lifestyle habits do you engage in regularly that may be self-destructive lifestyle habits?

_____

_____

9. What potential obstacles might come up for you?

_____

10. Other than myself, where do you find support? Who/what can be part of supporting you in reaching your goals? Let's put some supports in place. You will need help with: food prep, getting to and from treatments – conventional and naturopathic, medication taking, supplement taking, emotional support.

_____

_____

Informed Consent and Important Office Policies

** It is Important that you read this in its entirety and initial where necessary **

Naturopathic medicine is the treatment and prevention of diseases by natural means and by addressing the root causes of physiological disturbance. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual; in order to elucidate and address the root causes of disease and difficulty where possible. Gentle, non-invasive techniques are used to stimulate the body's inherent healing abilities. Several different approaches are used. Diet therapy, nutritional supplements, botanical medicine, homeopathy, Traditional Chinese Medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counseling are the mainstays of naturopathic medicine. Practitioners at VCIM are also trained in several other advanced integrative medical techniques.

Every person's body, processing genetics and health circumstances are different. What we see in medicine is that while serious adverse reactions to natural substances are very rare, anyone can react to any substance, be it a drug, food, supplement or body work, in any unexpected way.

The following information is listed to make sure you are aware of and consent to, the possible risks or adverse reactions with Naturopathic Medical care. We take great care to avoid all risk or interactions.

Individual Dietary Recommendations, Modification and or Specific Types of Diets (e.g. Anti-inflammatory, Ketogenic, vegetarian, paleo etc.) may be recommend as part of your care to optimize your health and treatment results.
Risks/Adverse Reaction: May cause changes to weight, energy levels, digestive function or symptoms, general feeling of wellness, reactions to new foods.

Nutritional Supplements are recommended to support repair, address deficiencies, treat medication side effects, aid in detoxification, and support anti-cancer actions.
Risks/Adverse Reactions: In general, digestive upset including nausea, diarrhea, constipation, headaches, allergic rashes, allergic symptoms, aggravation current symptoms, detoxification symptoms such as headache, fatigue, flu-like symptoms, changes to medication metabolism.

Botanical Medicine/Formulas is the use of herbal teas, tinctures, capsules and other forms of herbal preparations to support repair, strengthen organ function, aid in detoxification, complement anti-cancer actions of medications, anti-cancer actions alone, prevent or treat medication side effects. Botanical tinctures contain alcohol. The alcohol is needed to extract pharmacologically active Phyto-nutrients from plants.
Risks/adverse reactions: In general, as above.

Homeopathy is a form of medicine heavily used by doctors in Europe and around the world in both hospital and private practice. It is based on the use of minute doses of plant, animal or mineral origin to stimulate the body's ability to heal itself.

Traditional Chinese Medicine: Includes acupuncture, as well as the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sterile, single-use, individually wrapped needles are used. Botanical formulas may be given in the form of pills, tinctures, extracts or decoctions (strong teas) to be taken internally or used externally as a wash. Herbal formulas may include shell, mineral and animal materials as well as plants.

Acupuncture Risks/Adverse reactions: Pain, swelling, bruising, nerve-like pain, puncturing a tendon, ligament, nerve with a needle, aggravation of symptoms, dizziness, fainting.

Hydrotherapy: The use of hot and cold-water applications to improve circulation and stimulate the immune system.
Risks/Adverse reactions: As above. Burning the skin if improper temperature is used on oneself.

Cupping refers to the use of sterile silicone or hard plastic "cups" suctioned over an area of the body to increase the circulation of blood and lymph to relieve congestion and stagnation in injured areas to bring about and stimulate repair. Risks/Adverse reactions: pain, bruising, swelling, aggravation of symptoms, fatigue, detox like symptoms such as headache and flu-like symptoms.

Bowen Therapy refers to a gentle hands-on technique where skin slack is rolled over muscle bellies in specific areas of the body for treating pain due to injury, trauma or chronic degeneration of the musculoskeletal system.

Risks/Adverse reactions: aggravation of current symptoms, detox type reactions such as fatigue, flu-like symptoms, return of old symptoms for a time period.

Counselling, Coaching, Gestalt Therapy, Emotional Freedom Technique, Mindfulness Based Cognitive Therapy, Meditation Instruction:
Risks: Re-traumatizing past trauma, emotional discomfort, increased anxiety or depression.

Intramuscular Nutrient Injections refers to the injection of nutrients into a muscle belly, usually the posterior deltoid (upper arm) or buttocks.

Risks/Adverse Reactions: pain, swelling, bruising, nerve pain or injury, tendon or ligament injury, infection, rash, nausea, fainting, fatigue, better sleep, difficulty falling asleep, excess energy.

IV Nutrient Therapy: There is a separate consent form for IV Therapy.

Drug/Supplement/Botanical Interactions: Supplements can interact with medications by changing how medications are metabolized, causing them to be more slowly cleared or more quickly cleared from the body. This means that the medication dosing can be have a stronger or more toxic effect, or weaker, less effective effect. Some supplements work similarly to medications, thus making the overall effect stronger or more toxic. This also occurs with poly-pharmacy; when a patient is on more than 3 drugs, it becomes impossible to absolutely identify all interactions between medications. Your ND will make every effort to avoid drug-supplement interactions.

I have read, understand and consent to the above treatments should they be recommended to me, and take full responsibility for all risks and adverse reaction. _____
Initial

I understand that the Naturopathic Doctor will answer any questions I have to the best of her ability. I understand that results are not guaranteed. Because everyone may respond differently to treatment, I do not expect Dr. Tammy Grime to be able to anticipate and explain all risks and complications. I will rely on her to exercise judgment during treatment, which she feels at the time is in my best interest based upon the facts then known. _____
Initial

Privacy
I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or my representative or unless it is required by law. I understand that I may look at my record at any time and can request a copy of it by paying the appropriate fee.

_____
Initial

I understand that information from my record may be analyzed for research purposes, and that my identity will be protected and kept confidential. _____
Initial

I have read the above information and with this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions)

_____

_____

_____
Initial

Cancellation Policy

We require changes to your appointment time to be made by 10 am the previous day or full fees for your appointment will be applied. _____
Initial

- We do everything possible to keep our fees for service low, so that your care is affordable and accessible.
- We work very hard outside of office hours the day before your appointment preparing for your visit.
- As a small private clinic run solely on fees for service we incur costs for missed appointments.
- We do have a waitlist of people needing our help.
- If for any reason you cannot make your appointment, please be sure to notify us as per our cancellation policy so we can try to coordinate with someone else's schedule, and so to avoid last minute cancellation fees. We don't like having to charge them.

In Office Wait Times

We try our very best to keep appointments running on time which can be difficult in a health care setting. At times there are unexpected complexities, urgencies and needs that can affect the scheduling. Our longest wait time is 30 minutes.

Please don't hesitate to call to see if we are running on time. Please schedule your day around the appointment with a little extra time. We also ask that you be on time and adjust for traffic, transit delays and parking ahead of your visit time so that we use your visit time well.

Email Policy

Medical advice and care cannot be provided by email; it is not a safe or effective way to provide care. It is also very difficult to schedule appointments over email. Please call the office directly for any concerns, for prescription clarifications and appointment scheduling.

We do very much want to know how you are doing and any concerns you may have – alas we cannot address such concerns by email. _____
Initial

Consent

I intend this consent form to cover the entire course of treatment for my present condition.

I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read and understand all this form, including the risks, alternatives for treatment, and the Village Centre for Integrative Medicine office policies.

Name (Print): _____

Signature: _____ Date: _____/_____/_____
(Guardian if applicable) mm dd yyyy