ST. ALBERT NATUROPATHIC CLINIC

New Patient Intake

Name:_____ **Date**:_____
Date of birth: M:_____ D:_____Y:_____ **Sex**: M F
Email:_____ (To receive test results and newsletter)

Address:_____ Phone: _____h
City:_____ _____w
Postal Code: _____ _____c

May we leave messages relating to your visits? Y N

Emergency Contact- Name: _____ Phone: _____
Where did you learn of the St. Albert Naturopathic Clinic? _____

Please list your health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____

What are your goals or outcomes you hope to achieve by using Naturopathic Medicine?

_____
_____
_____

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any surgeries; along with approximate dates:

_____
_____

Do you have any known allergies (medicines, environmental, etc.)?

_____

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Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):

_____

_____

_____

Please list past prescription medications (used within last two years):

_____

_____

Do you frequently use any of the following? (circle)

Aspirin Laxatives Antacids Diet pills Birth control pills/implants/injections

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Non-Prescription Drugs—what and how often_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y N

Diet

Do you have any food allergies, intolerances or diet restrictions (vegetarian)? Please list.

_____

Family History

Indicate if a close relative (grandparent, parent, child, sibling) has had any of the following: ☐ I don't know my family medical history

Allergies		Asthma		Cancer	
Diabetes		High Blood Pressure		Heart Disease	
Digestive Disorders		Depression		Other Mental Illness	
Drug or Alcohol Abuse		Kidney Disease		Obesity	
Eczema		Psoriasis		Osteoporosis	

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Environment

Occupation: _____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y N

Are you frequently exposed to animals (work, pets, etc.)? Y N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?

Please describe: _____

Do you have dental mercury amalgams? Y / N Any history of metal work? Y / N

How would you describe the emotional climate of your home? _____

Do you consider yourself stressed? Y / N

Do you exercise regularly? Y / N

Is there anything that you feel is important that has not been covered?

_____

_____

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Welcome to the clinic. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please **read and initial** the following statements.

Initial

_____ Turn off your cellphones during your visit or refrain from answering unless an emergency.
_____ In winter, please remove your outdoor shoes at the front door. You may use slippers that are provided or bring your own indoor shoes to help us eliminate wet/dirt in the clinic
_____ Refrain from wearing scents for the health of our clients as some of our patients are highly sensitive to scents/perfumes.
_____ **There may be times when you may be required to wait as the Doctor is providing needed attention to a current patient.**
_____ If you have not seen the doctor in 6 years or longer, you will need to fill in the new patient intake forms and be scheduled for a 1 hour visit in order to fully address your health concerns.
_____ From time to time, the clinic may email you updates, newsletters, information about upcoming events, or similar communications. You agree to be contacted at the email provided. You may opt out of such emails at any time.
_____ Payment of services, dispensary items, and other fees are due in full at each visit. The clinic does not directly bill insurance providers, but will provide you with a receipt to submit your own claim.
_____ **Cancellations of less than 24 business hours or missed appointments will be charged a Missed Appointment Fee of $50**

Informed Consent

I have read the information and understand that the care I will receive is based on the principles of Naturopathic Medicine.

I confirm that the information I provided is complete and inclusive of all health concerns including risk of pregnancy; breastfeeding; and all medications, including over-the-counter drugs and supplements.

I understand that naturopathic medicine carries a risk of complications in certain physiological conditions and that resolution of symptoms is not guaranteed.

I acknowledge that the doctors and/or practitioners in the clinic may enhance my care periodically by discussing my case with each other. I will inform my naturopathic doctor if this is a concern to me.

I understand that I have the ability to accept or reject this care of my own free will and choice. I am here as a patient seeking naturopathic medical care and am not attending the clinic for any other reason or misrepresenting myself in any way to the practitioner without making my intention known to the practitioner and/or staff.

_____ _____
Patient Name (Please print) **Date**

_____
Parent/guardian name (if minor – under 18yo)

_____ _____
Patient Signature or parent/guardian (if minor – under 18yo)

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