CareMed
Integrative Health Centre

#102-88 Lonsdale Ave
North Vancouver, BC, V7M 2E6
p. 778-340-1114 f. 778-340-7702
e. info@drkennett.com
w. www.caremedhealth.com

Naturopathic Medicine - New Patient Intake Form

Please ensure the information that you provide is accurate and complete. All information collected is considered confidential and is kept in accordance with the College of Naturopathic Physicians of BC. Please make sure you sign the consent to treatment form, which is on page 5 of this document.

Registration Information:

Full Name:			Today's date:
Gender:	Age:	Birthdate:	Marital Status:
Email Address:		Occupation:	
Home Address:		Best phone number to reach you at:	
CareCard #:		Emergency Contact and ph #:	
Please tell us how you found out about our clinic:			

May we leave messages on your primary phone number related to your visits? Y or N
May we send confidential information regarding test results and treatments to your email address? Y or N

Health Care Team:

Type of Provider	Name	City / Province
Medical Doctor(s)		
Specialist(s)		
RMT/Chiro/Physio/Acupuncture		
Other:		

Please tell me about your main health concerns, in order of importance to you:

1.
2.
3.
4.
5.

Are there any particular areas of naturopathic testing or therapies that you would like to know more about?

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Medical History:

Do you have any allergies / sensitivities to:

Medications	
Environmenta l	
Foods	

Please list the name & dose of all current medications - even if you don't take them all of the time:

Prescriptions	
Over the counter	
Vitamins / herbs etc..	

Do you use, or have you used, any of the following on a regular basis? If so, how often/how much?

- ❏ Laxatives:____
- ❏ Diet Pills:____
- ❏ Antacids:____
- ❏ Aspirin / Tylenol / Advil:____
- ❏ Caffeine:____
- ❏ Alcohol:____
- ❏ Recreational Drugs:____
- ❏ Cigarettes / Chewing Tobacco:____

Please indicate if you have had any major hospitalizations, surgeries, implants, infections or other illnesses and the approximate date:

Lifestyle - historical and current:

Environmental Exposure to toxins / radiation / fumes / other health hazards:
How would you rate your general state of health on a scale of 1-10 (10 = best)
How would you rate your diet on a scale of 1-10 (10 = best):
How would you rate your sleep on a scale of 1-10 (10 = best)
Do you follow any special diet / nutrition plans? If so, please describe:
Describe your exercise routine:

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Current Weight & Height:	Weight 1 year ago:	Ideal Weight:

Family History

Please indicate if a close relative (parent, grandparent, or sibling) has, or has had any of the following:

- ❏ Allergies
- ❏ Artificial Heart Valves
- ❏ Arthritis
- ❏ Asthma
- ❏ Cancer (Type___________)
- ❏ Diabetes / Obesity
- ❏ Eczema
- ❏ Thyroid Disease
- ❏ Endometriosis
- ❏ Gallstones / Liver disease
- ❏ Heart Disease
- ❏ High Blood Pressure
- ❏ Kidney Disease
- ❏ Mental Illness
- ❏ Multiple Sclerosis
- ❏ ______________________
- ❏ Osteoporosis
- ❏ Infertility
- ❏ Rubella
- ❏ Rheumatic Fever
- ❏ Skin Disease
- ❏ Stroke
- ❏ Tuberculosis
- ❏ ______________________

GENERAL

□ Fatigue/Time of Day_________________ □ Poor sleep □ Bleed or bruise easily □ Poor appetite □ Fevers
□ Increased appetite □ Chills □Tremors □ Sweat easily □ Dizziness
□ Cold hands or feet □ Strong thirst

SKIN AND HAIR

□Sensitive Skin □Ulcerations □Hives □Itching □Eczema □Acne □Dandruff
□Warts □Hair Loss □Suspicious Moles or Lesions □Rashes

MUSCULOSKELETAL

□Whiplash □Osteoarthritis □Osteoporosis □Rheumatoid Arthritis □Re-occurring Sprains/Strains
□Tendonitis □Bursitis □Dislocations □Fracture □Non-specific joint pain

HEAD, EYES, EARS, NOSE AND THROAT

□Concussions □Migraines □Eye pain □Eye strain □Cataracts □Poor vision
□Night blindness □Blurry vision □Earaches or infections □Ringing in ears □Poor hearing □Sinus Problems
□Glasses or contact lenses □Spots in front of eyes □Nosebleeds □Jaw clicks □Teeth problems
□Recurrent sore throats □Grinding teeth □Sores on lips or tongue
□Headaches ______# of amalgam fillings (Mercury/Silver)

CARDIOVASCULAR

□ Fainting □Chest pain □Congestive Heart Failure □ High/Low blood pressure
□ Irregular heartbeat □ Swelling of hands/ feet □ Blood clotting disorders □Varicose veins

RESPIRATORY

□ Cough □ Asthma □Emphysema □ Bronchitis □Pneumonia □ Shortness of Breath
□ Phlegm (what color)?

GASTROINTESTINAL

□ Nausea □Heartburn/Reflux □ Indigestion □ Vomiting □Belching □ Blood in stools
□Gas □ Rectal pain □ Diarrhea □ Bad breath □Hemorrhoids □ Abdominal pain or cramps
□ Laxative use □Constipation □ Black stools □Ulcers/Gastritis

Travel outside of the country in the last 12 months?_________________

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GENITO-URINARY
□ Pain on urination □ Frequent urination □ Blood in urine □ Urgency to urinate □ Unable to hold urine □ Kidney stones □ Erectile Dysfunction □ Sores on genitals □ Decrease in flow
□ Do you wake to urinate (how often)?

WOMEN'S HEALTH
Date of last Menstrual Period____________
□Menstrual Irregularities □Light/Heavy □Clots □Painful periods □Endometriosis □ PMS
□ Fibrocystic Breasts □Breast cancer □Ovarian cysts □Menopause □Infertility
□ Pelvic Inflammatory Disease □Decreased sex drive □ Vaginal infections □Contraception, type: ____________

# of children:________ #of pregnancies:________ Date of last PAP exam____________ Mammogram___________

MEN'S HEALTH
□Benign prostatic enlargement □Prostate Cancer □Decreased sex drive □Erectile Dysfunction

NEUROPSYCHOLOGICAL
□ Seizures □ Panic Attacks □ Lack of coordination □Poor memory □Depression □ Anxiety
□ Quick temper / irritable

I am also interested in:
□Modifiable Genetic Risk factors for diseases such as cancer, cardiovascular disease and osteoporosis
□Heavy metal testing for mercury, cadmium, lead, arsenic, and other common toxic metals
□Determining underlying factors that cause difficult weight loss such as cortisol, thyroid function, serotonin, estrogen and testosterone
□Salivary or urinary hormone assessments for estrogen, progesterone, DHEA, DHT, etc.
□Metabolic assessment for nutritional status i.e. need for certain vitamins, minerals, essential fats
□Food and/or environmental sensitivity and allergy testing

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INFORMED CONSENT FOR NATUROPATHIC TREATMENT

Naturopathic Doctors (ND) assess the whole person, taking into consideration physical, mental, and emotional aspects of the individual. Your Naturopathic Doctor will take a thorough case history and answer any questions that may arise throughout the treatment process. A physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. The Naturopathic Doctor at CareMed Integrative Health Centre use the following modalities in their practice: diet and nutritional counseling, botanical medicine, homeopathy, parenteral therapy, chelation therapy, Traditional Chinese Medicine and acupuncture, lifestyle counseling, injection therapy and prescription medication. It is very important that you inform your Naturopathic Physician immediately of any disease process from which you are suffering and any medications/over the counter drugs or supplements that you are currently taking. Please advise your Naturopathic Physician immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

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

- Aggravation of pre-existing symptoms,
- Allergic reactions to certain supplements, herbs or prescription medications
- Pain, bruising or injury from venipuncture or acupuncture, injection therapy or parenteral therapy
- Fainting or puncturing of an organ with acupuncture needles

Please initial 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 Dr Jolene Kennett will answer any questions that I have to the best of 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 the full fee of the booked visit..

___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.

I confirm that I have given all relevant information to the best of my knowledge.

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: ______________________