ARGYLE NATURAL HEALTH CENTRE
NATUROPATHIC INTAKE FORM

Full Name: _____
(First) (Middle) (Last)

Date of Birth: ____/____/____ Age: _____ Sex: F o M o
dd mm yy

Marital Status: Single o Married o Common-law o Divorced o Widowed o

Street Address: _____

City: _____ Postal Code: _____

Tel (home): _____ Tel (work): _____Tel (cell):_____

Occupation/Employer: _____ Referred By:_____

Emergency Contact - Name: _____ Tel: _____

Health card number:_____

Medical Doctor(s): _____

Email address:_____

(EMAIL ADDRESSES ARE USED FOR CONFIRMATION OF APPOINTMENTS AND APPOINTMENT REMINDERS)

What are your major health concern? Please list them in order of importance:

_____

_____

Circle any of the following conditions you have or may have had:

abcess	diabetes	hepatitis	multiple sclerosis	rheumatic fever	tuberculosis
abortion	emphysema	HIV	mumps	rubella/German measles	typhoid fever
alcoholism	epilepsy	influenza	parasites	scarlet fever	venereal warts
anemia	frequent colds	kidney disease	peritonitis	sexual abuse	warts
arthritis	gallstones	leukemia	pelvic inflam. dis.	skin diseases	whooping cough
asthma	genital herpes	low/high blood pr.	pleurisy	sinusitis	worms
cancer	gonorrhea	malaria	pneumonia	stroke	yellow fever
chicken pox	gout	measles	PMS	strep throat	others:
cold sores	hayfever	miscarriages	prostatitis	syphilis	_____
depression	heart disease	mononucleosis	psychiatric illness	tonsilitis	_____

Have any of your family members suffered from any of the conditions listed above? If so, please indicate their condition(s), their relation to you and their age at the time of their illness or death (e.g. high blood pressure - mother - 76)_____

_____

For each of the following family members, please indicate present age and health status, or age at the time of death and cause of death:

Mother: _____

Father: _____

Mother's mother: _____

Mother's father: _____

Father's mother: _____

Father's father: _____

Children: _____ _____

_____ _____

Sister(s)/brother(s): _____

_____

What immunizations have you had, and did you react badly to any of them?

Immunizations	Reaction, if any
o Measles, Mumps, Rubella (MMR)	_____
o Smallpox	_____
o Diptheria, Pertussis, Tetanus (DPT)	_____
o Hepatitis	_____
o Polio	_____
o Others _____	_____
o Others _____	_____

What surgeries or major injuries have you had? _____

_____

_____

Have you ever been hospitalized? If so, why and when? _____

_____

What medications, if any, are you currently on? _____

_____

_____

What natural supplements (vitamins, minerals, herbs, ...) are you currently on?_____

_____

_____

Do you have any known allergies or intolerances? If so, what are they?_____

_____

Have you ever seen a naturopath or other complementary alternative health professional? If so, what were they? _____

Have you ever suffered any serious trauma in your life that you feel is still affecting you? _____

_____

_____

What is a typical day's diet for you?
Breakfast: _____
Lunch: _____
Supper: _____
Snacks: _____
Drinks: _____

Indicate if any of the statements below apply to you (please elaborate):

- Diet often _____
- Eat out often _____
- No regular exercise _____
- Consume caffeine _____
- Exposed to chemicals or environmental hazards _____
- Exposed to tobacco _____
- Consume alcohol _____
- Use recreational drugs _____

What is your:
Weight now? _____ *Minimum adult weight?* _____ *Maximum weight?* _____
Ideal weight? _____ *Height?* _____

How much leisure time do you usually have? _____

What are your typical leisure activities? _____
_____

Do you enjoy your job/school? Why or why not? _____
_____

Do you enjoy your relationships with your family and friends? Why or why not? _____
_____

What is your general outlook on life? _____
_____

How committed are you to making changes in your life in order to improve your health? _____
_____

Thank you for filling this out.
The information you provide will assist in providing you with quality naturopathic health care.

The Naturopathic Physician's primary purpose is to prevent disease, to promote health, and to restore, maintain and optimize health and well-being through individualized patient care and public education

ARGYLE NATURAL HEALTH CENTRE

"your natural choice for health care"
3643 Sherwood Drive, Regina SK S4R 4A7
Tel: (306) 352-4242 Fax (306) 352-1573
Dr. Kathleen Fyffe, N.D.

I, the undersigned, hereby give my consent to naturopathic care and treatment from the Naturopathic Physician. Naturopathic care and treatment may include, but are not limited to, a physical examination, naturopathic diagnosis, nutritional and dietary counselling, botanical medicine, homeopathy, acupuncture, and lifestyle counselling.

I understand that I am entitled to a full description and explanation of any procedure before it is preformed, and that I have the right to refuse treatment should I choose to do so.

I have read and understood the above.

_____ _____
Patient name (please print) Patient signature

_____ _____
Date Witness signature

Argyle Natural Health Centre Naturopathic FEE SCHEDULE

I understand that the fees of the Argyle Natural Health Centre are as follows:

VISIT	FEE
Initial Visit (includes ETAScan)	$225.00
Follow up visit	$100.00

The patient will be made aware of any additional costs for other procedures/test.

Please note that there is a 24-hour cancellation policy. If 24 hours notice is not given, a $25.00 missed appointment fee will be charged.

I acknowledge that I may purchase products/supplements prescribed from the N.D. or any health food store.

I, the undersigned do acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/treatments and have discussed these to my satisfaction. I further acknowledge and confirm that I have been informed of and understand the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having/following the procedures/treatment and what alternative course(s) of action are available to me.

I do hereby voluntarily give my informed consent for the recommended therapeutic procedures/treatments as prescribed by the N.D. and for any future modifications of the procedures/treatments. I also understand that I may change the status of my voluntary consent at any time. I intend this consent to apply to all my present and future naturopathic care.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

NAME OF PATIENT PRINTED DOCTOR'S SIGNATURE