NATUROPATHIC ADULT INTAKE FORM

Patient Information:

Name: ____ Date: ________________

Address: ____

City: ____________________ Province: ______________ Postal Code: _______________

Phone: (H) ____________________________(Cell) ______________________________

Date of Birth: ___________________(YYYY/MM/DD) Age: ____ Sex: M / F / □ __________

Occupation: _______________________ Email: _________________________________

By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.

In case of emergency, who should we contact: _________________________________

How did you find out about our services? _______________________________________

Patient Health History:

Please list your **health concerns** (from major to minor):

1. ____
2. ____
3. ____

Please list all **accidents**, **surgeries** or **hospitalizations** and the **year** they occurred:

____ __________

____ __________

____ __________

Please list any **medications** and **supplements** you are currently taking and **dosage**:

____

____

____

Are you currently seeing any other **alternative health care** professionals? (Chiro, Massage, etc)

____

____

____

Please list all **allergies**/**sensitivities**:

____

When was your **last physical exam**? ____

When was your **last blood test**? ____

Female patients: When was your last **breast exam/PAP smear**? _________________

Family Doctor's name: ____

Clinic Name/Area: ___________________________ Phone Number: ________________

Please list all immediate **family members** who have any major health conditions:

____

____

Please list all conditions for which you have been treated in the past **10 years**:

____

____

Please list **all other conditions** that you currently have but are not the primary concern:

____

____

Consent for Treatment with Essence Wellness Clinic

I am hereby requesting Naturopathic treatments from Essence Wellness Clinic. New complications and concerns, if they do arise, will be discussed with my practitioner/therapist, and appropriate action will be taken. I understand that although these are natural and alternative treatments I am seeking, there may be risks of bruising, pain in treated area, and worsening of symptoms during the healing process. I also understand that there are no guarantees for cure for any of my ailments or improvements of my symptoms. I hereby release Essence Wellness and all practitioners/therapists treating me from all liabilities.

I am also aware of the clinic's late cancellation policy of a charge **of 50% of the visit cost** if I fail to give **less than 24 hours notice for cancellations**. **I will be responsible to pay that charge before I can re-book.**

Signature ___________________________________ Date_________________________