

CLEAR MEDICINE PATIENT INTAKE FORM

Please answer the following questions to the best of your knowledge. All of the information provided is confidential. Please try to be as detailed as possible as it will help me complete a thorough evaluation of your health. If you have any questions, please do not hesitate to ask. Thank you.

NAME: _____ DATE: _____
(First) (Middle) (Last)

DATE OF BIRTH: _____ PLACE OF BIRTH: _____
dd / mm / yy city / country

AGE: _____ GENDER: _____

ADDRESS: _____
Street apt. # city postal code

PHONE: (home) _____ (work) _____

EMAIL: _____

CELL: _____ OCCUPATION: _____

EMERGENCY CONTACT: _____ Phone: _____

FAMILY PHYSICIAN: _____ Phone: _____

SOURCE OF REFERRAL: _____

OHIP NUMBER: _____

DOES YOUR EXTENDED HEALTH CARE PLAN COVER EXTENDED HEALTH SERVICES? YES NO
*Please note that Sun Life Insurance does not cover Osteopathic Services at this time.

CHIEF COMPLAINTS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Who diagnosed the conditions above? _____

How, if at all, have these conditions been treated? Was it successful? _____

Are you currently on any **medications**? Please include over the counter drugs and antibiotics.

Medication (include dose)	Illness/reason

Are you taking any **supplements or remedies** at the present time? (E.g. homeopathics, vitamins, herbal medicines)

Supplement (include dosage)	Illness/reason

Do you smoke? **Yes no** If yes, how long? _____ How much?
 Consume Alcohol? **Yes no** If yes, how much/many drinks per week? _____

Do you exercise? **Yes no** If yes, what do you typically do? _____

Do you use recreational drugs? **Yes no** If yes, indicate type, frequency, duration of use _____

Do you have any **allergies or sensitivities**? **No** ____ (or please circle applicable items below).

- | | | |
|-----------------------------|--------------------|----------------|
| Dairy products | Nuts | Pollen |
| Wheat | Penicillin | Mold |
| Soy | Sulfa drugs | Bees |
| Eggs | Aspirin | Animals |
| Citrus | Tylenol | |
| Strawberries | Dust | |
| Anything else? _____ | | |

How would you rate your **energy** at this time (1-very low...to... 10- exceptional)? _____

MEDICAL HISTORY:

Please indicate which, if any, of the following conditions you may have experienced:

- | | | |
|-----------------------|--------------------------------|------------------------|
| Allergies | Hay Fever | PMS |
| Abscesses | Heart disease | Prostatitis |
| Abortion | HIV | Rheumatic Fever |
| Alcoholism | Influenza | Scarlet Fever |
| Anemia | Insomnia | Sexual Abuse |
| Anxiety | Kidney stones/disease | Sinusitis |
| Arthritis | Leukemia | Stroke |
| Asthma | Low/High blood pressure | Strep throat |
| Cancer | Lyme disease | Syphilis |
| Chicken pox | Malaria | Tonsillitis |
| Cold Sores | Measles | Tuberculosis |
| Depression | Miscarriage | Typhoid fever |
| Diabetes | Mononucleosis | Venereal warts |
| Eczema | MS | Whooping cough |
| Emphysema | Mumps | Worms |
| Epilepsy | Parasites | Yellow fever |
| Frequent colds | Peritonitis | Other _____ |
| Gallstones | Pelvic Inflammation | |
| Genital Herpes | Disease | |
| Gonorrhea | Pleurisy | |
| Gout | Pneumonia | |

Have you ever had surgery, been hospitalized, or suffered major injuries? **Yes** __ **No** __

Past vaccinations: _____
Any complications? _____

FAMILY MEDICAL HISTORY:

Please circle any conditions that have affected your **parents, siblings, or grandparents**. Please specify whom condition affected in comments section.

Alcoholism	Depression	Hepatitis	Thyroid disease
Arthritis	Diabetes	HIV	Glaucoma
Asthma	Epilepsy	Lupus	Schizophrenia
Stroke	Hypertension	Tuberculosis	Herpes
Allergies	Eczema	Psoriasis	Anemia
Cancer	Hay fever	Parasites	Kidney disease
Cold sores	Heart disease	Rheumatic fever	Osteoporosis
Alzheimers	Goiter		

Comments/ Other conditions:

Please feel free to add any other concerns or comments that have not been addressed. If you may have insight into the possible cause of your complaint(s), please specify this below. Thank you for your time. _____

The following is for Acupuncture, Osteopathic, Massage and Physiotherapy clients only:

Visual Pain Rating Scale

Make a mark (/) along the line which you think represents your current level of pain

No pain at all _____ As bad as it could be

Pain Diagram

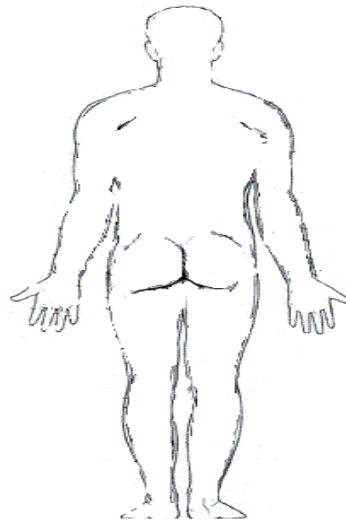
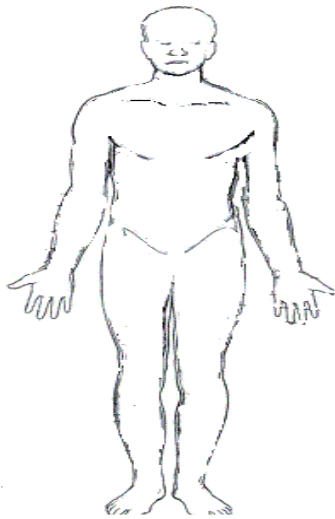
On the following diagrams, indicate all areas of:

Pain – xxxx

Stiffness - ///

Numbness - 0000

Other (Specify) - _____



DECLARATION AND CONSENT TO TREATMENT

I would like to take this opportunity to welcome you to our Clinic. **Clear Medicine** utilizes the principles of *Vis medicatrix naturae* (the healing power of nature) and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

A health professional, will conduct a thorough case history, conduct a physical exam and may utilize specific blood, urinary or other laboratory tests as part of the treatment work-up.

Statement of Acknowledgement

Printed name: _____

As a patient of the Clear Medicine, I have read the information and understand that the form of medical care is based on complementary and alternative medicine and other supportive therapies. As **Clear Medicine** is an integrated health clinic, I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications. The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs. The slight health risks of some treatments include, but are not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture, muscle strains and spasms, rib fractures, and disk injuries.

In the case of **spinal** treatment, there have been reported cases in literature of injury to the vertebral artery following cervical spinal manipulation. Vertebral artery injuries have been known to cause stroke sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal adjustments is extremely remote.

I also recognize the following:

Any treatment or advice provided to me as a patient of the Clinic is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider.

I am at **liberty to seek or continue medical care from a medical doctor or other healthcare provider licensed to practice in Ontario.**

I am aware that **no part of my treatment is covered by OHIP** and that I am solely responsible for **payment at the time services are rendered.**

I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.

I am aware that **I will be billed for the time spent with the doctor if the appointment extends beyond the time allotted.** I understand that the doctor will do his/her best to keep to the original appointment time, but I understand that issues or concerns may occasionally arise that may require additional time.

I have been informed of, and am aware of, the additional charges for body composition testing and in office urine testing. Even though these tests provide useful health markers to aid my treatment recommendations, I am aware that these tests are voluntary and can be refused at any time.

I understand that the health professional reserves the right to determine which cases fall outside of his/her scope of practice, in which event the **appropriate referral will be recommended.**

If for any reason I would like to transfer my file to another clinic, I am aware that there is a \$35 administrative fee for this service.

I am aware that Clear Medicine is a multi-disciplinary clinic. In order to provide optimal care, our clinicians will confidentially discuss patient files in order to obtain a multi-disciplinary outlook on your health. If you do **not** wish to have your case discussed by our multi-disciplinary team, please initial here: _____

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency to gather information without stating. I accept full responsibility for any fees incurred during care and treatment.

Signature: _____

Date: _____

Patient Consent Form For Collection, Use & Disclosure of Personal Information

Privacy of your personal information is an important part of Clear Medicine, while providing you with quality health care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly.

In this Centre, Linda Van Dyk acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what we are doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;

- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our practitioners' regulatory bodies.

How Clear Medicine Collects, Uses and Discloses Patients' Personal Information

Clear Medicine understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how we are using and disclosing your information.

Clear Medicine will collect, use and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care;
- To advise you of treatment options;
- To establish and maintain contact with you;
- To send you newsletters and other information mailings;
- To remind you of upcoming appointments;
- To communicate with other treating health care providers;
- To allow us to efficiently follow-up for treatment, care and billing;
- To comply with legal and regulatory requirements of our regulatory body, the board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners Act;
- To invoice for goods and services;
- To process credit card payments;
- To collect unpaid amounts;
- To assist the clinic to comply with all regulatory requirements;
- To comply generally with the law;
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for practice sale.

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent

I have reviewed the above information that explains how Clear Medicine will use my personal information, and the steps Clear Medicine is taking to protect my information.

I agree that Clear Medicine can collect, use and disclose personal information (as set out in the information about Clear Medicine's privacy policies) about _____.

Name of Patient

Signature

Print Name

Date

Signature of Witness