ZEN·TAI
wellness centre
"Helping You With Wellness, Not Just Illness"

Patient Intake Form

Personal Information

Name_____ Date _____
Date of birth _____ Age _____ Sex: □ Male □ Female
Address _____ City _____
Province _____ Postal Code _____
Phone: Home _____ Work _____ Other _____
Email _____ May we leave messages relating to your visits? □ Yes □ No
Would you like to receive our newsletter? □ Yes □ No
Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated □ Common-Law
Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual □ Other
Number of Children: _____
Occupation: _____ Employer: _____

Emergency contact:
Name _____Relation _____ Phone _____
How did you hear about our clinic? _____

Other health care providers (family physician, specialists, complementary and alternative therapy):

1._____ 2._____ 3._____
Ph:_____ Ph:_____ Ph:_____

What are your main health concerns that you would like addressed:
1. _____
2. _____
3. _____
4. _____
5. _____
If you are female, are you currently pregnant? □ Yes □ No

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 hospitalizations; along with approximate dates.

_____
_____
_____
_____

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

_____

_____

Please list all current medications, including dosages, duration of use and why you are taking them.

Medication	Dose	Duration	Condition Treating

Please list all natural health products you are taking (vitamins, supplements, herbs, homeopathics).

Natural Health Product	Dose	Duration	Condition Treating

Please list past prescription medications.

_____

_____

How frequently are you treated with antibiotics? _____

Do you regularly use any of the following?

□ 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 _____

Recreational drugs—what and how often _____

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Please indicate which immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster; when? _____
- ☐ MMR (measles, mumps, rubella)
- ☐ Haemophilus influenza B
- ☐ "Flu"
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Smallpox

Other _____

Please indicate if any caused adverse reactions: _____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? □ Yes □ No

When were your most recent tests performed? _____

Diet

Do you have any food allergies or intolerances? Please list.

_____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

☐ I don't know my family medical history

Environment

Occupation _____

Hobbies _____

Do you exercise regularly? □ Yes □ No

What do you do for exercise, for what duration and how often?

_____

_____

Are you exposed to significant tobacco smoke (at work, home, etc.)? □ Yes □ No

Are you frequently exposed to animals (work, pets, etc.)? □ Yes □ No

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

_____

_____

How would you describe the emotional climate of your home?

_____

_____

How would you rate your stress levels?

□ Overwhelming □ High □ Moderate □ Low □ Minimal

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

_____

_____

_____

Are there any other services you would like to learn more about?

□ Massage Therapy/Shiatsu

□ Psychotherapy

□ Chiropractic

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CONSENT TO TREATMENT
TO BE SIGNED PRIOR TO FIRST APPOINTMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your naturopath will take a thorough case history and do a screening physical examination for your initial visit.

It is very important therefore that you inform your naturopath immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your naturopath immediately.

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

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles

I realize that my identity will be protected at all times and if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the naturopath 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: _____.
I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print) _____

Signature of Patient (or Guardian): _____

CANCELLATION POLICY

Kindly review our cancellation policy before signing. By signing this form you are accepting the terms and conditions of our cancellation policy. We really appreciate your decision to access the services at Zentai Wellness Centre and are happy to facilitate your healing journey. If you have any questions or concerns, please feel free to contact the clinic.

Our time together is important. At Zentai Wellness Centre, we respect our clients' schedules and appointment times. Our practitioners expect the same courtesy in return. Unless there is an emergency, we request that you cancel or reschedule your appointment at least **48 hours prior to your scheduled appointment time for the 1st and 2nd appointment, and 24 hours prior to your appointment time for subsequent appointments**. **If you do not give adequate notice of cancellation you will be charged the full amount for your scheduled appointment time.**

In order to provide you and others with the highest standard of naturopathic care and access to appointments during peak times, we have a firm cancellation policy. Thank you for your understanding.

I _____ (please print name), have read the above policy and acknowledge that I will be charged the full amount and am responsible for payment of my scheduled appointment if I cancel or reschedule with less then adequate notice.

Signature of Patient (or Guardian): _____

Date: _____

Naturopathic Doctor: _____

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