

Are you under the care of any specialists? **Yes/No** _____
 (Name) (Specialty) (City)

Are you receiving other health care? Yes/No: _____

Please list your major health concerns in order of importance

Complaint	Since	Possible Cause(s)

What medications/supplements are you currently taking (prescription/over-the-counter/supplements/vitamins/mineral etc)?

Medication/Supplement	Since	Adverse Effects

List all surgeries you have had:

Procedure	Year	Complications?

List any major injuries you have sustained:

Injury	Year	Long Term Effects

Which of the following conditions have you had? (Check all that apply)

<input type="checkbox"/> Abscesses	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Syphilis
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herpes Genitalia	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Allergies	<input type="checkbox"/> Emphysema	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Parasites	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Amnesia	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Influenza	<input type="checkbox"/> Pelvic Inflammatory Disease	<input type="checkbox"/> Sexual Abuse	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gall Stones	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Peritonitis	<input type="checkbox"/> Skin Disease	<input type="checkbox"/> Typhoid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gonorrhoea	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Strep Throat	<input type="checkbox"/> Venereal Warts
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Malaria	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Whooping Cough
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Measles	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Sunstroke	<input type="checkbox"/> Worms
<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Miscarriage		<input type="checkbox"/> Stroke	<input type="checkbox"/> Yellow Fever

Which of the following do you currently use? (amount, how often, how much, how long)

Alcohol _____	Tobacco _____
Hormones _____	Coffee _____
Cortisone _____	Laxatives _____
Sedatives _____	Antacids _____
Recreational Drugs _____	

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at work, home, or travelling? **Yes/No**

If Yes, please explain: _____

Which of the following ailments listed, or any others, have affected your parents or siblings

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Depression	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Strep Throat
<input type="checkbox"/> Allergies	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Gout	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Skin Diseases	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High Blood Pressure			

Do you have any other medical conditions? _____

The general state of your health is: _____ Excellent
_____ Good
_____ Average
_____ Fair
_____ Poor

On average, describe your energy level (10 = highest & 1 = lowest) _____
When during the day is energy the best? _____ and worst _____

Do you exercise? **Yes/No** What forms? _____
How often? _____

What are your interests or hobbies? _____

How Often? _____

How many meals do you generally eat each day? _____
Who cooks and prepares your food? _____
Is it comfortable to chew your food well? **Yes/No**

List the primary foods included in your diet for:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

List the foods you exclude from your diet: _____
Why are these foods excluded? _____

List any of the foods that you crave (eg: chocolate, sweets, salty, sour, breads, rich/fatty or spicy foods): _____

Have you had a bad reaction to any foods? _____

Are you satisfied with your diet as it is now? **Yes/No**

Do you tend to be thirsty: **Yes/No**

How much WATER do you drink each day: _____

Do you prefer beverages: _____ Hot _____ Cold _____ Room Temperature

How many times do you urinate each day? _____

Do you get up in the night to urinate? **Yes/No**

How often do you have a bowel movement? _____

On average, how many hours sleep do you get per night? _____ hrs

Do you sleep well? **Yes/No**

Women Only

Age of first period: _____

Number of pregnancies: _____

Number of children: _____

Length of Cycle: _____

Length of Menses (period): _____

Have you had any adverse effects from a vaccination? **Yes/No**

If Yes, which one(s): _____

Have your weight changed lately? **Lost/Gained/No Change**

How many pounds? _____

Please list up to 5 of the most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (**Yes/No**)

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____
5. _____ Date: _____

Is there anything else I need to know about you personally, about your health condition, or about the circumstances relating to you or your condition?

Dear Patient,

Please find enclosed the intake form for you to fill out for your Initial Appointment. Below are a few requests that will help everything move smoothly.

1. Please fill out the enclosed "Intake Form" and "Informed Consent" ahead of time.
2. Please bring in any supplements and pharmaceuticals that you are taking (if any)
3. Please bring in a copy of any lab/imaging/other test results that you have in your possession that pertain to why you are coming in (tests that your family doctor or specialist(s) have done). Alternatively, You can ask your family doctor's office to fax a copy of the results directly to my office. The fax number is (306) 955-7715
4. I have a home based office. There is street parking right in front of the house. There is a sign on the front door to direct you where to go. Please walk in.
5. Initial Appointments take about 1 hour. The cost of the appointment is \$170 and payment is by cash or cheque.

I look forward to meeting you.

Sincerely,

Kent Bailey, ND

Informed Consent

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors 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.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet and nutritional supplements, botanical medicine, homeopathy, Asian medicine and acupuncture, hydrotherapy, physical medicine, and lifestyle counselling.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, increased gastrointestinal function, improved immunity, and general well-being.

Botanical medicine is a plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine that uses minute doses of plant, animal, or mineral substances to stimulate the body's ability to heal itself.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

Dry needling or Gokavi Transverse Technique (GTT) refers to the use of a combined technique of using micro-current administered to muscles via acupuncture needles, as well as the manual stimulation of trigger points to release tight muscles, scar tissue, and/or adhesions.

Injection Therapies include the administration of vitamins, minerals, amino acids, other natural substances, or emergency medications via subcutaneous, intramuscular, intravenous, or other injection methods.

Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, your Naturopathic Doctor will take a thorough case history, do a physical examination, and when indicated, take blood and urine samples.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g., pregnancy, lactation, very young children, or those taking multiple medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important, therefore, that

you inform your naturopathic doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your naturopathic doctor immediately.

There are some slight health risks associated with 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 venipuncture, acupuncture, or dry-needling
- Fainting or puncturing of an organ with acupuncture needles

_____ I understand that a record will be kept of the health services provided to me.
Initials This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medial record at any time and can request a copy of it by paying the appropriate fee.

_____ I understand that the Naturopathic Doctor will answer any questions that I have
Initials to the best of her ability. 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):

_____ I understand that charges are to be paid at the time of the visit unless specific
Initials 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 a fee will be charged (Missed Appointment Fee) for any
Initials missed appointments or late cancellations (less than 24 hours).

As the patient, you are responsible for the total charges incurred for each visit. We accept cash, chequet, or email money transfer (reception@axiomhealth.ca). If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company – we will provide you with all of the information necessary to send your claim for reimbursement.

Your Naturopathic Doctor may prescribe supplements that can be purchased at Axiom Health Services or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. 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: _____

Date: _____