**Rebecca Sagan B.Sc., N.D.**

Telephone 403.289.0989 Fax 403.289.0997

NATURALLY GOOD HEALTH CLINIC
1904 – B, 20 Avenue NW
www.naturallygoodhealth.com

# Naturopathic Patient Intake Form

Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to inform you of our office events and to distribute our newsletter 4-6 times a year; it will not be distributed for any other use.

First Name: _____ Last Name: _____

Address: _____

City: _____Province: _____Postal Code: _____

Telephone: (H)_____(W) _____(C) _____

E-mail: _____

Emergency Contact:

_____ _____ _____

(Full name) (Relation) (Telephone)

Occupation: _____ Employer:_____

Past Occupations:_____

Date of Birth: _____ Age:_____ Sex: M F

Number of children & their ages: _____

Blood Type: _____ Height: _____ Weight: _____ Ideal Weight: _____

Religion or personal philosophy (optional): _____

Name of Medical Doctor: _____ Telephone: (____)_____

Date of last physical: _____

Have you been treated by a Naturopathic Doctor?

Name: _____

When?_____

Other health practitioners?

Name: _____

When? _____

| Please list in order of importance your primary health concerns/ reason for your visit. | Please indicate any treatments that you have tried previously to address your health issues and how effective you found these treatments. |
|---|---|
| | |
| | |
| | |
| | |

Please list all medications you have taken, **Pharmaceutical, Herbal, Vitamins and Supplements, including Dosages:**

| Now | In the Past |
|---|---|
| | |

Please list any **allergies** you have and what kind of **reaction** occurs:

| | |
|---|---|
| | |

Please list all hospitalizations you have had:

| Type of illness or operation/procedure: | Date | Any ongoing concerns? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

What would you rate your **energy** level at? (1-10, 10 being highest)_____

Do you wake-up feeling refreshed? Y__ if N__ , give details. _____

How many glasses of **water** do you drink per day?

Tap_____ Filtered_____ Distilled_____ Reverse Osmosis_____ Spring_____

How many glasses of **pop**_____ **juice**_____ or milk_____ do you drink per day?

How many **cups/day** do you drink of the following?

Coffee_____ Black tea _____ Herbal/Green tea _____ Do you add milk/cream? _____ Sugar? _____

Do you **smoke**? Y / N # of cigarettes/ cigars day:_____ How many years?_____ In the past? Y__ Quit when ___

Do you drink **alcohol**? N__ Y__ # of drinks and type of drinks per week:_____

Do you use **recreational drugs**? N__ Y__ in the past? Y __

Do you watch TV? N__ Y__ number of hours per week:_____

Do you exercise? N__ Y__ Hours per week:_____ Type of exercise:_____

Please check all that are applicable to **you & your family** and note who:

| | | | | | |
|---|---|---|---|---|---|
| | Alcoholism | | | Glaucoma/Cataracts | |
| | Allergies | | | Gout | |
| | Arthritis | | | Heart Disease | |
| | Autoimmune diseases | | | Heart murmurs | |
| | Anorexia/Bulimia | | | High blood pressure | |
| | Asthma | | | Hypothyroid | |
| | Cancer | | | Hyperthyroid | |
| | Crohn's or Colitis | | | Kidney disease | |
| | Depression | | | Liver disease | |
| | Diabetes | | | Mental illness | |
| | Eczema | | | Stroke or aneurysm | |
| | GERD/hiatal hernia | | | Ulcers | |
| | Other | | | | |

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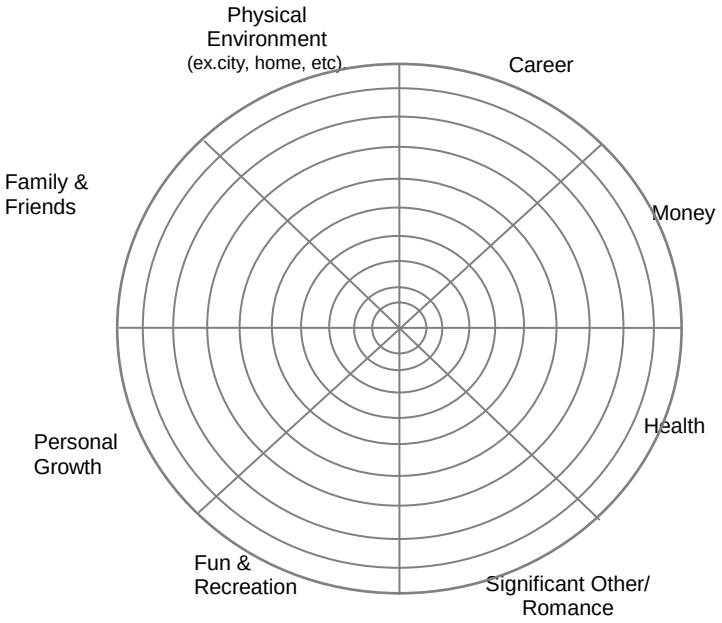
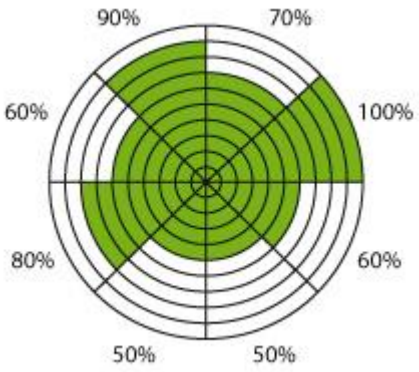
## Wheel of Health




Example:




## Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

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## Context of Care Overview

1. Why did you choose to come to this clinic?

What do you know about our approach?

2. What three expectations do you have from **this visit** to our clinic?

What **long term** expectations do you have from working with our clinic?

What expectations do you have of me personally as your naturopathic doctor?

3. What is your **present level of commitment** to address any underlying causes of your signs and symptoms that relate to your lifestyle?
   (Rate from 0 to 10, 10 being 100% committed)

   1 2 3 4 5 6 7 8 9 10

4. a) What behaviours or lifestyle habits do you currently engage in regularly that you believe **support** your health? (please list)

b) What behaviours or lifestyle habits do you currently engage in regularly that you believe are **self-destructive** lifestyle habits? (please list)

5. What **potential obstacles** do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

7. What do you **LOVE** to do?

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# Welcome to Naturopathic Care

I want you to enjoy and benefit from your visits.

Your first visit will consist of a **consultation, detailed history, a general physical exam and more specific naturopathic assessments**. Based on this information, initial recommendations for your treatment protocol will be made on your first visit. If it is necessary for a more complete analysis of your health status, you may be asked to have further laboratory tests done, these may include; blood testing, salivary hormone testing, urine, hair and stool analysis. Through this healthcare assessment, a baseline measure of health is established which will be used to monitor your progress.

Naturopathic treatment programs often include **dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy, acupuncture and Bowen therapy**. Any side effects or risks associated with your treatment will be explained to you. Part of the program will also involve lifestyle recommendations that are logical and sensible; I encourage you to have a support team as you make these changes, often having someone else, be it a partner, family member or friend, undergoing naturopathic care at the same time, will help ease you both toward better health. Your second visit is a good time to ask any questions that you may have had after your initial visit. If you need immediate clarification on remedies, dietary recommendations or have a concern over any unfamiliar symptoms that may arise, please call the office.

On your following visits your progress will be monitored and treatments will be modified accordingly. The second visit is usually one to four weeks after your initial visit. If you are receiving acupuncture treatments, visits will be more frequent, either once or twice weekly for 6-10 sessions, Bowen therapy sessions are usually 5-10 days apart. As you start to experience a new level of wellness, an office visit every three to four months is recommended for general disease prevention and health maintenance. If an acute, non-emergency condition occurs, please give us a call as we may be able to help with a naturopathic treatment.

Many patients have allergies and are environmentally sensitive. On the day of your visit to the office please do not wear any scented products (perfumes, shaving lotions, etc.).

**If you are unable to keep a scheduled appointment, please give the office 48 hours notice. We are then able to give the appointment time to someone else. If we do not receive sufficient notice you will be charged for the missed visit.**

Payment for visits shall be made at the time of the appointment

Please be advised of the fees
**Dr. Rebecca Sagan ND**
Initial visit 1.5 hr $210
Regular visit 30 min $95
Child Initial visit 60 min $175
Child Regular visit 30 min $89
Acupuncture follow-up 30 min $95
Bowen Therapy Initial 60 min $175
Bowen Follow-up 30 min $95

A dispensary of professional quality supplements, botanicals and homeopathics is maintained for the treatment of our patients. Items are individually priced.

We accept the following methods of payment:
**Visa, MasterCard, Debit card or cash**

If you have any concerns please contact the office and we be happy to assist you.

# Rebecca Sagan BSc ND Naturally Good Health Clinic

## INFORMED CONSENT

I would like to take this opportunity to welcome you to the Naturally Good Health Clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine 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.

Your practitioner will conduct a thorough case history. Your Naturopathic Doctor will complete a physical exam, as well as, specific blood, salivary and/or urinary laboratory reports as part of the treatment work-up if determined to be appropriate.

**Statement of Acknowledgement**

Printed name _____

As a patient of this clinic I understand that the form of medical care is based on Naturopathic and other supportive principles and practices. All information that is disclosed will remain confidential and will only be released with my permission. 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 and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic 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 sprains, disc injuries from spinal manipulations.

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 attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment. I acknowledge if prior notification of 48 hours is not given I may be charged for the full fee for a missed appointment.

_____ _____ _____

SIGNATURE/ Guardian Signature DATE WITNESS