STELLARHEALTH
Your path to optimal health

CONFIDENTIAL NEW PATIENT INTAKE FORM

Thank you for taking the time to fill out this lengthy intake form so that we can provide you with the highest standard of care. Please do so to the best of your ability.

Name: _____
(First) (Middle) (Last)

Name you prefer we use: _____ (if different)

Name of person filling out form: _____ (if different from above)

Age: ____ Gender: ____ Wt: ____ Ht:____

Date of Birth: _____/_____/_____ Age:____ Today's Date:_____
D M Y

Marital status:_____ # of Children: _____

Occupation_____

Sports/Hobbies/Pastimes_____

Care Card #: _____

Home Address: _____ City: _____

Postal Code: _____

Phone Numbers: Home _____ Work: _____

Cell:_____

Email (so handouts can be sent):_____
Would you like to receive our newsletters by email? _____

Emergency contact: Name:_____

Home #:_____ Cell #:_____

How did you find out about our clinic?
☐ Internet/website ☐ Newspaper ☐ Yellow pages ☐ Other _____

Referral. Whom may we thank?_____

Dr. Stella Seto, ND **www.stellarhealth.ca**
Alliance Wellness, #401-1177 West Broadway @Alder. Vancouver, BC, V6H 1G3
Phone (604) 737-1177
http://alliancewellness.ca/our-team-2/dr-stella-seto-nd/

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Please list your health concerns in the order of importance and the goal you would like to achieve.

Concern	Goal
1.	
2.	
3.	
4.	
5.	

Any additional notes:

HEALTH / LIFESTYLE

How would you rate your health: □ Excellent □ Good □ Fair □ Poor

Do you exercise regularly? _____

Type	Frequency/Duration	For what time period have you done this exercise?

Do any injuries or illness prevent you from keeping active?

_____

_____

_____

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Family Physician: _____ Phone Number:_____

Date of last physical exam:_____

Other Health Care Provider(s):

Name: _____

Profession:_____

Name:_____

Profession:_____

Name:_____

Profession:_____

ALLERGIES, if known (medical, environmental, foods):

Type:_____

□ Pollen: Type if know_____

□ Hay fever: Season/Months_____

□ Animals/Insects: Type_____

□ Medication:

Type:_____

Foods: □ Gluten □ Dairy □ Eggs □ Soy □ Fish □ Shellfish

Nuts/Seeds: □ Peanuts □ Sesame □ Other:_____

Fruits: □ Citrus □ Strawberries □ Melons □ Apples

Other:_____

_____

Additives: □ MSG □ Artificial sweeteners □ Food colouring

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Other:_____

DIET

Dietary Restrictions, if any
(religious/vegetarian/vegan):_____

What is your typical diet like?

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Beverages_____

What foods/beverages do you crave?_____

What food/beverages do you dislike/hate?_____

Do you skip meals? _____ How often?_____

How much water do you drink per day?_____

How often do you use the following?

Substance	Type	Frequency/Duration
Alcohol		
Antacids		
Caffeine		
Cigarettes		
Laxatives		
Recreational drugs		
Pain meds (ie.Tylenol, Aspirin, Advil, opiates)		

Any additional notes_____

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MEDICAL HISTORY

Past serious conditions, illnesses, injuries and/or hospitalizations & dates:

Date (d/m/y)	Illness, injury, reason for hospitalization	Treatment/Tests received
/ /		
/ /		
/ /		
/ /		
/ /		
/ /		

Family Health History:

Relative	Illness, condition	Date: d/m/y	Treatment
Mother		/ /	
Father		/ /	
Sibling		/ /	
Sibling		/ /	
Maternal grandmother		/ /	
Maternal grandfather		/ /	
Paternal grandmother		/ /	
Paternal grandfather		/ /	
Aunt		/ /	
Uncle		/ /	
Other		/ /	
Other		/ /	

Any other medical conditions?_____

Any additional notes:_____

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CURRENT MEDICATIONS (prescription, over-the-counter, vitamins, herbs etc):

Name	Dose	Duration

PAST MEDICATIONS (prescription, over-the-counter, vitamins, herbs etc):

Name	Dose	Duration

Any other notes or comments:_____

ANTIBIOTIC use:
Number of times in the last 5 years?_____ Type:_____
Did you finish the prescription?_____

Were you frequently treated with antibiotics as a child or at any time in your life?_____
What was being treated?_____

IMMUNIZATIONS / VACCINATIONS

Type	**Date: d/m/y**	**Adverse Reactions**
Hepatitis A/B	/ /	
Mumps, Measles, Rubella	/ /	
Diphtheria-Tetanus-Pertussis	/ /	
Flu Shot	/ /	
Human Papillomavirus (HPV)	/ /	
	/ /	
	/ /	

Any additional notes_____

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Do you get regular screening/diagnostic tests/check-ups?

Test	Date	Result
Blood tests	/ /	
Cholesterol	/ /	
Mammogram	/ /	
Pap smear	/ /	
Prostate	/ /	
Eye	/ /	
Dental	/ /	
	/ /	

Other tests/screens you have had.

MRI	/ /	
CT	/ /	
Ultrasound	/ /	
X-Ray	/ /	

Are you regularly or have you in the past been exposed to any toxins or hazards? (i.e. at work, home, sports, hobbies, pastimes)

Please explain:_____

_____

On a scale of 1-10 rate your energy level. /10 (1=lowest and 10=highest)
How stressful is your work?

_____

_____

On a scale of 1-10 rate your stress level. /10 (1=lowest and 10=highest)
How do you manage your stress?

_____

_____

Thank-you, for taking the time to fill out this confidential intake form. The information will allow me to get a better insight into what makes you as a whole and to come up with an individualized treatment plan. I look forward to working with you on your path to optimal health.

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INFORMED CONSENT

We would like to take this opportunity to welcome you to **Alliance Wellness.** Therapies used by a naturopathic doctor may include: Clinical nutrition, traditional Asian medicine & acupuncture, botanical medicine, intravenous and chelation therapy, neural therapy, pharmaceutical medication, homeopathy, lifestyle counseling & stress management, hydrotherapy, and physical medicine.

Statement of Acknowledgement

I, (print your name) _____, acknowledge that as a patient of this clinic I have read the information included herein, and understand that the form of medical care is based on naturopathic medicine and other supportive principles and practices. I also recognize that even the gentlest therapies have potential complications in certain physiological conditions such as pregnancy, lactation, very young children, very elderly patients, or those on multiple medications. I therefore confirm that I have informed (and will continue to inform) my practitioner fully of my medical history, family history, medications and / or supplements I am currently taking (prescription and over the counter), or was previously taking. If female, I have advised my practitioner of any chance that I am pregnant, and will continue to do so.

Despite the low incidence, there are some slight risks to some naturopathic treatments.
These 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 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 without my consent, unless required by law. I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.
I understand that my practitioner will answer any questions I have to the best of her ability.

I understand that the results are not guaranteed. I do not expect the practitioner to anticipate and explain all risks and/or complications. With this knowledge I voluntarily agree to the diagnostic and therapeutic treatments outlined above.

I understand that charges are to be paid at the time of the visit unless previous arrangements have been made prior to my scheduled appointment. As the patient, I am responsible for the total charges incurred for each visit, and have been informed of the fee schedule and accepted methods of payment. (Please note: If you have coverage for naturopathic medicine you are responsible for billing your insurance company- the required information to send your claim for reimbursement will be given to you.)
I understand that 24 hours notice is required for appointment cancellation, otherwise I am responsible to pay a 100% cost of the visit cancellation fee.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment I receive at **Alliance Wellness**. I understand that I am free to withdraw my consent with written notice and to discontinue treatment at any time.
I also confirm that I have the ability to accept or reject this care of my own free will and choice.

_____ _____

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(Patient's signature) (Date) (Witness's signature) (Date)

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