KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St., Burlington ON L7R 1M5
Tel: 905. 592.0095 Fax. 905.592.0106

New Patient Intake Form

Date:_____

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care.

Name:_____ Occupation: _____

Gender: _____ Employer: _____

Date of Birth: _____ Work Tel #: _____

E-Mail Address: _____ Emergency Contact #: _____

Home Tel #:_____ Contact Relationship: _____

Cell: _____ Marital Status: _____

Home Address: _____

Health Priorities/ Chief Concerns:

List your main health concerns in order of importance

1. _____

_____

2. _____

_____

3. _____

_____

Medical History:

How would you describe your general state of health? (circle one)

Excellent Good Fair Poor

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Please indicate any serious illnesses, conditions, or reasons for hospitalizations

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list all current medications/supplements

Medications/Supplements	Dose	Prescribing Physician	Length of use

Please list all past medications/supplements in the last 5 years

Medications/Supplements	Dose	Prescribing Physician	Length of use

Please indicate any allergies and/or food sensitivities

Allergy/Food sensitivity	Symptoms

How many times have you taken antibiotics within the last 5 years _____

Were you frequently given antibiotics as a child? _____

Have you had any adverse reactions from any vaccinations? _____

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Do you use any of the following?

Type	Circle one	How much/How often/Form
Alcohol	Yes No	
Tobacco	Yes No	
Caffeine	Yes No	
Recreational Drugs	Yes No	
Aspirin	Yes No	
Laxatives	Yes No	
Antacids	Yes No	
Diet pills	Yes No	
Birth control pills	Yes No	
Birth control implants/injections	Yes No	

Please indicate which of the following screening tests do you receive (if known)

Test	Circle one	How often/Recent date
Breast exam	Yes No Never	
Mammogram	Yes No Never	
DEXA scan (Bone scan)	Yes No Never	
PAP test (women)	Yes No Never	
Digital rectal exam (men)	Yes No Never	
PSA (men)	Yes No Never	
Cholesterol	Yes No Never	
Blood Glucose	Yes No Never	
Other (X-Ray, ultrasound, EEG, ECG, CT scan, MRI etc.)	Yes No Never	

Please list any other medical providers:

Type of Medical Provider	Name	Phone #	Address

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Family History:

Indicate if any family member has had any of the following

Illness	Circle one	Family Member
Allergies	Yes No	
Asthma	Yes No	
Diabetes	Yes No	
Heart Disease	Yes No	
High Blood Pressure	Yes No	
Kidney Disease	Yes No	
Cancer	Yes No	
Depression	Yes No	
Other mental illness	Yes No	
Infertility	Yes No	
Other	Yes No	

Lifestyle:

Do you exercise?_____ How often? _____

Have you recently gained or lost weight? (circle one) YES NO
Weight gained/lost _____lbs

Hobbies: _____

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

_____

Where did you learn about this clinic?

Friend/Family; name:_____
Internet:
- ☐ Google
- ☐ OAND/CAND
- ☐ Yellow pages (online)
- ☐ Canadian Naturopaths website

☐ Media
☐ Yellow pages book
☐ Seminars
☐ Robert Schad Naturopathic Clinic
☐ Other: _____

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CORELINK WELLNESS CENTRE

INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

Name_____

Address_____

City and Postal Code_____

Attending N.D._____

RECOMMENDED THERAPEUTIC PROCEDURE(S) / PLAN
(Including those by referral to another practitioner)
(Filled in at visit)

_____
_____
_____

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/ plan and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of and understand the therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects the likely consequences of not having/following the procedure(s)/plan, and what alternative course(s) of action are available to me.

As a result I do hereby voluntarily consent/ withhold/ my informed consent for the recommended therapeutic procedure(s)/plan as specified above. I also understand that I may change the status of my voluntary consent at any time.

Signature_____ Print Name_____

Date _____Witness Signature_____

PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this clinic, Payam Kiani, ND 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.

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Our privacy policy outlines what our Clinic is 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 or our regulatory body, the Board of Directors of Drugless Therapy — Naturopathy.

How our clinic collects, uses and discloses patients' personal information

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

This clinic 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 complete claims for insurance purposes
- 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 accounts
- To assist this 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 a 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 your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I agree that the Core Link Wellness Clinic can collect, use and disclose my personal information as set out above in the information about the clinic's privacy policies.

Signature_____ Print Name_____

Date _____ Witness Signature_____

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7 Day Diet Diary

Name: _____
Date:_____

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Breakfast							
Lunch							
Dinner							
Snacks							
Fluids							
Comments							

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Name: _____ Date: _____

Check the conditions that you are currently experiencing, or have experienced often in the past. If more space is required please use the reverse side of this sheet.

	current	previous
General Symptoms		
Loss of consciousness		□
Numbness / tingling	□	□
Fever	□	□
Sweats	□	□
Fainting	□	□
Dizziness	□	□
Loss of sleep/insomnia		□
Frequent colds / flus	□	□
Loss of weight	□	□
Head / Neck		
Headaches	□	□
Type _____		
Vision problems	□	□
TMJ concerns	□	□
Earaches	□	□
Decreased hearing	□	□
Sinus problems	□	□
Difficulty swallowing	□	□
Skin		
Rashes / Eczema	□	□
Itching	□	□
Bruise easily	□	□
Dryness	□	□
Boils / Hives	□	□
Contagious skin disease		□
Respiratory		
Chronic cough	□	□
Shortness of breath	□	□
Smoking	□	□
Breathing problems	□	□
Asthma / Bronchitis	□	□

	current	previous
Cardiovascular		
High blood pressure		□
Low blood pressure		□
Bleeding disorders	□	□
Chest pain	□	□
Stroke	□	□
Artery hardening	□	□
Varicose veins	□	□
Swelling of the ankles		□
Poor circulation	□	□
Angina	□	□
Heart disease	□	□
Genitorurinary		
Trouble urinating	□	□
Blood in the urine	□	□
Kidney infections	□	□
Bed wetting	□	□
Prostate trouble	□	□
Gastrointestional		
Poor digestion	□	□
Indigestion	□	□
Excessive hunger	□	□
Belching or gas	□	□
Nausea / Vomiting	□	□
Abdominal pain	□	□
Constipation	□	□
Diarrhea	□	□
Hemorrhoids	□	□
Liver concerns	□	□
Gall bladder trouble		□
Bladder concerns	□	□
Ulcer	□	□
Diabetes	□	□

	current	previous
Infections / Illnesses		
Herpes	□	□
Hepatitis	□	□
Plantar warts	□	□
TB	□	□
HIV / AIDs	□	□
Cancer	□	□
Allergies	□	□
Muscles and Joints		
Stiff neck	□	□
Backache	□	□
Swollen joints	□	□
Painful tail bone	□	□
Foot trouble L / R	□	□
Shoulder pain L / R	□	□
Elbow pain L / R	□	□
Wrist pain L / R	□	□
Hip pain L / R	□	□
Knee pain L / R	□	□
Arthritis	□	□
Weakness / loss strength		□
Women's Health		
Painful menstruation	□	□
Excessive flow	□	□
Irregular cycle	□	□
Hot flushes	□	□
Cramps or backache	□	□
Vaginal discharge	□	□
Swollen breasts	□	□
Lumps in the breast	□	□
Are you pregnant Yes □ No □		
On birth control Yes □ No □		
# of pregnancies _____		
# of children _____		

Please list anything not covered above:

_____

_____