DR. JESSICA WU, ND

Helping you flourish, naturally

PATIENT INTAKE FORM

Full Name: _____

Date of Birth: _____ Age: _____

Birth sex: M / F Gender identity: _____ Sexual orientation: _____

Address: _____

Phone: _____ Email: _____

Would you like to receive newsletters through email? Yes / No

Personal Health #: _____ Extended Medical Insurer: _____

ICBC or WorksafeBC Claim # (if applicable): _____

If you are under 18 years of age, please fill out the information of the person legally responsible for you:

Name: _____ Relation: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Phone: _____

Medical Doctor: _____

Are you under the care of any other health care professionals? (Please list)

_____

How did you hear about the clinic? _____

What is the reason for your visit?

_____

What are your short-term expectations?

_____

What are your long-term expectations?

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle (10 being 100% committed) 0 1 2 3 4 5 6 7 8 9 10

GENERAL

Height: _____ Weight: _____ Weight 1 year ago: _____

The most I've ever weighed and when: _____

Occupation: _____ Hours worked/week: _____

Blood Type: A / B / AB / O

Relationship Status: _____ Sexually Active: _____

Number of Children: _____ Number of Siblings: _____

This information will be kept strictly confidential as per the Health Professions Act, Personal Information Protection Act, the regulations of each of the professional governing bodies for the professionals at Empower Health and Canadian law. Your personal information is collected for the purpose of providing health care and for administrative purposes. It will not be disclosed for other purposes without your consent other than for reasons stated in the laws.

MEDICAL HISTORY

List any Previous Diagnosis and Year of Diagnosis:

	Dose	Frequency	Date started	Reason
Prescription Medications:				
1.				
2.				
3.				
4.				
5.				
Supplements:				
1.				
2.				
3.				
4.				
5.				

Surgeries (appendix, wisdom tooth, etc):

Accidents (motor vehicle, trauma, etc):

Allergies (or intolerances):

Infectious diseases:

In My Immediate Family There Are The Following:

❑ Cancer ❑ Diabetes ❑ Heart Diseas ❑ High Blood Pressure ❑ Crohn's / Colitis
❑ Stroke ❑ ADHD ❑ Seizures ❑ Auto Immune Disease ❑ Addiction
❑ Anxiety ❑ Celiac ❑ Epilepsy ❑ Asthma / Allergies ❑ Kidney Disease
❑ Suicide ❑ Dementia ❑ Depression ❑ Mental Illness ❑ Glaucoma
❑ Anemia ❑Tuberculosis ❑ Osteoporosis ❑ Arthritis

In Addition To The Above I Have A History Of:

❑ Cancer ❑ Stroke / Aneurysm ❑ Myocardial Infarction ❑ High Cholesterol
❑ Heart Attack ❑ Irritable Bowel / Colitis ❑ Bleeding Disorder ❑ Varicose Veins
❑ Sinusitis ❑ Kidney Disease ❑ Ankylosing Spondylitis ❑ Liver Dysfunction
❑ Lung Disease ❑ Asthma ❑ Digestive Conditions

I Have Had The Following Vaccines:

❑ Polio ❑ Hepatitis ❑ Measles / Mumps / Rubella ❑ Tetanus ❑ Hpv
❑Flu ❑ Pertussis ❑ Diphtheria ❑ Chicken Pox

Have you seen a naturopathic doctor before? How was your experience?

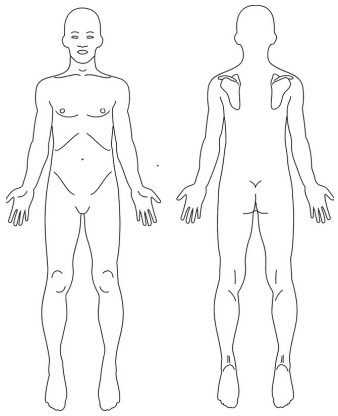
LIFESTYLE

Have you had long visits or lived in a foreign country? Yes / No
If yes how long and where?_____.
Please report your utilization of the following and their frequency.

	Daily	Weekly	Any History?
Cigarettes	_____	_____	_____
Coffee	_____	_____	_____
Alcohol	_____	_____	_____
Recreational Drugs	_____	_____	_____

Time you sleep: _____ Time you wake: _____
Do you have problems getting to sleep? Yes / No Staying asleep? Yes / No

Exercise (Hours per week): _____
Type of Exercise: _____
How is your appetite?_____
What do you usually crave?_____
Have you experienced any recent nausea, vomiting, or fever? Yes / No
_____
Have you had any fevers or night sweats during the past week? Yes / No
Do you suffer from pain? Yes / No If yes please circle where:
Average number of bowel movements per day? _____
Are your bowel habits (please circle):
Regular Diarrhea Prone Constipation Prone



Do you experience any blood in your stool? Yes / No

How much water do you drink per day? _____
(please elaborate on types of drinks) _____

How would you generally describe the occurrence of colds and flu that you have experienced over your lifetime? Please circle all that apply to you.
Almost Always Often Never Once or twice a year

If you have a cancer diagnosis, please rate the occurrence before your diagnosis.
Almost Always Often Never Once or twice a year

What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health?

_____

What behaviours or lifestyle habits do you currently engage in regularly that you believe are less constructive lifestyle habits?

_____

INFORMED CONSENT

As a naturopathic physician, our treatments involve gentle, typically non-invasive techniques to stimulate the body's inherent healing capacity. Your naturopathic doctor will take a thorough case history, may do a relevant screening physical examination, and if required evaluate blood and urine samples.

It is important that you inform your naturopathic doctor of any change in your health status while under their care as this may necessitate changes to your naturopathic treatment plan such as any new disease process or diagnosis, if you are prescribed a new medication or over the counter drug, or if you become pregnant or are breast-feeding.

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, herbs or intravenous therapy contents
- Pain, bruising and injury from venipuncture or acupuncture.
- Dizziness, lightheadedness or nausea from IV therapy and acupuncture

I understand that a confidential health record will be kept of the health services provided to me. This record will not be released to others unless so directed by myself or required by law. If appropriate (and with my explicit consent) I understand that my naturopathic doctor may discuss my case with other healthcare providers.

I understand that the results are not guaranteed. I do not expect the doctors to be able to anticipate and explain all risks and complications.

Cancellation policy - I understand that if I fail to appear for my scheduled appointment or cancel with less than 24 hours notice (one business day) I will be charged a **Missed Appointment Fee of $55.00**

I understand that any lab tests prescribed are non-refundableI intend this consent form to cover the entire course of my treatment and understand that I am free to withdraw my consent at any time. With this knowledge, I voluntarily consent to naturopathic care with Dr. Jessica wu, ND

Patient Name (Please Print): _____

Signature of Patient or Parent/Guardian: _____

Date Signed: _____