Integral Health Clinic

Naturopathy and Homeopathy
Client Agreement and Intake Form

Dr Shahram Ayoubzadeh

Personal information **Date:** _____

Name: _____ Date of Birth(dd/mm/yy): _____

Marital Status:_____ Occupation:_____

Address:_____

Street City Province Postal Code

Office phone: _____ Home phone: _____

Cell phone: _____ E-mail: _____

Name of guardian if under 16yrs:

_____

How did you hear about us? _____

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1. I understand that the services offered by Integral health Clinic are not covered by the provincial government; however, some of the services may be covered by private insurance plans or be tax deductible. It is the responsibility of the client to verify with their Insurance provider of their coverage for services offered at Integral Health Clinic.

2. The fees and services have been clarified in advance. I have verified them with the receptionist or my practitioner. **Payment is due prior to, or at the end of each visit. The clinic does not bill insurance companies directly.** Cash, cheque, interac, Master Card and Visa (no other credit cards) are acceptable payment methods. Interest will be charged to overdue accounts.

3. I understand that natural health care is a joint responsibility between myself (the client) and the practitioner. Improving my lifestyle can be as important as remedies and treatments.

4. My health records may be used in research providing that my name is not revealed. At all other times, my health records will be held in strictest confidence.

5. I realize that the services offered by the Integral Health Clinic are not an isolated system and that our practitioners welcome teamwork with Medical Doctors, Chiropractors and other Health Practitioners.

6. The decision to discontinue prescription drugs or any other prescribed medical treatment is **my responsibility.** If I forgo standard medical treatment in favour of natural healing, I assume responsibility for any potential risk that may entail. Integral Health Clinic practitioners will explain procedures, probable outcomes and possible risks in advance.

7. For Homeopathic and Naturopathic consultations I am aware that **appointments that run over the scheduled time may be charged the difference in 15 minute increments.**

☐ I have read and understand the above terms.

8. **Video Recording**

I am informed that the consultations will be video recorded **for the strict personal use of the Doctor** and if at any time my information is going to be used for any research or teaching purposes, **my permission will be requested first.**

I have read and understand the above terms. Date: _____

☐ I do not wish to be video recorded.

9. **Integral Health Clinic Cancellation Policy**

We try to provide exceptional service to our clients. To help us achieve this we ask that you provide us with **at least 48 hours notice if you need to reschedule or cancel your appointment.** This enables us to make your time slot available to others who may need to see us, and to be able to maintain our consultation fees at the present rate. Appointments missed or cancelled without 48 hours notice inconvenience us and other clients, and we reserve the right to charge you for the appointment if we cannot allocate the time reserved for you to another client. Even though we try our best to send you a reminder by phone or via email, it is ultimately your responsibility to remember your scheduled appointments. We will be there for you at the time reserved for you; we hope you can be there too.

☐ I am aware of the Cancellation Policy. I have read and understand the above terms.

10. Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge.

11. Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree.

Signature (client or guardian):_____

Date: _____

Present Weight: _____ Normal Weight: _____When last this weight? _____

Name of family medical doctor: _____

What is your chief concern about your health? _____
_____
_____

If this is a chronic illness, how long have you had this condition? _____
Who diagnosed your illness? _____
When was this diagnosis made? _____
What specialists have you seen? _____
_____
How has this illness been treated until now? _____
_____

What else would you like to see changed in your health? (Indicate how long each of these conditions has existed.)
1. _____
2. _____
3. _____
4. _____
5. _____

How long has it been since you were totally well? _____

Previous History:
(please check all that apply)

_____Measles	_____Gallstone	_____Bowel Disease	_____Concussion
_____Mumps	_____High Blood Pressure	_____Hives	_____Warts
_____Scarlet Fever	_____Pleurisy	_____Malaria	_____Thyroid condition
_____Whooping Cough	_____Arthritis	_____Gonorrhea	
_____Croup	_____Rheumatism	_____Chlamydia	
_____Pneumonia	_____Gout	_____Asthma	
_____Tuberculosis	_____Genital Herpes	_____Constipation	
_____Mononucleosis	_____Hay Fever	_____Diphtheria	
_____Ear Infection	_____Chicken Pox	_____Candida	
_____Depression	_____Allergies	_____Hypoglycemia	
_____Sinusitis (chronic)	_____Influenza	_____Swollen glands	
_____Eczema	_____Cancer	_____Shingles	
_____Kidney stones	_____Diabetes	_____ Herpes	

Other (please specify): _____

Were any of the above severe? If so give age, severity and duration._____
_____
_____

Describe your general state of health as a child _____

_____

_____

Describe your general state of health as a teenager:_____
_____
_____

Surgeries:

Please indicate the type of surgery, and when and where it was performed.

_____
_____
_____
_____
_____
_____

Accidents:

Please indicate the severity, injuries sustained, when it occurred, and any treatment required.

_____
_____
_____
_____

Family History:

Please indicate the age of all relatives living and indicate the age at which any family member became deceased. (L-living, D-deceased)

Father:	L _____	D _____	Mother:	L _____	D _____
Brothers:	L _____	D _____	Sisters:	L _____	D _____
	L _____	D _____		L _____	D _____

Indicate if there have been any of the following diseases in your grandparents, parents, or siblings. Please indicate and state their relationship to you.

Diabetes _____ Cancer _____ Hypertension _____
Mental Illness _____ Alzheimer's _____ Rheumatism _____
Tuberculosis _____ Arthritis _____ Stomach Disorders _____
Allergies _____ Goiter _____ Kidney Disease _____
Heart Disease _____ Thyroid Condition_____

Additional History (If Female):

Age of first menses _____ Age of cessation of menses _____
Regularity of menses? _____

check all that apply
Menopause _____ Tubaligation _____ I. U. D. _____ Birth control pills _____
Pre-menstrual pain _____ Post-menstrual pain _____ Sensitive breasts _____ Blood Clots_____
Vaginal Discharge - consistency, colour, and odour: _____

Describe any PMS symptoms _____
_____

Have you ever had fibrocystic disease of the breast? _____ Uterine fibroids? _____
Do you have recurring vaginal infections?
Never_____ Rarely_____ Frequently_____ More than 3 times a year _____

How often do you experience cystitis (bladder infection)?
Never_____ Rarely_____ Frequently_____ More than 3 times a year _____

Single _____ Married / long term relationship_____ How many years_____

Number of children _____ Ages _____ No. of pregnancies _____
Deliveries _____ Miscarriages _____ Abortions _____

Any complications associated with the above _____
_____

Additional History (if Male):

Any history of the following problems?
Bladder _____ Prostate _____ Sexual function _____

Medications:

List all prescribed medications presently being taken. Indicate the drug name, dosage, frequency, and how long you've taken it.

_____
_____
_____
_____
_____

List any prescribed medication you have had a bad reaction to in the past. Indicate the drug name, when you took it, and the reaction you had.

_____
_____
_____
_____

How many courses of antibiotics have you had in the past 10 years? _____
Have you ever had a bad reaction to an antibiotic? _____

List any over-the-counter medications you take (i.e. Aspirin, Tums, etc.). Indicate whether you take rarely, occasionally, frequently or daily.

_____
_____
_____
_____

Do you use any recreational drugs? If so, indicate type and frequency of usage:

_____
_____
_____

Have you ever used recreational drugs in the past? If so, indicate type and frequency of usage.

_____
_____
_____

Have you ever had a severe reaction from a vaccination? If so, explain vaccination type, when it was administered and the reaction caused.

_____
_____
_____

List all food supplements you are presently taking. Indicate the total dosage taken in one day (i.e. if you take 2 tables of Vitamin C 500 mg/day, the total is 1000 mg/day).

_____
_____
_____
_____
_____

Lifestyle:

How many cups/bottles/glasses per day do you drink on average of the following?
Coffee _____ Tea _____ Herbal tea _____Water _____
Milk 2% _____ Milk (skim) _____Fruit juice _____ Veg juice _____
Soda (diet) _____ Soda (reg) _____ Liquor _____Beer _____ Wine _____

Do you smoke? If so, for how long? _____ Have you ever smoked, and if so for how long? _____
How many per week cigarettes? _____ cigars? _____
Does anyone else smoke in your household? _____ Does anyone smoke in your workplace? _____

How many hours of sleep do you get on average? _____

What do you do for exercise? (indicate type, how often you participate, and for how long each occasion)._____
_____
_____
_____

When was your last vacation? _____

What do you do for recreation and relaxation? _____
_____
_____
_____

What level of personal stress are you experiencing right now? (check one)
_____Minimal _____Average _____Considerable _____Unbearable

Is the main stressor (check all that apply):
Financial _____Job related_____ Interpersonal_____ Marriage _____
Health _____ Unfulfilled Expectations_____ Spiritual _____Family Members _____

Do you participate in any spiritual discipline or belong to a church or religious group?_____
Are you an active participant? _____

Anything else you would like to share with us? _____
_____
_____
_____
_____

Thank you for taking the time to fill out the requested information. It will help greatly in our study of your present health and will assist us in choosing an appropriate direction to take in working toward your desired restoration of health.

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