

Integrated Health Clinic™

working together for your health

FORT LANGLEY, BC

NEW PATIENT INTAKE FORM – YOUTH (Ages 0 – 13)

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.

Today's Date: _____

Child's Name: _____ Name you prefer we use: _____
(First) (Middle) (Last) (if different)

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

Child's Date of Birth: ____/____/____ Age: ____ Gender: ____ Wt: ____ Ht: ____
M D Y

Care Card #: _____

Home Address: _____ City: _____ Postal Code: _____

Parent's Phone Numbers: Home _____ Work _____ Cell _____

Parent's Email: _____ Would you like to receive our newsletters by email? Y / N

Emergency contact: Name _____ Home # _____ Cell # _____

How did you find out about our clinic?

- | | |
|---|---|
| <input type="checkbox"/> Internet/website | <input type="checkbox"/> Referral, Whom may we thank? _____ |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Seminar |
| <input type="checkbox"/> Yellow pages | <input type="checkbox"/> Other _____ |

Family Physician: _____

Other Health Care Provider(s): _____

Allergies, if known (medical, environmental, foods): _____

Number of antibiotic treatments: _____

Screening tests your child has had, if applicable (e.g., blood, hearing, vision):

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Current Medication(s) & dosage (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Past prescription medications:

_____	_____	_____
_____	_____	_____

Family Health History – Has a close relative (parent, grandparent, sibling) has had any of the following

- Unknown, my child was adopted
- Allergies
- Arthritis, e.g., Juvenile
- Asthma
- Cancer; Type/s: _____
- Diabetes
- Eczema
- Kidney disease
- Mental illness
- Skin disease
- Tuberculosis

Any other medical conditions? _____

Please list your child's health concerns, in order of importance to you:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Child's general state of health: Excellent / Good / Fair / Poor

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

Which of the following has your child had?

	Never	Mild	Average	Severe
Chicken Pox				
Ear Infections				
Impetigo				
Measles				
Mononucleosis				
Mumps				
Roseola				
Rubella, german measles				
Scarlet fever				
Strep throat				
Whooping cough				

Immunization History

- My child has not been immunized
- DPT (diphtheria, pertussis, tetanus)
- “Flu”
- Haemophilus influenza B
- Hepatitis A
- Hepatitis B
- MMR (mumps, measles, rubella)
- Polio

History of adverse reaction(s) to immunization: Y / N _____
 (Describe if applicable)

Prenatal Health of the Parents

	Unknown	Poor	Good	Excellent
Health of mother at conception				
Health of father at conception				
Health of mother during pregnancy				
Mother’s diet during pregnancy				

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Mother's age at child's birth: _____

Did the mother receive prenatal care: Y / N / Unknown (my child is adopted)

Experienced by mother during pregnancy:

- Bleeding
- Diabetes
- High blood pressure
- Nausea
- Thyroid problem
- Trauma, physical or emotional
- Vomiting
- Other: _____

Used by the mother during the pregnancy?

____ Tobacco ____ Alcohol ____ Recreational drugs: _____

- Prescription medications: _____
- Over-the-counter medications: _____
- Supplements: _____
- Other: _____

Does either parent have a chronic disease? Y / N Description: _____

Birth History

- Term length: __ Full __ Premature: _____ wks __ Late: _____ wks Length of Labour: _____
- Child's weight at birth: _____
- Method of Delivery: __ Vaginal __ C-section __ Induced __ Forceps __ Vacuum __ Anesthesia used

Experienced by child at or shortly after birth?

- Jaundice:
- Rashes:
- Seizure:
- Birth defect: _____
- Birth injury: _____
- Other complication(s): _____

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- How is the child's home heated? _____
 - Toxins or other hazards the child is regularly exposed to: _____
 - How would you describe the emotional climate of the child's home? _____
 - Is there anything that you feel is important that has not been covered? _____
-

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Billing Procedure, excluding GST:

Treatment Description	Fee	Treatment Description	Fee
Acupuncture treatment, 30 min.	\$65	Laser therapy	
Annual physical exam, 30 min.	\$95	- 30 min.	\$55
Blood collection	\$25	- 45 min.	\$63
Colon hydrotherapy screen	\$25	- 60 min.	\$85
Colon hydrotherapy	\$85	- 75 min.	\$93
Chiropractic		Naturopathic	
- Initial visit, 45 min.	\$80	- Initial consultation, 60 min.	\$190
- Follow-up, 30 min.	\$70	- Initial consult, 60 min., Dr. G. Parmar	\$299
- Follow-up, 15 min.	\$50	- Initial consult, 60 min., Cancer, Dr. J. Ghazali	\$299
- Pediatric & senior, 15 min.	\$45	- Follow-up, 45 min.	\$142.50
Detoxification screen	\$25	- Follow-up, 30 min.	\$80
Escariotic treatment, 30 min.	\$65	- Pediatric & senior initial visit, 60 min.	\$145
Hyperbaric oxygen therapy		- Pediatric & senior follow-up, 30 min.	\$65
60 min.	\$150	- Phone consultations, 15 min.	\$50
90 min.	\$225	- Shiatsu massage, 60 min.	\$80
Missed appointment fee, without 24hrs notice			\$35

We currently accept VISA, Mastercard, AMEX and Debit. We are unable to accept cheques.

Informed Consent to Treatment

1. I understand that the practitioners at this health centre are Naturopathic Physicians, and will use only natural, non-invasive methods of assessment and treatment.
2. I understand that any advice given to me as a patient at the Fort Integrated Health Clinic is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.
3. I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in BC.
4. I understand that the Naturopathic Physician reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.
5. I understand that I am accepting or rejecting this care by my own free will.
6. I understand that no employee or physician at the Fort Integrated Health Clinic is suggesting to me to refrain from seeking the advice of another health care provider.
7. I understand that the services offered here are not covered by MSP, and that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.
8. I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the cancellation fee.
9. I understand that any therapies recommended will be explained to me in full by the physician, and that I will give consent to treatment based on informed consent.

I, _____ have read, understood and agree to the above statements on behalf of _____.

Signature _____
Parent/guardian

Date _____

Thank you for taking the time to complete this intake form. We look forward to working with you to optimize your health and well being.