

# HYDRATE

IV WELLNESS CENTRE

## CONTACT INFORMATION

LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER: M / F / OTHER

ADDRESS:

\_\_\_\_\_ STREET \_\_\_\_\_ CITY \_\_\_\_\_ PROVINCE \_\_\_\_\_ POSTAL CODE

PREFERRED PHONE #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

MARITAL STATUS: \_\_\_\_\_ # OF CHILDREN: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

CARE CARD NUMBER: \_\_\_\_\_

CAN HYDRATE CONTACT YOU VIA EMAIL? Y / N (PLEASE CIRCLE)

WOULD YOU LIKE TO RECEIVE OUR MONTHLY NEWSLETTER ABOUT CLINIC SPECIALS, MEDICAL NEWS AND A RECIPE?  
Y / N

## EMERGENCY CONTACT

NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

## HOW DID YOU HEAR ABOUT US?

WALK-IN  HYDRATE WEBSITE  REFERRAL: \_\_\_\_\_

NEWSPAPER  SOCIAL MEDIA  OTHER: \_\_\_\_\_

## PLEASE LIST ANY HEALTHCARE PROVIDERS YOU ARE CURRENTLY SEEING

DR. \_\_\_\_\_ SPECIALTY: \_\_\_\_\_ PHONE: \_\_\_\_\_

DR. \_\_\_\_\_ SPECIALTY: \_\_\_\_\_ PHONE: \_\_\_\_\_

DATE OF LAST PHYSICAL/ANNUAL EXAM: \_\_\_\_\_ DATE OF LAST BLOOD TESTS: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

## HEALTH HISTORY

PLEASE LIST YOUR MAIN HEALTH CONCERNS IN ORDER OF IMPORTANCE

CONCERN	WHEN IT BEGAN?	SEVERITY 1-10
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

PLEASE LIST THE TREATMENTS YOU HAVE TRIED FOR THE ABOVE MENTIONED CONCERNS:

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DO YOU HAVE ANY EMOTIONAL ISSUES THAT YOU WOULD LIKE TO ADDRESS?

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DO YOU HAVE ANY SEXUAL ISSUES THAT YOU WOULD LIKE TO ADDRESS?

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DO YOU HAVE ANY SOCIAL ISSUES THAT YOU WOULD LIKE TO ADDRESS?

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DO YOU HAVE ANY FAMILY ISSUES THAT YOU WOULD LIKE TO ADDRESS?

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### OFFICIAL MEDICAL DIAGNOSES (NAME, WHEN IT WAS DIAGNOSED, AND BY WHOM)

DIAGNOSIS	DATE	MEDICAL PROFESSIONAL

## REVIEW OF SYSTEMS

ARE YOU HAVING ANY ISSUES WITH THE FOLLOWING

HEAD (eyes, ears, nose, throat): \_\_\_\_\_

RESPIRATORY SYSTEM (lungs): \_\_\_\_\_

DIGESTIVE SYSTEM (stomach, intestines, bowel movements): \_\_\_\_\_

URINARY SYSTEM (kidneys, urine): \_\_\_\_\_

SEXUAL SYSTEM (any body parts or sexual health, libido): \_\_\_\_\_

NERVOUS SYSTEM (nerves, tremors, brain problems, shooting pains): \_\_\_\_\_

CARDIOVASCULAR (heart, veins): \_\_\_\_\_

SKIN: \_\_\_\_\_

ENDOCRINE SYSTEM (sweating, body odor, fatigue, mood): \_\_\_\_\_

MUSCULOSKELETAL (Muscles, body, aches pains): \_\_\_\_\_

## GENERAL MARKERS OF HEALTH

SLEEP (how many hours do you get each night, difficulty falling asleep, waking in the night): \_\_\_\_\_

ENERGY (level, duration throughout the day): \_\_\_\_\_

APPETITE: \_\_\_\_\_

MOOD: \_\_\_\_\_

MENSES: \_\_\_\_\_ LENGTH OF CYCLE: \_\_\_\_\_

HOW HEAVY IS THE FLOW: \_\_\_\_\_ HOW MANY DAYS OF FLOW: \_\_\_\_\_ PMS: \_\_\_\_\_

PROSTATE HEALTH: \_\_\_\_\_

STRESS- WHAT ARE YOUR BIGGEST STRESSORS IN LIFE, HOW INTENSE IS YOUR STRESS (1-10): \_\_\_\_\_

ALLERGIES (drugs, herbs, foods, environmental): \_\_\_\_\_

SMOKING- (Cigarettes, marijuana, other + How often/many): \_\_\_\_\_

HOSPITALIZATIONS: \_\_\_\_\_

SURGERIES: \_\_\_\_\_

## ANY AND ALL MEDICATION

HOW MANY TIMES HAVE YOU TAKEN ANTI-BIOTICS IN YOUR LIFETIME? \_\_\_\_\_

DID YOU DO A ROUND OF PROBIOTICS? \_\_\_\_\_

## FAMILY HISTORY

CANCER, HEART ATTACK, DIABETES, ANXIETY DISORDER ETC. FOR YOUR PARENTS AND GRANDPARENTS:

ON A SCALE FROM 0-10, HOW INTERESTED ARE YOU IN CHANGING YOUR HEALTH STATUS:

## FOR YOUR FIRST VISIT PLEASE BRING

- COPIES OF ANY RECENT LAB WORK OR IMAGING
- CASH, CHEQUE, OR CREDIT CARD FOR PAYMENT

## INFORMED CONSENT FOR NATUROPATHIC MEDICINE

Naturopathic Medicine is considered a primary health care service in British Columbia, which focuses on individualized treatment, the prevention of disease, and the choice of less harmful (or more “natural”) treatments. Naturopathic physicians assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Naturopathic physicians are licensed to diagnose and treat illness. We provide a wide range of treatment options, including, but not limited to nutritional and lifestyle counselling, botanical medicine, physical therapies, acupuncture, spinal manipulation, homeopathy, laboratory diagnosis, supplements, vitamins, water fasting and pharmaceutical prescriptions in order to stimulate the body’s inherent healing capacity. We are governed by the Health Professions Act of BC and the Canadian College of Naturopathic Physicians of British Columbia (CNPBC).

Naturopathic Physicians like to take time with people to cultivate a doctor-patient relationship that is built on mutual trust and respect. While it is possible for some treatments to be rapid and effective on the first visit, naturopathic often requires repeated visits. The course of treatment is always discussed and individualized to your needs.

## INFORMED CONSENT FOR SPECIALISED TREATMENTS

For specialised or invasive treatments, your physician may have you sign a consent form and/or have you verbally agree to the proposed treatment options. Scheduling an appointment for a specific treatment will be considered consent to that treatment. Prior to treatment, your physician will ensure you are informed of the risks, benefits, cost, adverse effects and alternatives of the proposed treatment as well as the risks of not treating the diagnosed condition. You always have the right to refuse or withdraw consent to any treatment at any time with no consequences for other future treatments.

### *Please check each box below to indicate you have read and understood the following*

- I understand that the practice of naturopathic medicine requires taking a thorough case history, and may require a physical exam. In some cases, diagnostic testing, including the collection of blood, urine and/or saliva may be required.
- I understand that if my case requires specific examinations or diagnostic imaging not available in office, an appropriate referral will be made to another health professional.
- I will inform my doctor if I am pregnant, suspect I am pregnant, having unprotected sex or breastfeeding.
- I will inform my doctor of any disease process that I am suffering from, or have been diagnosed with in the past, and any medications/over the counter drugs that I am currently taking.
- I understand that a record of my visits and medical history will be kept electronically, that this record will be strictly confidential and will not be released to any persons without my written consent.
- I understand that the details of my case may be discussed between the doctor and other medical professionals, with no identifying information being given, for the purpose of giving me the best medical care possible.
- I understand there are no guaranteed treatment results.
- I confirm that I have the ability to accept or reject the recommended treatment at my own free will.
- I understand that I have the ability to seek and/or continue medical care from another qualified health care practitioner

***I understand that some treatments carry the following risks and adverse effects***

- Allergic reactions from supplements, intravenous/injection therapy or botanical medicine.
- Pain, bruising, fainting or injury from blood tests, injections or acupuncture.
- Muscle strains, sprains, disc injuries, or stroke (rare) from spinal manipulation or other physical therapies.
- Aggravation of pre-existing symptoms.
- Punctured lung or other organ during insertion of needles for prolotherapy, neural therapy, acupuncture, and other techniques involving needles.
- Dizziness, nausea, vomiting, fainting, lethargy, body and head aches during water fasting.

We thank you for taking the time to read and fill out this form and welcome to the clinic.

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PATIENT NAME

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DATE

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SIGNATURE

# ADMINISTRATIVE POLICIES

## APPOINTMENTS

We understand the value of your time. We are committed to efficient appointment scheduling to minimize wait times for all our patients and clients. However, we do provide emergency appointments that can sometimes affect your wait time. We trust that you appreciate the value of our time as well. A scheduled appointment is valuable time scheduled just for you. Should you become unable to keep any appointment, we ask that you please provide us with **24 hours notice**. Failure to arrive for one appointment will result in a visit fee equal to half your scheduled appointment, a full visit charge will apply for any further no-shows or last minute cancellations. **It is very important to be aware that WCB, ICBC and 3rd party insurance providers DO NOT cover missed or cancelled appt fees.** Please ensure you note your appointment times on your personal calendar.

## RATES

I have seen the rates and am aware of the fees for services rendered as they are displayed

## ACCOUNTS

- I understand that payment is due after each visit/treatment/purchase on the day of service
- Outstanding balances after 30 days are subject to a compound interest charge of 1.5% per month (18% per annum) at the discretion of the doctor.
- I also agree and personally guarantee that I will be responsible for any payment(s) that may be denied, for whatever reason, for services and/or products already received, which the doctor claimed on my behalf with my knowledge and my consent, from B.C. Health, my extended health insurance provider, ICBC, WCB, or from others that may arise from time to time.
- I further understand that if non-payment of my account or balance requires it to go to collection, it will incur an administration fee and a collection fee of 35%.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, in Victoria, in the Province of British Columbia.

\_\_\_\_\_  
PATIENT (OR GUARDIAN) SIGNATURE

\_\_\_\_\_  
WITNESS SIGNATURE

\_\_\_\_\_  
PRINT PATIENT NAME

\_\_\_\_\_  
PRINT WITNESS