METROTOWN NATUROPATHIC

202-6411 Nelson Avenue, Burnaby
www.metrotownnaturopathic.com
604-451-1737

General Patient Information

Full Name: _____Today's Date: _____
mm / dd / yy

Date of Birth: _____ Age: _____ Gender: _____
mm/ dd / yy

Home Address:
_____
_____
_____

Home Telephone: _____ Cell:_____

Emergency contact: _____Phone:_____

Email Address:
_____

How did you find out about us?

□ Referral: _____
□ Web
□ Social Media
□ Other: _____

Family Physician: _____ Phone: _____

Other Health Care Provider(s):

Name: _____ Type: _____Phone: _____

Name: _____ Type: _____Phone: _____

Name: _____ Type: _____Phone: _____

□ I authorize communication between Dr. Hamid Tajbakhsh, ND and my other health care providers.

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INFORMED CONSENT FOR CONSULTATION & TREATMENT

I understand that the practice of naturopathic medicine requires taking a thorough case history and may require a physical exam. Some cases may require diagnostic testing which may include the collection of blood, urine, and/or saliva.

I understand that if after an initial course of treatment, results are not as expected or if my practitioner is concerned that I need additional assessment, further workup may be recommended.

I confirm that the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, the use of all current medications and supplements, and any past/current serious health condition(s).

I understand that naturopathic medicine carries a risk of complications and that a resolution of symptoms in not guaranteed. Health risks of some naturopathic treatments include but are not limited to: temporary aggravation of pre-existing symptoms, allergic reactions and/or other adverse effects, pain, fainting, fatigue, irritability, bruising or injury from venipuncture, acupuncture, cupping, or moxibustion.

I confirm that I have the ability to accept or reject the recommended treatment(s) of 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 recognize that I am encouraged to speak freely regarding the treatments received and recommendations made to me with the rest of my health care team.

I understand that a record of my visits and medical history will be kept, that this record will be strictly confidential and will not be released to any person or entity without my written consent.

I acknowledge that naturopathic medicine is only partially covered by certain extended health plans and therefore I am responsible for payment of goods and services in full at each visit.

I understand that there is a cancellation fee of $40 for appointments missed or canceled with less than 24 hours notice.

I acknowledge that if I arrive late for my scheduled appointment, the visit will be shortened to ensure that other patients' visits are kept on time.

I understand that my naturopathic doctor reserves the right to determine which cases fall outside their scope of practice in which case the appropriate referral will be recommended.

Patient (or legal guardian) Signature:_____ Date:_____

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Chief Health Concerns

What are your health concerns:
1. _____
2. _____
3. _____

Please list treatments tried:

_____
_____
_____
_____
_____

Medical History

How would you describe your general state of health?

Excellent Good Fair Poor

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations? Include approximate date(s).

_____
_____

Do you have any allergies (medications, environmental, foods, etc.)?

_____
_____

Please list ALL current medications and supplements (prescription, over-the-counter, vitamins, herbs, etc.):

_____
_____
_____

Have you been vaccinated? Please list known vaccinations:

_____
_____
_____

Are you currently pregnant or possibly pregnant? Y N

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Are you menopausal? Y N Date of last period: _____

Do you use any of the following?

☐ Laxatives	☐ Antacids
☐ Diet pills	☐ Pain medication
☐ Sweets	☐ Caffeine
☐ Alcohol	☐ Tobacco
☐ Marijuana	☐ Other recreational drugs: _____

Do you get regular screening tests done by a doctor? (blood tests, etc.) Y N

Diet

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

List any food cravings you have:

_____

Describe your typical diet:

Breakfast

_____

Lunch

_____

Dinner

_____

Snacks

_____

Beverages

_____

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Family History

Please check any that your relatives are affected by:

☐ Allergies	☐ Depression	☐ Osteoporosis
☐ Anxiety	☐ PMS	☐ Kidney Disease
☐ Arthritis	☐ Heart Disease	☐ Thyroid Disease
☐ Asthma	☐ High Blood Pressure	☐ Autoimmune Disease
☐ Cancer	☐ Kidney Disease	☐ Stroke
☐ Diabetes	☐ Mental Illness	☐ Neurological Disease
☐ Obesity	☐ Multiple Sclerosis	☐ Addiction
☐ Lung Disease	☐ Chronic Pain	☐ Liver Disease

☐ Others: _____

Social History

Occupation(s):

_____

_____

Please list any known toxins you may be exposed to:

_____

_____

How would you rate your stress level?

High Average Low

How do you deal with stress:

_____

_____

_____

How would you rate your energy level?

High Average Low

Do you exercise regularly? Y N