DR. JULIE CHAN
NATUROPATHIC DOCTOR
REGISTERED ACUPUNCTURIST

# ADULT INTAKE FORM

*Please complete the intake form as thoroughly as possible and return it to the clinic reception. Please be advised that some of the questions may be very detailed and that is intended so your Naturopathic Doctor can attend to your needs in the most holistic manner.*

**Contact Information**

| | | | | | |
|---|---|---|---|---|---|
| **Last Name** | **First Name** | | **DOB**: _____/_____/_____ DD / MM / YYYY | **Sex** | **Age** |
| **Address** | | | **City, Province** | **Postal Code** | |
| **Home Phone** | **Cell Phone** | **Work Phone** | **Email address:** | | |
| **Emergency Contact** | | **Emergency Number** | **Would you like to be on our mailing list to receive quarterly health newsletters and updates?** | **Y** | **N** |
| **Doctor's Name:** | | **Doctor's Number** | **Doctor's Address:** | | |
| **Are you under the care of other health practitioners? If yes, please list names and their specialty:** | | | | | |
| **How did you hear about our clinic?** □ **Referred by your doctor** □ **Referred by friend/family (Name)** _____ □ **Internet** □ **Other** | | | | | |

**Health Concerns:**

| Chief Health Concerns (in order of importance) | Duration: | Past or Current Treatments |
|---|---|---|
| **1** | | |
| **2** | | |
| **3** | | |
| **4** | | |

**Medical History**

| | |
|---|---|
| How would you rate your current state of health: Excellent Good Fair Poor | |
| List any history of accidents, surgeries, drug/allergic reactions, hospitalizations, major illnesses, and complications in the past | When? |
| 1. | |
| 2. | |
| 3. | |
| Please list all food, environmental, vaccine and drug allergies: | |
| How many times in one year do you have a cold, sinusitis, flu, sore throat or lung infection? | |
| How many times have you been treated with antibiotics in the last 5 years? 0-5 5 to 10 >10 | |
| What is your energy level (10 being the highest) 0 1 2 3 4 5 6 7 8 9 10 | |
| What is your stress level (10 being the highest) 0 1 2 3 4 5 6 7 8 9 10 | |
| What are your main sources of stress? | |
| How would you describe the emotional climate at home? | |

| |
|---|
| How do you deal with your stress? |
| Is there any history of drug or substance abuse? |
| What is your main goal of seeing a Naturopathic Doctor |

**Medications and Supplements** – Please list

| Medications | Supplements and Vitamins |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

**Family History**

**Please indicate if any immediate family members (parents, siblings, grandparents) have had or have the following conditions:**

| | | | | |
|---|---|---|---|---|
| □ Diabetes | □ Heart Disease | □ High Blood Pressure | □ Autoimmune disease | □ Depression |
| □ High Cholesterol | □ Stroke | □ Cancer | □ Alcohol/drug abuse | □ Arthritis |
| □ Seizures | □ Kidney Disease | □ Thyroid Dysfunction | □ Schizophrenia | □ Allergies |
| □ Asthma | □ Other Mental Illness | □ Other: _____ | | |

**Diet**: Describe a typical diet for one day and amounts:

| | |
|---|---|
| Breakfast: | Snacks: |
| Lunch: | Beverages: |
| Dinner: | Other: |

**How many times a week do you have these foods?**

| | | |
|---|---|---|
| ___ Fruit/Fruit juices | ___ Sugar, sweets (candy, cookies etc.) | ___ Herbal tea |
| ___ Vegetables | ___ Salty snack foods (eg. Chips) | ___ Coffee |
| ___ Luncheon meat/smoked meat | ___ Artificial sweeteners (Splenda etc.) | ___ Regular tea |
| ___ Wheat products (bread, pastas, | ___ Fast food (McDonald's etc.) | ___ Alcohol |
| ___ Bagels, pastries, cakes etc.) | ___ Dairy products (milk, cheese etc) | |

**What kind of water do you primarily drink?** ☐ Tap ☐ Well ☐ Bottled ☐ Filtered ☐ Distilled

**Lifestyle**

| |
|---|
| Do you exercise? □ Never □ < 1/wk □ 1-3/wk □ 3-5/wk □ >5/wk |
| Do you smoke currently? □ Yes □ No Have you ever smoked in the past? □ Yes □ No |
| How many hours of sleep do you get? Do you have difficulty staying asleep? □ Yes □ No |
| Do you have any difficulty falling asleep? □ Yes □ No Do you feel well-rested when you wake up? □ Yes □ No |
| What is your occupation? |
| What is your status? □ Married □ Divorced □ Single □ Single parent □ Common-law |
| Who lives with you at home? Do you have children? □ Yes □ No How many? |

**On a scale of 0 -10, how satisfied are you with the following areas of your life? (0 being not satisfied, and 10 being extremely satisfied**

_____ Career _____Family _____ Personal Growth_____ Health _____Friends _____Money

_____ Love _____Physical Environment _____ Fun/Recreation

**Treating illness and maintaining health does not occur overnight. It requires commitment to making lifestyle changes and following treatment protocols. On a scale of 1-10, how would you describe your level of commitment at this time? (0=not committed, 10=fully committed)**

0 1 2 3 4 5 6 7 8 9 10

**What is your main goal seeing a Naturopathic Doctor?** _____

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# REVIEW OF SYSTEMS

(Please check with a ✓ for current symptoms or put a "P" for past symptoms)

## NEUROLOGICAL

□ Fatigue
□ Chills
□ Seizures
□ Dizziness
□ Fainting
□ Paralysis
□ Mood swings
□ Quick temper
□ Speech problems
□ Insomnia
□ Feeling stressed
□ Poor memory
□ Loss of balance
□ Headaches
□ Feeling anxious
□ Feeling nervous
□ Phobias
□ Neuralgia
□ Numbness/ tingling
□ Jerking
□ Tremors
□ Alcohol/drug use
□ Learning difficulties
□ Confusion
□ Dementia
□ Prolonged sadness/ grief
□ Depression
□ Irritability
□ Mental illness
□ Panic attacks
□ Hyperactivity
□ Poor focus
□ Aggression
□ Autism
□ Schizophrenia
□ Had Concussion
□ Poor Self Esteem
□ Other _____

## GASTRO-INTESTINAL TRACT

□ Poor appetite
□ Poor thirst
□ Bloating
□ Burping or gas
□ Heartburn
□ Ulcers
□ Bad breath
□ Abdominal pain
□ Constipation
□ Laxative Use
□ Difficult digestion
□ Diarrhea
□ Difficulty swallowing
□ Vomiting
□ Nausea
□ Incomplete bowel movements
□ Hard stools
□ Loose stools
□ Hemorrhoids
□ Mucus in stool
□ Green stool
□ Undigested food in stool
□ Black tarry stool
□ Blood in stool
□ Pale stool
□ Anal itching
□ Anal fissures
□ Rectal pain
□ Rectal bleeding
□ Liver disease
□Gallbladder disease
□ Gall stones
□ Jaundice
□ Fatty Liver
□ Other _____

## NOSE & SINUSES

□ Allergies
□ Itchy nose
□ Nasal discharge
□ Loss of smell
□ Postnasal drip
□ Nosebleeds
□ Sinus infections
□ Nasal congestion
□ Hoarseness
□ Sinus pain
□ Snoring
□ Sleep apnea
□ Other _____

## RESPIRATORY and IMMUNE SYSTEM

□ Prone to getting sick
□ Colds
□ Sore throats
□ Ear infections
□ Swollen lymph nodes
□ Chest pain
□ Chronic cough
□ Phlegm
□ Wheezing
□ Bronchitis
□ Pneumonia
□ Tuberculosis
□ Asthma
□ Emphysema
□ Pleurisy
□ Coughing blood
□ Pain breathing
□ Smoking
□Shortness of breath (SOB)
□ Chronic Fatigue Syndrome
□ Frequent antibiotic use
□ Chronic infections
□ Steroidal use
□ Other _____

## EYES

□ Impaired vision
□ Glasses/contacts
□ Colour blindness
□ Far-sighted
□ Near-sighted
□ Double vision
□ Blind spots
□ Difficulty seeing at night
□ Sensitivity to sun
□ Infections
□ Eye pain
□ Redness
□ Discharge
□ Dryness
□ Blurring
□ Excessive tearing
□ Spots/Floaters
□ Glaucoma
□ Cataracts
□ Styes or lumps
□ Eye strain
□ Eye fatigue
□ Other _____

## MOUTH AND THROAT

□ Swollen/sore lips
□ Swollen/sore tongue
□ Swollen/sore gums
□ Bad breath
□ Mouth Sores/Cankers
□ Gum bleeding
□ Cold Sores
□ Dentures
□ Cavities
□ Mercury Fillings
□ Sensitive Teeth
□ Grinding teeth
□ Other _____

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CARDIO-VASCULAR
□ High cholesterol
□ High blood pressure
□ Low blood pressure
□ Rapid heart rate
□ Slow heart rate
□ Arrhythmia
□ Palpitations
□ Murmurs
□ Angina
□ Chest pain
□ Poor circulation
□ Blood clots
□ Deep leg pain
□ Varicose veins
□ Heart valve problems
□ History of stroke
□ History of heart attack
□ Hardening of arteries
□ Rheumatic fever
□ Cold extremities
□ Swelling of limbs
□ Easy bruising
□ Other_____

ENDOCRINE
□ Hypothyroid
□ Hyperthyroid
□ Thyroid issue
□ Goiter
□ Excessive sweating
□ Heat intolerance
□ Cold intolerance
□ Excessive thirst
□ Excessive hunger
□ Diabetes I
□ Diabetes II
□ Hypoglycemia
□ Weight issues
□ Hormone therapy
□ Other _____

MUSCLE AND JOINT
□ Neck pain
□ Back pain
□ Joint pain
□ Joint swelling
□ Joint stiffness
□ Muscle weakness
□ Muscle pain
□ Shoulder pain
□ Knee pain
□ Foot/ankle pain
□ Hip pain
□ Elbow Pain
□ Hand/wrist pain
□ Sacral Pain
□ Herniated Disc
□ Arthritis
□ Curvature of the spine
□ Sciatica
□ Fractures
□ Osteoporosis
□ Loss of height
□ Bursitis
□ Fibromyalgia
□ Other _____

SKIN AND HAIR
□ Eczema
□ Hives
□ Rash
□ Acne
□ Lumps/Bumps
□ Colour Change
□ Scarring
□ Dry skin
□ Itching
□ Skin cancer
□ Nail changes
□ Warts
□ Herpes
□ Change in moles
□ Psoriasis
□ Strong body odour
□ Easy perspiration
□ Dandruff
□ Hair Loss
□ Other _____

EARS
□ Ringing in ears
□ Trouble hearing
□ Ear discharge
□ Ear pain
□ Tubes in ears
□ Ear infections
□ Wax build-up
□ Itching
□ Other _____

GENITO-URINARY TRACT
□ Blood in urine
□ Incontinence
□ Kidney / urinary Infections
□ Urgency
□ Frequent urination
□ Night urination
□ Bad odour urine
□ Painful urination
□ Flank pain
□ Bedwetting
□ Kidney stones
□ Other _____

MALE REPRODUCTIVE
□ Hernia
□ Low libido
□ Prostate problems
□ Sores or lumps
□ STDs
□ Sexually active
□ Testicular pain
□ Testicular masses
□ Erectile dysfunction
□ Herpes
□ Premature ejaculation
□ Undescended testicles
□ Low sperm
□ Discharges
□ Other _____

FEMALE REPRODUCTIVE
□ Heavy menses
□ Light menses
□ Clots
□ Painful periods
□ Irregular periods
□ Vaginal discharge
□ Abnormal PAP
□ Bleeding between periods
□ Vaginal itching
□ Vaginal sores
□ Use of tampons
□ Odour to discharge
□ Painful intercourse
□ Low libido
□Yeast infections
□ Endometriosis
□ Uterine fibroids
□ Hysterectomy
□ Ovarian cysts
□ Sexually active
□ Menopausal
□ Hotflashes
□ Difficulty conceiving
□ Infertility
□ Diagnosed with STD
□ History of ovarian, uterine or cervical cancer
□ Other _____

BREAST HEALTH
□ Sore breasts
□ Lumps
□ Breast Pain
□ Nipple discharge
□ Fibrocystic breasts
□ Skin puckering
□ History of breast cancer
□ Other _____

ADDITIONAL CONCERNS:

_____

_____

Liberty Wellness Clinic, Dr. Julie Chan Naturopathic Doctor and Registered Acupuncturist - 3621 Highway 7 East, Suite 307, Markham, ON, L3R 0G6 T: (905) 604-8480 F: (905) 604-8484 E: info@libertywellness.ca W: www.libertywellness.ca

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# Informed Consent to Naturopathic Therapies

This is to acknowledge that I have been informed and I understand that:

1. Any treatment or advice provided to me as a patient of Dr. Julie Sook-Man Chan, Naturopathic Doctor and Registered Acupuncturist, is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another health care provider. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario;

2. I have not been recommended to refrain from seeking or following the advice of another licensed health care provider

3. No employee, agent, or anyone else under the direction of Naturopathic Doctor and Registered Acupuncturist, Dr. Julie Sook-Man Chan is suggesting or recommending to me to refrain from seeking or following the advice of another health care provider.

4. The treatment and therapies rendered or recommended by Naturopathic Doctor and Registered Acupuncturist, Dr. Julie Sook-Man Chan may be different than those usually offered by a medical doctor or other health care provider.

5. There are some risks, however rare, to Naturopathic Medicine. These include but are not limited to:

   • aggravation of pre-existing symptoms,
   • reaction to supplements or herbs,
   • bruising from an acupuncture needle

6. Naturopathic Doctors use a variety of therapeutic approaches, either alone, or in combination. These include Traditional Chinese Medicine and Acupuncture, Nutritional and lifestyle counseling, nutritional supplementation, Botanical Medicine, Homeopathic Medicine, Vitamin Injections, Intravenous and Parenteral Therapy.

**Service Fee List**

| **Service** | **Fee as of August 1, 2016** |
|---|---|
| Initial Consultation (120 minutes) | $225.00 |
| Initial Consultation (90 minutes) | $195.00 |
| Follow-up Visits (60 minutes) | $145.00 |
| Follow-up Visits (45 minutes) | $115.00 |
| Follow-up Visits (30 minutes) | $80.00 |
| Email or Telephone Consultation | Same as visits |
| Acupuncture (Acupuncture or Naturopathic visit) | $70.00 |
| B12 Injections | $20.00 + HST |
| Nebulized Glutathione | $35.00 + glutathione |
| Intravenous (IV) Drip | $80.00 + nutrients |
| Intravenous (IV) Push | $45.00 + nutrients |

I do hereby voluntarily give my informed consent for the recommended therapeutic procedures/treatments as and for any future modifications of the procedures/treatments. I also understand that I may change the status of my voluntary consent at any time. I intend this consent to apply to all my present and future naturopathic care. State here any exceptions:

_____

I further acknowledge and confirm that I have been informed of and understand the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having/following.

I, the undersigned understand that I will be made aware of any additional costs for other procedures/tests. Payment of all services rendered is due at the time of service to Naturopathic Doctor and Registered Acupuncturist, Dr. Julie Sook-Man Chan B.Sc., ND, R.Ac.

Please note that there is a 48 hour cancellation policy. If 48 hour notice is not given, a full visit fee will be charged. I acknowledge that I may purchase products/supplements prescribed from an ND or any health food store.

**I understand that emails are allowed for booking, changing and rescheduling appointments. They are allowed if there are urgent, brief questions. However, if there are new concerns and/or information or you need a new recommendation, this must be done as a follow-up visit. A regular 30 minute follow-up fee will be charged for every 30 minutes required for reviewing and/or responding to ongoing email inquiries.

| _____ | _____ | _____ |
|---|---|---|
| PRINT NAME | SIGNATURE | DATE |

DR. JULIE CHAN
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REGISTERED ACUPUNCTURIST

# Informed Consent to Acupuncture Treatments

I have discussed with my Acupuncturist, Dr. Julie Sook-Man Chan, R.Ac. Reg. #569, the specifics of my assessment or treatment and understand the nature, risks and reasons for this procedure. I voluntarily consent to Acupuncture and understand that I may withdraw my consent and halt my participation at any time.

1. I understand that some of the techniques used under the scope of Acupuncture include the use of sterile, single-use needles to penetrate the skin. Additional treatment methods can include, but are not limited to: acupuncture, acupressure, electrical stimulation of needles, cupping or moxibustion. Before any of these procedures are performed, my practitioner will discuss my treatment options and only proceed if my consent is given.

2. My practitioner has informed me of the risks and symptoms of treatments, which can include, but are not limited to slight pain, light headaches or nausea, soreness, bruising, bleeding, or discolouration of the skin and the possibility of other unforeseen risks. I freely accept the risks involved with my procedure.

3. I will inform my practitioner if I currently have or develop any major health issues, if I suffer from any type of bleeding disorder or if I use a pacemaker.

4. I understand that I must let my practitioner know if I am carrying, or believe to have any infectious diseases including but not limited to HIV, TB and Hepatitis. In some cases where cross infection is high, my practitioner may withhold treatment.

5. I understand there are not guarantees for the results of my treatments. Traditional Chinese Medicine does not often provide and instant cure. The length of my treatment depends on the severity of my condition. In some cases, my symptoms may temporarily worsen before they begin to improve.

6. I understand that the fees charged for my treatment are not covered under OHIP and must be covered in full by myself or through third party insurance. I am responsible for the full and prompt payment after services have been rendered.

7. I have discussed the content of this form with my practitioner. I acknowledge that I have asked any questions I may have and received answers I understand. By signing this form, I give my informed consent for Traditional Chinese Medicine treatments.

N.B. Female Patients:
I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I herely state that I am not pregnant nor is there any possibility that I may be
pregnancy

| PATIENT NAME | SIGNATURE | DATE |
|---|---|---|

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# Patient Consent for Collection, Use and Disclosure of Personal Information

The privacy of your personal information is important to us at Liberty Wellness. We understand the importance of protecting your personal information and are committed to using and disclosing your personal information responsibly. In this clinic, Dr. Julie Sook-Man Chan, ND, R.Ac acts as the Health Information Custodian, and hence the Privacy Information Officer.

Our privacy policy outlines what our Clinic is doing to ensure that:

- Only necessary information is collected about you which includes your contact information, personal or family medical history
- We have your information only with your consent;
- Storage, retention and destruction of your personal information complies with existing privacy legislation and privacy protection protocols given by our regulatory body, the College of Naturopaths of Ontario and the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario.

In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this information from family members or other listed contacts without your prior written consent.

How our clinic collects, uses and discloses patients' personal information for the following purposes:

- To assess your health concerns and provide you with health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with your other health care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To fulfill any obligations mandated by law
- To comply with legal and regulatory requirements of our regulatory body, the CONO and CTCMPAO
- To invoice goods and services and process payments by credit card
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To insurance companies if they request further information for rendered service
- To prevent or assist patients in cases of emergencies or threat to their health and safety

By signing the consent you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above. I understand that I can access my personal health information except as outlined above. I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

| PRINT NAME | SIGNATURE | DATE |
|---|---|---|