REFINED HEALTH
Re-find health. Discover life

Box 60
Roland, MB R0G 1T0
204-343-2018

Patient Intake Form

Date (dd/mm/yy): _____

First Name: _____ **Date of Birth (dd/mm/yy):** _____
Last Name: _____ **Gender:** Male ☐ Female ☐

Manitoba Health card: PHIN (9digit) _____ **MHSC(6digit)**_____

Full Mailing Address: _____
_____
_____
_____

E-mail Address: _____

Home Phone Number: _____
Other Phone Number: _____
May we leave messages relating to your visits? Yes ☐ No ☐
How did you hear about Refined Health? _____

Emergency Contact **Name:** _____
Relation: _____
Phone Number: _____

Marital Status: Single Relationship Married Separated Divorced Widowed
Number of Children:_____ **Ages of Children:** _____

If patient is a child:
Mother's name: _____ Father's name: _____
Occupation: _____ Occupation: _____

Other Healthcare Providers
Name: _____ **Name:** _____
Specialty: _____ **Specialty:** _____
Phone Number: _____ **Phone Number:** _____
If needed, may we contact your other healthcare providers for information regarding your health, current/previous care, tests, prescriptions, or diagnosis? Yes ☐ No ☐

List your health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

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If you are female, are you pregnant? Yes ☐ No ☐ Trying ☐

Please list any diagnosed medical conditions:

1. _____ Year diagnosed: _____
2. _____ Year diagnosed: _____
3. _____ Year diagnosed: _____
4. _____ Year diagnosed: _____

Please list any previous accidents, surgeries, hospitalization, or medical procedures or tests:

1. _____ Year: _____
2. _____ Year: _____
3. _____ Year: _____
4. _____ Year: _____

Please list any allergies (food, environmental, medications, etc):

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Reaction: _____
4. _____ Reaction: _____

Please list all prescription drugs, over-the-counter medications, herbs, and/or supplements you are taking:

1. _____ Dose:_____
2. _____ Dose:_____
3. _____ Dose:_____
4. _____ Dose:_____
5. _____ Dose:_____
6. _____ Dose:_____
7. _____ Dose:_____
8. _____ Dose:_____

Vaccinations/ Immunization Record (check all that apply):

- ☐ DPT (Diptheria, Pertussis, Tetanus)
- ☐ Pneumococcal Conjugate (Meningitis, Pneumonia)
- ☐ Meningococcal C Conjugate (Meningitis)
- ☐ Hib (Haemophilus influenza type b)
- ☐ Varicella (Chicken Pox)
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Varicella
- ☐ Hepatitis B
- ☐ Flu
- ☐ Hepatitis A
- ☐ Tetanus Booster
- ☐ HPV (Human Papillomavirus)
- ☐ I don't know

Please indicate if you had any reaction:

_____

_____

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Family History

Please indicate if there is a history of any of the following in your family and the relationship of family member.

Alcoholism		Heart Disease	
Allergies		Heart attack	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Autoimmune Disease		Mental disease (type?)	
Cancer (type?)		Multiple Sclerosis	
Celiac		Osteoporosis	
Colitis		Stomach Ulcers	
Depression		Stroke	
Diabetes		Thyroid dysfunction	

Lifestyle

Smoking (amount/day): _____ **#of years:** _____
Alcohol: **type** _____ **amount/week** _____
Caffeine (drinks/day): **coffee** _____ **tea** _____ **soda** _____
Recreational drugs: **type** _____ **amount** _____

Are you constipated? _____ **Number of movements/day** _____
Do you use antacids? _____ **Frequency** _____ **Type** _____
Do you use laxatives? _____ **Frequency** _____ **Type** _____
Do you exercise regularly? _____ **Frequency** _____ **Type** _____
Do you use pain medications? _____ **Frequency** _____ **Type** _____
On average, how many hours of sleep do you get per night? _____
Do you have troubles falling asleep? _____
Do you have trouble staying asleep? _____
Are you sexually active? _____ **If you use contraceptives, please indicate type** _____
What are the things you find stressful and how do you react? _____

What are your hobbies and how do you relax? _____

Are you satisfied with your present weight? _____
Have you ever had weight problems? _____
Height: _____ **Current Weight:** _____
Min Adult weight: _____ **Max Weight:** _____

Is there anything else that you feel is important for us to know?

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Informed Consent to Treatment

1. I understand that I am seeing a registered naturopathic doctor who uses natural, non-invasive methods of assessment and treatment.
2. I understand that any health related advice from my naturopathic doctor does not negate other advice received from another health care provider.
3. I understand that I may continue or begin care with any other qualified health care provider while seeing my naturopathic doctor and will not be required to discontinue in order to be a patient at Refined Health.
4. I understand that my naturopathic doctor will treat within her scope of practice and will refer out to other medical providers when needed.
5. I understand that I am accepting or rejecting care of my own free will.
6. I understand that service offered at Refined Health are not covered by Manitoba Health and that fees are payable at the time of appointment or upon receiving supplements or tests.
7. I understand that 24hrs notice is required for cancelling an appointment and will otherwise be charged a cancellation fee.
8. I understand that recommended treatments will be explained and I can choose to use or not to use any treatment that has been recommended.

Informed Consent for Communication

We want to make things as easy as possible for you at Refined Health and would like to send you information electronically. This would include **appointment reminders** or any other important notifications or changes in services/ hours. Otherwise we will only communicate with you electronically in response to emails you might send to Refined Health. Please check one of the following:

☐ Yes, you can send me electronic information. ☐ No, do not send me electronic information.

I, _____ have read, understood and agree to the above statements
First Name Last Name

Signature or legal guardian: _____ Today's Date: ___ /____ /_____
DD MM YYYY

Patient name if signed by parent/ legal guardian: _____
First Name Last Name