***Krista E. Ingram*, B.Sc. N.D.**
Naturopathic Doctor
Telephone: 250.545.0103

Balance Natural Health Clinic
3105 36th Avenue
Vernon, B.C., V1T 2V7

Patient Information Today's Date:_____

Name: _____
------- (First) --------- (Middle) ---------- (Last)

Birthdate: _____ Age: _____ BC Care Card #: _____
(month/day/year)

Address: _____
(Number) (Street) (Apt #)

_____
(City) (Province) (Postal Code)

Phone #: _____ E-mail: _____

We direct bill to Pacific Blue Cross and Green Shield extended health plans.

Pacific Blue Cross:
Policy #:_____
ID#:_____

Green Shield:
Plan Member (Cardholder) ID:_____
Plan Member Name:_____

Emergency Contact:

Name: _____Relationship to you: _____

Home Phone #: _____Alternate Phone #:_____

How did you hear about us? _____

Have you ever seen a naturopathic doctor before? Y/N

Please list other healthcare practitioners: (e.g. MD, chiropractor, RMT, counselor, etc.)

1) _____ 4)_____

2) _____ 5)_____

3) _____ 6)_____

Personal Information

Height: _____ Weight:_____Occupation: _____

Relationship Status: Single In a Relationship Live-in partner Married Separated Divorced Widowed

Partner's/Spouse's name: _____

# of children: _____ Children's ages: _____

Current Health Concerns:
Please list your major health concerns in order of importance:

1) _____

2) _____

3) _____

4) _____

Please list any past injuries, major illnesses, surgeries or hospitalizations:

1) _____

2) _____

3) _____

4) _____

Please list current medications and natural health products, their dose, and how long you've been taking:

1) _____

2) _____

3) _____

4) _____

5) _____

Please list past medications and natural health products, their dose, and how long you were taking:

1) _____

2) _____

3) _____

4) _____

5) _____

How committed are you to implementing changes to your lifestyle?
{Rate 0% to 100% : 0 = not committed to 100= fully committed}

_____

What habits/lifestyle choices do you have that you feel are harmful to your health and wellness?

_____

_____

_____

What habits/lifestyle choices do you have that you feel are beneficial to your health and wellness?

_____

_____

_____

Please list the 5 most significant/stressful events in your life, from the most recent to the most distant. Are you aware of any of these events continuing to impact your life?

_____

_____

_____

_____

_____

Review of Systems

Please circle all that apply, whether you have currently [C] or have had in the past [P]:

Skin/Hair/Nails	C	P		C	P
Redness/Rashes/Hives/Itching			Hair changes (colour/shine/loss/growth)		
Eczema/Psoriasis/Shingles/Acne			Nail changes (shape/strength/thickness)		
Easy bruising			Temperature changes/Night sweats		
Excessive dryness/moisture			Skin ulcers/Skin cancer		
Colour changes/mole changes					

Head/Neurologic	C	P		C	P
Headache			Seizure/Convulsions/Epilepsy		
Head Injury			Numbness/Tingling		
TMJ problems/Teeth grinding			Speech problems/slurring		
Dizziness/Fainting/Loss of balance			Involuntary movement		
Stroke/Aneurysm/Transient Ischemic Attacks			Paralysis		

Eye	C	P		C	P
Glasses/Contacts			Excess tearing/Dryness/Redness		
Impaired vision/Double vision/Blurring			Floaters/Blind spots		
Eye pain/Itching/Discharge			Glaucoma/Cataracts		

Ear	C	P		C	P
Impaired hearing/Hearing aid/Ear tubes			Ruptured ear drum		
Ringing/Tinnitus			Excess ear wax/discharge		
Earache/Infection					

Nose/Sinus	C	P		C	P
Frequent colds/Stuffiness			Nose bleeds		
Sinus problems/Chronic congestion			Sensitive to smells		
Allergies/Hay fever			Change in ability to taste		

Mouth/Throat/Neck	C	P		C	P
Gum problems /bleeding			Frequent sore throat /Hoarseness		
Cold sores /Canker sores			Lumps /swollen nodes in neck		
Sore or dry tongue /mouth			Thyroid problems/Goiter		
Cavities /Fillings			Neck pain /Stiffness		
Type of fillings:			How often do you brush & floss?		

Respiratory	C	P		C	P
Cough /Wheezing			Pleurisy		
Sputum /Mucus			Tuberculosis		
Spitting /coughing up blood			Tuberculin Test		
Pain /difficulty breathing /Shortness of breath			Do you/Have you smoked?		
Shortness of breath at night /Sleep apnea			How long: How many:		
Asthma			Chest X-ray		
Emphysema			Date of last chest x-ray:		

Cardiovascular	C	P		C	P
Heart Disease /Coronary Artery Disease			Rheumatic fever		
Angina /Chest pain			Blue extremities		
High blood pressure			Swelling in ankles		
High blood cholesterol			Varicose veins		
Heart murmur/irregular heart beat/palpitations/fluttering			Pacemaker		
Myocardial Infarct /Heart attack					

Breast	C	P		C	P
Lumps /puckering of skin			Nipple discharge / changes		
Pain /tenderness			Implants /reduction /surgery		
Have you ever breastfed?			Do you perform self-exams? Howoften?		
Any problems with breastfeeding?			Family history of breast cancer?		

Gastrointestinal	C	P		C	P
Heartburn /Acid reflux			Diarrhea /Constipation		
Belching /Passing gas			Rectal bleeding /Hemorrhoids		
Offensive breath /Bad taste in mouth			Blood /mucus /undigested food in stool		
Trouble swallowing			Liver disease /hepatitis		
Changes in appetite /thirst			Gall bladder disease /stones /removal		
Bloating /Abdominal pain			Jaundice /Yellow skin		
Nausea/Vomiting			Black tarry stool		
Vomiting blood			Hernia		
Ulcers			Food allergies /sensitivities		

Indigestion					

Urinary	C	P		C	P
Pain /Pressure/ Blood with urination			Inability to hold urine /incontinence		
Urgency /Hesitation			Frequent urinary infections		
Increased frequency day or night			Kidney stones /infections		

Male Reproductive	C	P		C	P
Testicular masses /pain			Discharge /Sores		
Prostate problems /BPH /Prostatitis			Sexually Transmitted Infections		
Date of last prostate exam:			Problems with sperm /conceiving		
Are you sexually active?			Birth Control? Type used:		

Female Reproductive

Age menses began:			Average number of days bleeding:		
Length of cycle (# of days from first day of period to day before next period):					
Bleeding between periods	C	P	Irregular cycles	C	P
Heavy flow	C	P	Painful periods	C	P
PMS	C	P	Endometriosis	C	P
Ovarian cysts	C	P	Uterine cysts /Fibroids	C	P
Sexually Transmitted Infections	C	P	Pain/difficulty during intercourse	C	P
Number of pregnancies:			Number of miscarriages/abortions:		
Number of live births:			Difficulties conceiving	C	P
Yeast / Candida infections	C	P	Abnormal pap / Cervical dysplasia	C	P
Vaginal discharge / itching /redness	C	P	Date of last pap	C	P
Birth control	C	P	Type of birth control used:		
Menopause	C	P	Age at menopause:		
Hot flashes / Night sweats	C	P	Vaginal atrophy /dryness	C	P
Decreased / Loss of libido	C	P	Hormonal therapy for menopause	C	P
Are you sexually active?					

Musculoskeletal	C	P		C	P
Joint pain /stiffness/swelling /Arthritis			Broken bones/fractures		
Muscle weakness /spasms /cramps			Back pain		
Sciatica			Have you had a bone density test?		

Endocrine	C	P		C	P
Sensitive to heat / cold			Diabetes		
Thyroid problems			Hypoglycemia (Low blood sugar)		
Excessive thirst / hunger			Hormone / Steroid therapy		
Excessive urination / sweating					

Blood/Lymphatic	C	P		C	P
Anemia			Easy bleeding / bruising		
Past transfusions			Lymph node swelling		
Hemophilia / Clotting problems			Blood type:		

Allergies	C	P		C	P
Drug sensitivity			Reaction to vaccine		
Please list allergies:					

Mental/Emotional	C	P		C	P
Depression			Mood swings		
Sleeping difficulties / Insomnia			Phobias		
Anxiety / Nervousness			Excessive stress		
Substance abuse			Treatment for substance abuse		
Thoughts of suicide / Attempts					

Family Medical History

Has anyone in your family (siblings/parents/grandparents) had the following conditions?		Which family member?	Age
Heart disease / High blood pressure			
Asthma / Allergies			
Diabetes / Blood sugar problems			
Cancer (breast, colon, skin, prostate, lung, etc.)			
Psychiatric (depression, anxiety, addiction, etc.)			
Kidney problems			
Hormonal problems (thyroid, pituitary, estrogen, etc.)			
Congenital / Developmental problems			
Neurological problems (MS, Parkinson's, Alzheimer's, etc.)			
Arthritis			
Digestive (Crohn's, gall bladder, IBS, Celiac, colitis, etc)			
Other			

Please indicate your consumption of the following:

	High	Moderate	Low	None
Salt				
Sugar				
Caffeine				
Tobacco				
Alcohol				
Recreational Drugs				
Water				
Exercise				

Please use this space to add anything else you think would be helpful in forming your treatment plan:

_____

_____

_____

_____

_____

Statement of Acknowledgement

I understand that Krista Ingram is a Naturopathic Doctor (ND) and not a Medical Doctor (MD), and that if a standard medical treatment (e.g. pharmaceutical drugs, surgery) is necessary it must be obtained from a Medical Doctor.

I understand and agree that I have the option of seeking and/or continuing care from a Medical Doctor, and that naturopathic medicine and conventional medicine are not mutually exclusive.

I accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered. I understand that cancelling or rescheduling an appointment must be done one day in advance.

I understand that Krista Ingram, ND, reserves the right to decline or suspend the provision of services.

I understand that my health is ultimately my responsibility and that Krista Ingram, ND, supports me in that endeavour. I am free to accept or reject her naturopathic care and suggestions of my own free will and choice, and can discontinue treatment at any time.

I _____ (print name)
have read, understood and acknowledge the above statements.

Signature_____

Date_____ Witness:_____

Balance
NATURAL HEALTH CLINIC

Cancellation/ No Show Policy

Missed Appointments

When you book an appointment with us, that time is set aside for you - and ONLY you. Please understand that missed appointments prevent us from working with other clients.

Our Cancellation Policy

You may sometimes need to cancel your appointment with us, so we have tried to make our cancellation policy as simple as possible.

If you provide us with:

- **At least 24 hours notice** – there is no charge for cancelling your appointment
- **Less than 24 hours notice** – there will be a $60 charge for the missed appointment
- **Less than 3 hours notice OR you simply don't show up** – we consider this a "no-show" and you are expected to pay 100% of the fee for the missed appointment ($45 for counselling appointments)

If you do not reach us, please leave a message on our voice-mail system. Note that with Monday appointments we will need to hear from you the Friday before as the receptionists do not check voicemail on the weekend and it won't be heard until Monday at 9 am.

Note: We recognize that there are circumstances that are out of your control (sudden illness, family emergencies, etc.) and so your healthcare provider may make an exception to the above policies on those rare occasions. You will need to speak to your service provider directly for an exception.

I understand the above policy and agree to pay for missed appointments and for cancellations with less than 24 hours notice.

Signature: _____ Date: _____

_____
Signature of parent or guardian if client is under 19 years of age