Profile Information — Step 1 of 4

You are completing New Patient Intake form Dr. Nicole Shortt

Hello,

Thank you for booking an initial consultation with Dr. Nicole Shortt.

Your initial consult with Dr. Shortt is a 90 minute appointment at the cost of $375.00 (current pricing subject to change prior to your appointment). We direct bill to Pacific Blue Cross and Greenshield. All other third party benefits will need to be submitted by you for reimbursement.

Please take some time to complete the intake form. You will need 20 minutes or so to complete it as it is very thorough and gives us the best glimpse of your medical history and current concerns.

Please list any medications by name and dosage where applicable. Please ensure you have included your Personal Health Care Number and have completed the consent forms where necessary.

Once your forms are completed, we will update your priority status on our cancellation list. If you do not return your intake forms 48 hours prior to your appointment, you will be taken out of the schedule and your appointment will have to be rescheduled.

We look forward to seeing you soon!

Contact Information

First Name: _____

Last Name: _____

Preferred Name (if different): _____

Please provide at least one phone number. Your mobile number can be used to look up your Account and receive text message appointment reminders.

Mobile Phone: _____

Home Phone: _____

(A mobile phone is required if you would like to receive SMS appointment reminders.)

Street Address: _____

Suite Number (i.e. Suite #100): _____

City: _____

Province: _____

Postal / Zip: _____

Date of Birth (MM/DD/YYY): _____

Sex: _____

This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file or what is indicated on your medical record.

Personal Health Number: _____

Occupation: _____

Guardian: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Emergency Contact Relationship: _____

Family Doctor: _____

Family Doctor Phone (if known): _____

Family Doctor Email (if known): _____

How did you hear about us? _____

Were you referred to a specific practitioner? _____

Credit Card Information — Step 2 of 4

Balance Natural Health Clinic requires that you put a card on file for contactless payments. This helps keep both you and us safe, as well as spend more time with you, rather than taking a payment after your session. This card will also be used for payment if a cancellation is made within 24 hours of the scheduled appointment time.

We accept Visa and MasterCard

Name on card: _____

Card Number: _____

Expiry Date: _____

CVV (digits on back of card): _____

☐ I am aware of the Cancellation Policy. Please read the cancellation policy at the end of this intake form in “Consents – Step 4 of 4”.

Questionnaires — Step 3 of 4

Third Party Insurance/Medical Benefit Coverage

We currently direct bill to Pacific Blue Cross and GreenShield.

Insurance provider: _____

Insured Person's First and Last Name: _____

Plan #: _____

ID: _____

Please list any other current Health Care Providers (MD, Chiropractor, RMT, Counselor, etc.:

_____

_____

Personal Information

Height: _____

Weight: _____

Occupation; _____

Relationship Status: Please circle

Single In Relationship Live in Partner Married Separated Divorced Widowed

Partner/Spouse's Name: _____

# of Children: _____

Children's Ages: _____

Please list and describe your current health priorities / chief concerns.

2

3

4

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

1

2

3

4

5

Please list any current medications, the dose and how long you've been taking them.

1

2

3

4

5

Please list any current natural health supplements, the dose and how long you've been taking them.

1

2

3

4

5

How committed are you to implementing changes to our lifestyle? Rate 0% to 100%: 0= not committed, 100=fully committed

_____

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

_____

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

_____

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

1

2

3

4

5

Review of Systems:

Please check all that apply currently.

Skin & Hair

	Redness/Rashes/Hives/itching		Eczema/Psoriasis
	Shingles		Acne
	Bruises easily		Dryness/cracking skin
	Color Changes/Mole Changes		Nail changes
	Loss of hair		Thinning hair
	Dandruff		Other skin/hair concerns

Neurological

	Headaches		Head Injury
	TMJ problems/Teeth grinding		Dizziness/Fainting/loss of balance
	Numbness/Tingling		Stroke/Aneurysm/Transient Ischemic Attacks
	Seizure/Convulsions/Epilepsy		Speech problems/slurring
	Involuntary movement		Paralysis

Endocrine

	Sensitive to heat/cold		Thyroid problems
	Extensive thirst/hunger		Excessive urination/sweating
	Diabetes		Hypoglycemia (low blood sugar)
	Hormone/Steroid therapy		

Eyes

	Glasses/Contacts		Eye pain/Itching/Discharge

	Impaired vision/Double vision/Blurring		Excess tearing/Dryness/Redness
	Floaters/Blind spots		Glaucoma/Cataracts

Ear

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

Nose/Sinus

	Frequent colds/Stuffiness		Sinus problems/Chronic Congestion
	Allergies/Hay fever		Nose Bleeds
	Sensitive to smells		Change in ability to taste

Mouth/Throat/Neck

	Gum problems/bleeding		Cold sores/Canker sores
	Sore or dry tongue/mouth		Cavities/Fillings
	Frequent sore throat/Hoarseness		Lumps/swollen nodes in neck
	Thyroid problems/Goiter		Neck pain/Stiffness
	Brush Teeth 1-2 times a day		Brush Teeth less frequently than everyday

Respiratory

	Coughing/Wheezing		Sputum/Mucus
	Spitting/coughing up blood		Pain/difficulty breathing/shortness of breath
	Shortness of breath at night/Sleep apnea		Asthma
	Emphysema		Pleurisy
	Tuberculosis		Tuberculin Test
	Do you/have you smoked?		Recent Chest Xray

Cardiovascular

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

Musculoskeletal

	Joint pain/stiffness/swelling/arthritis		Muscle weakness/spasms/cramps
	Sciatica		Broken bones/fractures
	Back pain		Recent Bone Density Test

Blood/Lymphatic

	Anemia		Past transfusions
	Hemophilia/Clotting problems		Easy bleeding/bruising
	Lymph node swelling		

Blood Type: _____

Gastrointestinal

	Indigestion		Pain or discomfort in belly
	Abdominal bloating or distention		Poor appetite
	Excessive Appetite		Weight changes
	Nervous stomach		Full feeling after small meal
	Heartburn		Acid reflux
	Nausea		Vomiting
	Vomiting blood		Gas
	Diarrhea		Constipation
	Changes in Bowel		Rectal bleeding
	Bloody stools		Black/tarry stools
	Undigested food in stools		Rectal itching
	Laxative use		Anal fissures
	Hemorrhoids		Ulcers
	Intestinal parasites		Liver disease
	Jaundice		

Kidney/Urinary Tract

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

Allergies

Drug Sensitivity:

_____

Reaction to Vaccine:

_____

Please list allergies:

_____

Mental/Emotional

	Depression		Sleeping Difficulties/Insomnia
	Anxiety/nervousness		Substance abuse
	Treatment for substance abuse		Mood swings
	Phobias		Excessive stress
	Thoughts/attempts of suicide/self harm		

General

	Fever		Chills/cold all over
	Aches/pains		General weakness
	Difficulty sweating		Sweat easily
	Night sweats		Swollen glands
	Cold hand & feet		Fatigue
	No dream recall		Early waking
	Daytime sleepiness		Weight gain
	Weight loss		

Additional info:

_____

_____

Women's Health

Please indicate dates, number of times/ongoing:

Pregnancy: _____

C-section: _____

Vaginal Deliveries: _____

Miscarriage: _____

Abortion: _____

Living children: _____

Post Partum depression: _____

Toxemia: _____

Gestational Diabetes: _____

Baby of 10lbs or more: _____

Breastfeeding: _____

Date of last breast exam: _____

Urinary Frequency: _____

Are you currently or could you be pregnant? _____

If yes, how many weeks? _____

Are you sexually active? _____

Breast

	Lumps		Puckering of skin
	Pain/Tenderness		Nipple discharge/changes
	Implants/reduction/surgery		Perform self exams
	Family history of breast cancer		Have you ever breastfed?
	Any problems with breast feeding?		

Menstrual History

At what age did you have your first period? _____

At what age did you stop menstruating (menopause)? _____

Are your periods and cycles regular? _____

What is the length of your cycle? (from first day of bleeding to the last day before it starts again)

_____

When was the. first day of your last period? _____

Are you currently using a form of birth control? _____

If yes, what type? _____

Date of last gynecological exam? _____

Have you experienced any of the following:

	Cramping		Irritability
	Anxiety		Mood swings
	Low mood		Bloating/water retention

	Headaches		Breast tenderness
	Cravings		Low back pain
	Clotting		Fibrocystic breasts
	Heavy flow		Light flow
	Weight gain in waist		Weight gain in hips
	Fibroids		Cysts
	Oily skin		Foggy thinking
	Fatigue or drowsiness		Increased facial hair
	Bone loss		Vaginal dryness
	Decreased sex drive		Incontinence
	Loss of scalp hair		Fertility challenges
	Abnormal Pap tests		Vaginal discharge
	Vaginal itching		Nipple discharge

Have you experienced any of the following:

	Fibrocystic breasts		Nipple discharge
	Infertility		Endometriosis
	PCOS		Ovarian cyst
	Ruptured cyst		Iron deficiency anemia
	Fibroids		Myometriosis
	Adenomyosis		Irregular Pap
	Other		

Additional info:

_____

_____

Have you experienced any of the following (functional symptoms):

	Hot flashes		Mood swings
	Vaginal Dryness		Weight gain
	Decreased libido		Urinary leakage
	Concentration/Memory problems		Heavy bleeding
	Palpitations		Other

Additional info:

_____

_____

What type of birth control or hormone replacement have you used in the past or are using now?

	Oral contraception		Diane 35
	Seasonique		IUD (copper or hormonal)
	Depo-Provera		Provera
	Estrace		Premarin
	Other (specify)		

Additional info:

_____

_____

Male Reproductive

Function/Condition (please check all that apply)

	Prostatic Enlargement		Prostate Infection
	Sexually Active		Change in Libdo
	Erectile Dysfunction (achieving or maintaining an erection)		Nocturia (urinate at night)
	Urgency or Hesitancy		Loss of Control of Urine
	Hernia		Testicular mass or pain
	Discharge or sores		Sexually Transmitted Infections
	Recent prostate exam		

Social History

Occupation: _____

Nature of your work: _____

Hours spent sitting: _____

Level of job satisfaction: 0=Completely unsatisfied 10=Completely satisfied

1 2 3 4 5 6 7 8 9 10

How would you currently rate your level of stress at this time? Please check one.

	Minimal		Considerable
	Average		Unbearable

Energy: Please circle one

0 (none) 1 2 3 4 5 6 7 8 9 10 (the most)

Family History

Please check all that apply and list which family member is affected.

	Asthma	
	Arthritis	
	Autoimmune disease	
	Birth defects	
	Bleeding problems	
	Cancer	
	Depression	
	Diabetes	
	Eating disorders	
	Epilepsy	
	Fertility challenges	
	Gout	
	Hayfever/allergies	
	Heart problems	
	High Cholesterol	
	Hypertension	
	Kidney problems	
	Mental disorders / Mood disorders	
	Multiple Sclerosis	
	Obesity	
	Osteoporosis	
	Parkinsons	
	Post-partum depression	
	Stroke	
	Substance abuse	
	Tuberculosis	
	Thyroid problems	
	Other	
	Family History Unknown	

Digestion & Dietary Health

Please indicate your consumption of the following as High, Moderate, Low or None

Salt: _____

Sugar: _____

Caffeine: _____

Tabaco: _____

Alcohol: _____

Recreational Drugs: _____

Water: _____

Exercise: _____

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

_____

_____

Please attach recent blood work and reports if available

Consents — Step 4 of 4

Email Communication

Transactional Emails

You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

	I would like email notifications of new, cancelled, and rescheduled appointments
	Text Message (SMS) 2 days before appointment
	Text Message (SMS) 2 hours before appointment
	Email 2 days before appointment
	Phone Call 2 days before appointment

News and Special Promotions

	Check here to stay connected with clinic news and updates important information from our practitioners and our monthly newsletter. You may unsubscribe at any time.

New Patient Intake form Dr. Nicole Shortt — Consents

Accuracy of Information

☐ I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for

my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

☐ I agree

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged your full visit appointment cost.

☐ I am aware of the Cancellation Policy.

Acknowledgment & Consent to Treatment

Naturopathic Medicine: Naturopathic doctors provide primary and complementary health care by focusing on the scientific use of natural therapies to support and stimulate healing processes.

Naturopathic doctors use standard medical diagnostic tools (physical exam, fitness testing, health history and imaging studies, etc.) Therapies used in naturopathic practice are:

-Botanical Medicine -Clinical Nutrition -Homeopathic Medicine -Lifestyle/Fitness Counseling -Eastern Medicine/Acupuncture -Physical Therapeutic Procedures/Bowen Technique

A confidential record will be kept of your health consults and will not be released without your consent unless directed by law. I permit Dr. Shortt to use her discretion in consulting with other professionals (who are also bound by provincial privacy laws) regarding my health in order to provide me with optimal medical care. (You may look at your file at any time and can request a copy by paying a minimal fee.)

I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I understand that there are health risks involved with Naturopathic Medicine services and I hereby release Dr. Shortt, N.D. and Balance Natural Health Clinic (its employees and owners) from any claims, demands and causes of action arising from my voluntary participation in these services.

I understand that failure to follow Naturopathic prescriptions could undermine the expected results. Naturopathic Doctors reserve the right to determine which cases fall outside his/her scope of practice, in which event an appropriate referral will be made.

I allow communication via Email as it saves resources and response times. Dr. Shortt makes every attempt to prevent computer/internet criminal activity. I understand the inherent risk involved with computer and internet use and release Dr. Shortt from any liability.

All fees for services and supplements are payable at the time of the appointment. There is a fee for completing insurance forms, letter writing, and telephone consultations greater than 5 minutes. Please give 24 hour notice for appointment cancellations as per the clinic cancellation policy form.

I have read and understand the above statements. I intend this consent form to cover the entire course of treatment. I am free to withdraw my consent and/ or terminate my treatment at any time.

☐ I agree

Name: _____

Signature: _____

Date: _____

Please check that all required questions have been answered.