Patient Intake Form

Name: _____ **Date:** _____
(First) (Middle) (Last) (mm/dd/yr)

B.C. Personal Health Number (Care Card): _____
Date of Birth: _____ **Age:** _____ **Gender: M F**
(mm/dd/yr)

Address:
Apt/Suite: _____
Street: _____
City/Province: _____
Postal Code: _____
Telephone: **home: (____)** _____ **work: (____)** _____
Email: _____

Occupation: _____ **Employer:** _____

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

How did you hear about us? _____

Other Healthcare Providers (medical doctor, chiropractor, optometrist, dentist, etc.)

Name	Type of Practitioner (eg. MD, Chiropractor, etc.)	Phone Number (if known)

Do you have any health concerns? Is so, please list them in order of importance.

Complaint	Since	Cause (if known)

What medications do you take? (Please include any regular/frequent over the counter medications.)

Medication	Dose & Frequency	Since	Who prescribed?

What supplements or remedies do you take? (Please include any regular/frequent herbs, vitamins, homeopathics, etc.)

Supplement/Remedy	Dose & Frequency	Since	Who prescribed/recommended?

Are you currently under the care of another physician? Y / N If so, what treatments are you receiving?

_____

What surgery or major injuries have you had? _____

_____

Do you have any known allergies? Y / N Please list: _____

_____

CIRCLE any of the following you have had:

Abscess	Diabetes	Hepatitis	Measles	PMS	Strep Throat
Abortion	Emphysema	High cholesterol	Miscarriage	Prostatitis	Syphilis
Alcoholism	Epilepsy	HIV	Mononucleosis	Rheumatic Fever	Tonsillitis
Anemia	Frequent colds	High Blood Pressure	Multiple Sclerosis	Rubella	Tuberculosis
Arthritis	Gallstones	Influenza	Mumps	Scarlet Fever	Typhoid Fever
Asthma	Genital herpes	Kidney disease	Parasites	Sexual Abuse	Venereal Warts
Cancer	Gonorrhea	Leukemia	Pelvic Inflammatory Disease (PID)	Skin Diseases	Warts
Chicken pox	Gout	Lyme disease	Peritonitis	Sinusitis	Whooping Cough
Cold sores	Hay fever	Low Blood Pressure	Pleurisy		Worms
Depression	Heart disease	Malaria	Pneumonia	Stroke	Yellow Fever

Any other conditions? _____

General Family History:

Relative	Age if alive	Age at death	Conditions
Mother			
Father			
Siblings (please list):			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

CIRCLE if you:

Diet often **Do not exercise regularly** **Are exposed to smoke** **Are under excess stress**
Are exposed to chemicals (past or present) **Are exposed to chemicals at work**

CIRCLE if you regularly use the following:

Alcohol	Candy	Carbonated beverages	Tobacco	Coffee	Non-sugar sweetener
Tea	Margarine	Eat fast foods often	Fried foods	Antacids	Salt without tasting
Laxatives	Sweets	Luncheon meats	Distilled water		

Weight Now: _____ **Weight 1 year ago:** _____ **Maximum weight:** _____
Ideal weight: _____ **Height:** _____

Dr. Ina Wong
Naturopathic Physician
Registered Acupuncturist

#8 - 310 Goldstream Avenue
Victoria, BC V9B 2W3
(250) 478-4057

Fee Schedule, Informed Consent, Authorization, Disclaimer, and Release:

I understand that all services are charged directly to me and that I am responsible for final payment of services regardless of insurance coverage. I consent to treatment as the doctor sees fit and understand that there is no promise or guarantee of improvement in health.
Complications associated with examination and treatment while rare, can occur. Understanding this, I agree to dismiss the doctor of any and all legal liability. I authorize the doctor to release all information and records they deem necessary to secure payment of benefits or benefits to my health.

Fees:

• Initial Examination Consultation for naturopathic and/or acupuncture care	$205.00
• Subsequent Visit for naturopathic and/or acupuncture care	$110.00
• Emergency Visit	$400.00
• House Visit	$400.00
• Professional supplements (if required) are additional.	Variable

Fees are subject to change and do not include taxes if applicable.

Extended Health Plans:

If you have extended coverage, please inquire with your plan administrator or coverage booklet for reimbursement rates and procedures. All fees must be paid in full before submittal for reimbursement.

Please note: Dr. Wong is a naturopathic physician and registered acupuncturist.
Extended health plans may have different coverage for naturopathic and acupuncture care.

Missed Appointments Policy/Cancellations Without 24 Hour Notice:

A time slot is reserved for you. If you are unable to make your appointment, please call to reschedule so that we are able to make this time slot available to others. We reserve the right to charge the full fee for missed appointments.

I have read and understand the above information and agree to the fees concerning my treatment.

Name (please print): _____

Signature: _____

Date: _____