FULL CIRCLE
FAMILY HEALTH CARE
Good Medicine. Naturally.

601 Lake Street
Nelson, BC V1L 4C7
P: (250) 352-3150
F: 1(250)483-1597
www.fullcirclefamilyhealth.com

PERSONAL INFORMATION
(please print clearly)

Today's Date:

Full (Legal) Name:	Are you on MSP Premium Assistance?
Home Address:	BC MSP#:
City/Prov: Postal Code:	Birthdate (M/D/Y): Age:
Mailing Address:	Number of Children: Currently Pregnant?
City/Prov: Postal Code:	Gender:
Home phone:	Family Doctor:
Work phone:	Family Doctor Phone:
Cell phone:	Other Healthcare Provider:
Fax number:	Other Provider Phone:
Email:	Extended Health Insurance Provider:
Emergency Contact (Name):	Occupation:
Relationship:	Employer:
Emergency Contact (Phone):	Hours/week:
Marital Status: Single □ Partnership □ Married □ Separated □ Divorced □ Widowed □	
Live with: Spouse □ Partner □ Parents □ Children □ Friends □ Alone □ Other _____	

HEALTH STATUS

CURRENT HEALTH CONCERNS: list by priority and describe the diagnosis (name of condition), tests performed, symptoms (what you experience), when it started, what makes it better or worse, and what treatments have been used and their effects:

1) _____

_____

_____

2) _____

_____

_____

3) _____

_____

_____

What are your goals for your visits? _____

_____

On a scale of 1 to 10 (1 being very poor, 10 being excellent), rate the status of your health and well-being today: 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY

Childhood Illnesses:		
□ Measles	□ Diphtheria	□ Varicella (Chickenpox)
□ Mumps	□ Pertussis (Whooping Cough)	□ Rheumatic Fever
□ Rubella	□ Tetanus	□ Other:_____
Surgeries:		
Accidents/Injuries/Trauma:		
Hospitalizations:		
Results of Medical Investigations (X-Rays, CT Scans, MRI, EKG, EEG...):		
Infections:		
Degenerative conditions (e.g. rheumatoid arthritis):		
Allergies:		

Genetic/Congenital disorders:
Other diagnoses you have received:
Substance Use: □ Cigarettes □ Alcohol □ Marijuana □ Other Drugs:_____
Immunizations: □ Measles □ Hepatitis B □ Pneumococcus □ Mumps □ PolioV □ Influenza □ Rubella □ Varicella (Chickenpox) □ Tuberculosis (BCG) □ Diphtheria □ HPV □ Meningococcus □ Tetanus □ Hib □ Influenza □ Pertussis (Whooping Cough) Other:_____

Please list the CURRENT MEDICATIONS you are using including dosages, duration of use, reason for use and its effects:

Name	Dosage	Duration	Reason	Effects

List the CURRENT SUPPLEMENTS (e.g. vitamins, minerals, herbs) you are using including dosages, duration, reason for use, and effects:

Name	Dosage	Duration	Reason	Effects

Please indicate if there is FAMILY HISTORY of the following conditions:

□ Asthma
□ Allergies
□ Eczema/Psoriasis
□ High blood pressure
□ Heart disease
□ Stroke
□ Mental illness
□ Depression
□ Alzheimer's
□ Parkinson's
□ Hemophilia
□ Cancer
□ Diabetes
□ Epilepsy
□ Other: _____

NEW PATIENT CHECK-LIST FORM

Please check any of the following health conditions that you have experienced in the past 12 months.

General

- □ Poor sleep
- □ Poor appetite
- □ Chills
- □ Fevers
- □ Night sweats
- □ Sweat easily
- □ Strong thirst
- □ Weight gain
- □ Weight loss
- □ Sudden energy drop
- □ Bleed/bruise easily
- □ Peculiar tastes/smells
- □ Fatigue
- □ Change in appetite
- □ Cravings

Neuropsychological

- □ Depressed mood
- □ Anxiety/nervousness
- □ Tension
- □ Mood swings
- □ Quick temper
- □ Susceptible to stress
- □ Considered suicide
- □ Seasonal depression
- □ Poor memory
- □ Difficulty concentrating
- □ Dizzy/light headed
- □ Fainting
- □ Loss of balance
- □ Lack of coordination
- □ Numbness
- □ Tingling
- □ Concussion
- □ Seizures

Endocrine

- □ Hypothyroid
- □ Hyperthyroid
- □ Heat/cold intolerance
- □ Goitre
- □ Diabetes
- □ Hypoglycemic
- □ Excessive hunger
- □ Excessive thirst

Immune

- □ Chronic swollen glands
- □ Frequent/chronic infections
- □ Slow wound healing
- □ Food allergies
- □ Environmental allergies
- □ Drug allergies
- □ Regular flu shots
- □ Antibiotic use
- □ Autoimmune condition

Skin & Hair

- □ Eczema
- □ Psoriasis
- □ Hives
- □ Acne
- □ Boils
- □ Other rashes
- □ Ulcerations
- □ Itching
- □ Sensitive to touch
- □ Color change
- □ Recent moles
- □ Lumps
- □ Hair loss
- □ Dandruff
- □ Hair dye/bleach

Head, Ears, Eyes, Nose & Throat

- □ Headaches
- □ Migraines
- □ Nose stuffiness
- □ Nose bleeds
- □ Loss of smell
- □ Sinus problems
- □ Earaches
- □ Ear infections
- □ Ruptured tympanic membrane
  Ear tubes
- □ Difficulty hearing
- □ Ear ringing
- □ Eye strain
- □ Glasses/contacts
- □ Spots in eyes
- □ Blurriness
- □ Night blindness
- □ Double vision
- □ Cataracts
- □ Sensitive to light
- □ Tearing/dryness
- □ Eye pain
- □ Itchy/inflamed/infected eyes
- □ Glaucoma
- □ Teeth grinding
- □ Jaw pain/clicking
- □ Gum problems
  Dental cavities
- □ Copious saliva
- □ Dry mouth
- □ Sore tongue/lips
- □ Mouth sores
- □ Hoarseness
- □ Sore throat
- □ Difficulty swallowing
- □ Lump in throat

Respiratory

- □ Chronic cough
- □ Difficulty breathing
- □ Shortness of breath
- □ Pain on breathing
- □ Coughing up blood
- □ Coughing up mucous
- □ Wheezing
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Pneumonia

Cardiovascular

- □ High blood pressure
- □ Low blood pressure
- □ Irregular heart beat
- □ Heart racing/pounding
- □ Palpitations
- □ Murmurs
- □ Congenital heart disease
- □ Dizziness
- □ Fainting
- □ Chest pain
- □ Swelling of hands
- □ Swelling of feet
- □ Cold hands/feet
- □ Varicose veins
- □ Angina
- □ Heart disease
- □ Rheumatic fever
- □ Stroke

Peripheral vascular/Blood

- □ Anemia
- □ Easy bleeding/bruising
- □ Varicose veins
- □ Deep leg pain
- □ Cold hands/feet
- □ Stroke

Gastrointestinal

- □ Change in appetite
- □ Indigestion
- □ Bad breath
- □ Abdominal pain/cramps
- □ Nausea
- □ Vomiting
- □ Heartburn/reflux
- □ Ulcer
- □ H. pylori infection
- □ Gas
- □ Rectal pain
- □ Rectal cuts/fissures
- □ Hemorrhoids
- □ Blood in stool
- □ Black stools
- □ Mucus in stool
- □ Constipation
- □ Diarrhea
- □ Jaundice (yellow skin)
- □ Liver disease
- □ Gallbladder disease
- □ Gallstones
- □ Chronic laxative use

Bowel movements:
How often? _____
Is this a change?_____
Consistency?_____

Genitourinary

- □ Frequent urination
- □ Urgency to urinate
- □ Pain on urination
- □ Wake to urinate
- □ Unable to hold urine
- □ Decrease in flow
- □ Blood in urine
- □ Cloudy urine
- □ Change in color
- □ Change in odor
- □ Kidney stones
- □ Kidney infection/disease

Male Reproductive

- □ Hernias
- □ Testicular pain
- □ Impotence
- □ Premature ejaculation
- □ Testicular masses
- □ Prostate exams
- □ Last exam (date): _____
- □ Prostate disease
- □ Discharge or sores
- □ Herpes
- □ Chlamydia
- □ Gonorrhea
- □ Condyloma
- □ Syphilis
- □ Birth Control

Female Reproductive

Age of first menses _____
Age of menopause _____
Duration of menses _____
Length of cycle _____

- □ Variable cycle length
- □ Menstrual cramps
- □ Heavy menses
- □ Light menses
- □ Bleeding between menses
- □ PMS
- □ Menopausal symptoms
- □ Sexual difficulties
- □ Pain during intercourse
- □ Endometriosis
- □ Ovarian cysts
- □ Fibroids
- □ Regular PAP exams

Last PAP (date): _____

- □ Abnormal PAP
- □ Cervical dysplasia
- □ Vaginal discharge
- □ Vaginal sores
- □ Gonorrhea
- □ Herpes
- □ Chlamydia
- □ Condyloma
- □ Syphilis
- □ Pregnancies: _____
- □ Live births: _____
- □ Miscarriages: _____
- □ Abortions: _____
- □ Birth control

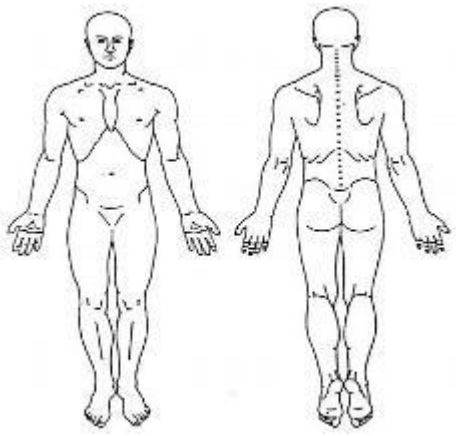
Type: _____

- □ Breast lumps
- □ Nipple discharge
- □ Self breast exams
- □ Mammograms
- □ Regular breast exams

Last breast exam (date):
_____

Musculoskeletal *Please indicate on the attached picture where you are getting pain/stiffness/discomfort with the following symbols.*

A Aching
B Burning pain
S Sharp stabbing pain
C Cramping pain
N Numbness
T Tingling
St Stiffness
W Weakness
□ Broken bones
□ Arthritis
□ Scoliosis
□ Injury



Lifestyle *Please circle the choices that apply to you.*

□ Drink coffee/tea/pop
□ Drink beer/wine/liquor
□ Smoke cigarettes/cigars/marijuana
□ Recreational drug use/abuse
□ Trouble sleeping/relaxing
□ Exercise regularly/rarely
How many hours/week? _____
□ Relationship difficulties
□ Unhealthy/stressful work conditions
□ Other stressful conditions
□ Eat chicken/turkey/eggs/fish
□ Eat beef/lamb/buffalo
□ Eat cold cuts/sausages/hot dogs
□ Eat cheese/yogurt/ice cream/milk
□ Eat bread/pasta/rice/ potatoes/cereal
□ Eat sugar/chocolate/candies/chips
□ Eat fresh/frozen/canned vegetables
□ Eat fresh/frozen/canned fruit
□ Drink tap/filtered/spring water
□ Drink fresh/canned/bottled juices
□ Cook with microwave/aluminum
□ Steam/poach/bake/broil/fry/BBQ foods
□ Eat often in restaurants/fast food
□ Use salt regularly
□ Eat mostly organic/local/non-organic
□ Eat mostly pre-packaged/home made foods

Is there anything else you can think of that affects your health?

_____

_____

_____

FINANCIAL POLICY

MSP POLICY FOR B.C. RESIDENTS

Non-insured Fee (Office Fee): Naturopathic Doctors (ND) are registered with the College of Naturopathic Physicians of BC. There is a fee charged for consultations based on the amount of time spent with the ND. Please review the information below for more details.

Insured Fee (MSP Fee): If you have a valid BC Medical and are receiving MSP premium assistance, you will be reimbursed $23.00 for each consultation (up to a combined maximum of 10 visits). Premium assistance patients are insured for a total of 10 visits per calendar year for any combination of services provided by the following licensed health professionals: Naturopathic Physicians, Chiropractors, Registered Massage Therapists, Physiotherapists, Acupuncturists, and Podiatrists. For example: 8 visits to a Naturopath, 2 visits to a Chiropractor equals the 10-visit insured maximum limit. If you have used up your allowable visits for the year, then no more reimbursements can be issued. We submit an MSP claim on your behalf so that you can receive the partial reimbursement for all eligible consultations. The MSP will mail a cheque directly to your home address (processing will take approximately 6 to 8 weeks).

Extended Health Coverage: Some extended health insurance plans cover Naturopathic services. Please verify with your Extended Healthcare provider whether consultations, testing, and/or treatments are covered under your plan. We will issue a receipt for you to submit to your extended health insurance carrier at each visit.

NATUROPATHIC SERVICES

Consultation	Duration	Fee
Initial visit	60 - 90 minutes	$215.00 to $322.50
Follow-up visit	30 - 45 minutes	$107.50 to $161.25

□ CANCELLATION POLICY: 48-hr notice is required for cancellations or you will be billed a $75 cancellation fee.
□ MISSED APPOINTMENTS: A $75 cancellation fee is charged for missed appointments unless proof of emergency is provided.
□ $25 processing fee for NSF cheques.
□ All products sold are subject to GST.
□ The clinic reserves the right to change fees at any time without notice.
□ Please see the Clinic Policy posted at the Clinic for current fee guidelines and policies.

By signing the bottom of this policy, you are indicating that you have read and understood the above statements and agree to pay upon receiving the products and services as outlined.

Signature: _____ Date: _____

Please indicate, “Yes” or “No”, regarding the use of your email address for Clinic Announcements and appointment reminders:

Yes_____ No_____

INFORMED CONSENT TO NATUROPATHIC TREATMENT

Naturopathic Medicine uses natural approaches to the treatment and prevention of disease. Naturopathic Doctors (ND) take into account physical, mental and emotional aspects of the individual and develop treatment protocols based upon the unique needs of each individual. NDs generally use natural and non-invasive treatment modalities with the intention of stimulating the body's own inherent healing abilities.

Naturopathic Treatment Modalities

Dietary Counseling and Nutritional Supplements
Diet and nutrition are used to address possible nutrient imbalances and/or deficiencies, to treat and/or prevent illness and to improve overall health. This may include recommendations to include and/or avoid particular foods, and the use of nutritional supplements that may include vitamins, minerals and/or other nutrients, plant and/or animal matter, enzymes, or amino acids.

Lifestyle and Wellness Counseling/Coaching
Your ND will help you to identify the lifestyle factors that may be negatively impacting your health. This may include identifying risk factors for illness and providing recommendations for reducing your risk.

Botanical (Herbal) Medicine
Refers to the use of plant-derived products in the treatment and/or prevention of illness and can include teas, tinctures (alcohol-based preparations), baths, topical applications (creams, ointments, etc.), capsules or tablets.

Oriental Medicine and Acupuncture
Can include acupuncture (the insertion of thin, sterile needles into specific points in the skin and underlying tissues, diet therapy, moxa or moxibustion (the burning of a stick of compressed herb over acupuncture needles that have been inserted into the skin and underlying tissue), herbal formulas, and the examination of the tongue and pulse for diagnostic purposes.

Homeopathy
Refers to the use of minute doses of plant, mineral and/or animal matter to treat and/or prevent illness.

Physical Medicine
Physical medicine can include the use of soft tissue and joint manipulation as well as hydrotherapy (the use of hot and/or cold water to manipulate the circulation of blood and lymphatic fluid in the body and to stimulate the immune system.) This may also include the use of Laser therapy to help heal chronic tissue inflammation and injuries by using low-intensity lasers and infrared lights to warm the tissues and improve circulation.

Consultation Visits
Consultations can vary depending upon your requirements or requests. Initial consultations and interpretation of test results take approximately 60 to 90 minutes, while most follow-up consultations are approximately 30 minutes. The initial consultation may include an extensive health history review, a detailed discussion of your main health concerns, and physical examination as required.
Your ND may request information, such as results of recent tests that may have been performed, from your other healthcare practitioners (medical doctor, chiropractor, etc.) in order to create a complete health profile. Your ND may recommend laboratory blood tests, biochemical tests, and/or other tests as required. You will be

informed of the cost of all tests before they are performed and have the right to refuse any test.

Treatment Risks
Naturopathic medicine utilizes primarily non-invasive and low-risk treatment modalities. You will be informed of the cost of all treatments before they are performed and have the right to refuse any treatment. However, all therapies are associated with some potential risks. Side effects from naturopathic treatments are relatively uncommon but can include (but not limited to):
Aggravation of symptoms, allergic reactions to herbs or supplements, complications from acupuncture (pain, bruising, bleeding, lightheadedness or fainting, nausea and vomiting, puncture of internal organs), injury to soft tissues and/or joints/bone/spine arising from the use of physical medicine, accidental burns associated with the use of moxa, or unforeseen interactions between recommended herbs/supplements and over the counter or prescription medications.

Confidentiality
A record of all interactions with your ND including health history, exams/tests performed and treatments recommended will be kept by your ND. This record is kept strictly confidential and is not released to others without written consent provided by you or your representative or unless your ND is required to do so by law. Information from your file may be used for the purposes of research, teaching, or development of treatment protocols. In all cases, your identity will be protected. In the event that you require naturopathic consultation and/or treatment and your regular attending ND is not available, the ND substituting for your regular ND will be permitted full access to your naturopathic health record for the purposes of providing you with appropriate advice and/or treatment.

STATEMENT OF CONSENT

I understand the description of the treatment modalities that my naturopathic doctor may recommend for me. I understand that there may be potential risks and side effects of naturopathic treatment and that my naturopathic doctor cannot anticipate and/or explain all risks and complications that may arise. I agree that any questions or concerns that I may have about my naturopathic care will be addressed with my naturopathic doctor. I understand that my naturopathic doctor, like all medicine, cannot guarantee results. I further understand that advice and/or treatments offered to me by my naturopathic doctor are not intended to substitute for or replace advice and/or treatment provided by my other healthcare practitioners.
With this knowledge I voluntarily consent to the diagnostic and therapeutic procedures outlined above which may be recommended by my naturopathic doctor except for (please list exceptions, if any).

_____

_____

This consent form is intended to apply to the entire course of my care by my naturopathic doctor (and/or naturopathic doctor substituting for him/her). I understand that at any time I may (in writing) withdraw consent for any further treatment and discontinue treatment at any time.

_____ _____
Signature of Patient or Guardian Date