MOMENTUM HEALTH NATUROPATHIC ADULT INTAKE FORM

Thank you for taking the time to complete the following new patient forms to the best of your ability. They are an important step towards defining your health care needs and achieving your health goals. Please scan and email this form back to us before your initial visit, drop it off in advance, or bring this completed form to your first appointment. Please also bring any relevant blood work, testing or health reports. All the answers on this form will be held **absolutely confidential.**

Name: _____ Birthdate:_____
Address: _____ City: _____Prov_____PC:_____
Phone (Home):_____Cell:_____Work:_____
Email: _____ Occupation:_____
Family Doctor: _____Phone#:_____
Referring Professional: _____Phone #:_____
AB Health #: _____Preferred method of communication: _____
Partner/ Spouses name _____
Children's names and ages_____
Emergency Contact (name, relationship): _____Phone:_____
Why did you choose to come to this clinic?:_____
Have you seen a Naturopathic Doctor before? Y/N When: _____Dr_____
Are you aware of the fees for the initial consultation and follow up visits? Y/N
Consent to receive email reminders: ☐ Yes ☐ No Initials: _____
Consent to receive newsletters ☐ Yes ☐ No Initials: _____

Signature of Patient: _____ Date: _____

PRESENT HEALTH CONCERNS:

Please list your most important health concerns in their order of significance. Describe your symptoms in your own words.	How long have you had this concern?

What do you think causes your most important health concerns?

ALLERGIES: (please list your allergy, your reaction and severity on a scale of 1-10)

Medications:_____

Food:_____

Environmental:_____

MEDICATIONS:

Please list any medications or supplements you take regularly (including birth control, allergy medications, painkillers, heartburn medications): _____

_____

_____

PAST MEDICAL HISTORY:

Have you ever been hospitalized Y/N, Why and dates?

_____

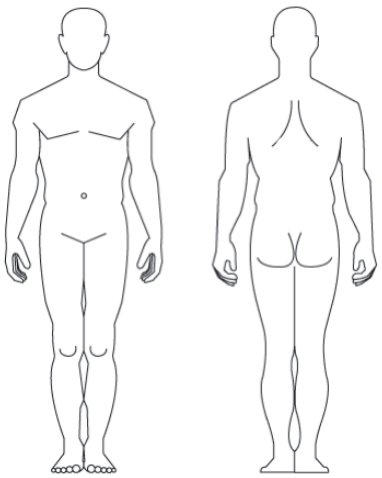
_____

Have you ever had any major accidents, traumas or surgeries? Y/N explain, dates:

_____

_____

PHYSICAL CONDITION:



Please indicate on the diagram the nature of your symptoms using the provided symbols.

Aching	?
Stabbing	✕
Shooting	=
Burning	~
Numbness or Tingling	^

If you have indicated pain above, please explain the onset, duration and frequency with which you experience this pain:

_____

_____

Please describe your current physical activity:

Exercise: Daily 5x Week 3x Week Weekly Monthly or Never

Type (length, aerobic, strength, intensity):_____

PLEASE MARK CONDITONS/ SYMPTOMS YOU PREVIOUSLY OR CURRENTLY EXPERIENCE WITH P or C (P= past, C= current)

☐ **Fever or chills** ☐ **Hot flashes** ☐ **Unusual hair growth** ☐ **Weight change**

☐ **Skin eruptions** ☐ **Joint pain** ☐ **Numbness/tingling** ☐ **Loss of libido**

☐ **Gas/bloating** ☐ **Heartburn** ☐ **Abdominal pain** ☐ **Diarrhea/constipation**

☐ **Nausea/vomiting** ☐ **Headache** ☐ **Dizziness** ☐ **Vision changes**

☐ **Sinus congestion** ☐ **Hearing loss** ☐ **Fainting** ☐ **Chest pain**

☐ **Shortness of Breath** ☐ **Heart Palpitations** ☐ **Cough** ☐ **Wheezing**

☐ **Frequent urination** ☐ **Painful urination** ☐ **Incontinence** ☐ **Anxiety**

☐ **Depression** ☐ **Insomnia** ☐ **Appetite Change** ☐ **Fatigue**

☐ **Poor memory** ☐ **Alcohol/ drug abuse** ☐ **Eating disorder** ☐ **High Blood Pressure**

☐ **Other**_____

_____

WOMENS HEALTH (men do not fill out this section)

MENSTRUAL CYCLE:

Are your cycles regular? _____. Periods begin every _____ days and last for _____ days

What is the color of your menstrual blood? _____ Is the flow heavy or light? _____

Is there clots or strings? _____ Is there spotting between periods? _____

Do you have vaginal discharge? _____ If yes, please describe _____

Rate the following pre-menstrual symptoms from 1-5 (1 minimal to 5 extreme change)

Breast pain/ tenderness _____ PMS Bloating _____ Muscle pain/ back aches _____
Weight fluctuations _____ Edema/ Water retention _____ Moodiness _____
PREGNANCY:
Are you or could you be pregnant? _____ If yes, how many weeks? _____
Do you have problems getting pregnant?_____ Have you ever had a miscarriage? _____
Current birth control method: _____ Past Methods: _____

LIFESTYLE
DIET:
Please describe a typical days diet:
Breakfast:_____
Lunch: _____
Dinner:_____
Snacks: _____Beverages: _____
How MUCH and HOW OFTEN do you consume:
Alcohol: _____
Recreational Drugs (which ones):_____
Caffeine:_____Water:_____Tobacco:_____
Please list your travel history to the developing world in the past 3 years: _____
_____

EMOTIONAL HEALTH:
Please rate the following on a scale of 1 (low) to 10 (high):
Overall stress: _____ Overall energy: _____ How happy you are generally: _____
Stress in the home: _____ Satisfaction in relationship: _____
Have you ever felt sad or depressed for 2 weeks or more at a time in the past year: Y or N
Do you have concerns regarding your emotional or mental health (ie: anxiety, memory loss, voices, hallucinations, depression, binge eating etc)? :
_____
_____
SETTING THE STAGE:
What is your main expectation from this visit: _____
What long term expectations do you have: _____
What expectations do you have of me professionally: _____
What is your present level of commitment to address any underlying causes of your signs and

symptoms that relate to your lifestyle: (1(low)- 10 (high):_____

What behaviors or lifestyle habits do you currently engage in regularly that you think support your health: _____

What potential obstacles do you foresee in addressing lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you:

_____

What do you LOVE to do? _____

How did you hear about Dr. Coombs? _____

Informed Consent For Treatment

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honor to take your care and health seriously. The following document is an agreement between you and I that states that you are entitled to understand any detail you wish about your health condition, treatment and diagnosis. It states that you are aware of the costs of naturopathic medicine (including late cancellation policies), the benefits and potential risks and side effects. Your health is ultimately up to you, therefore you also have the right to refuse any suggested treatment. We are in this together, so be sure to ask any questions you have, no matter what they are, at anytime and I will do my best to fulfill the meaning of doctor (docere) "To Teach".

STATEMENT OF ACKNOWLEDGEMENT

I, _____, as a patient of Dr. Kathryn Coombs, ND, understand that I am being treated under the practice philosophy and scope of naturopathic principles and practices. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my naturopathic doctor because I understand that safe care requires that I truthfully and completely disclose this information. I also will inform my naturopathic doctor if I am pregnant or breastfeeding so that she can take proper precautions for treatment.

I am aware and understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative treatments that may be applicable. I am encouraged to take an active role in my care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that he has answered all of my questions to the best of his ability.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some treatments. This may include, but no limited to: aggravation of pre existing symptoms, allergic reactions to supplements, herbs or pharmaceuticals and bruising or injury from acupuncture or intravenous therapies.

I understand that my naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at anytime. I accept full responsibility for any fees incurred during care and treatment, including a 100% late cancellation fee if providing less than 24 hours notice for cancellation of any appointments. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

Signature (of patient, or legal guardian): _____

Date: _____

PATIENT CONSENT FORM

a. Consent to collect and disclose personal information

Personal information that Momentum Health collects, retains, uses, and discloses may include, without limitation, your name, age, contact information, health benefit information, occupation information, personal health information, medical history, and other information deemed necessary to fulfill the following purposes:

- ✓ To provide assessment and treatment services.
- ✓ To comply with the requirements of professional regulatory bodies, including file audits.
- ✓ To invoice you directly for services provided, and to process payment for those services.
- ✓ To provide information to Third Party Payers, Physicians and Legal Counsel already involved in your care
- ✓ To determine best clinical practices and ensure quality of service by the staff of Momentum Health.

I understand that Momentum Health may use, share, disclose and retain my personal information, in order to fulfill the purposes noted above, or where otherwise permitted by law. I hereby give Momentum Health permission and consent to maintain personal information on file. When requested, I hereby give consent for information to be released as required unless specified in writing.

b. Consent to be contacted

I give consent that I may be contacted at any of the phone numbers and/or mailing addresses provided to Momentum Health. I give consent to Momentum Health to leave messages at my contact number. In the case of a change in address or telephone number, I give Momentum Health consent to release information as needed so that I may be contacted.

c. Signature

Momentum Health requires the patient to agree to the above consents (Consent to Collect and Disclose personal information, Consent for the cost of our services, Consent for payment) prior to the initial treatment consultation. I hereby give Momentum Health my permission and consent for all of the above.

Patient Signature	Date
Witness Signature	Date

BILLING OPTIONS & CREDIT CARD AUTHORIZATION FORM

Billing and Payment:

- ✓ **OPTION 1** – You will pay Momentum Health directly for treatments received at the time of each visit.
- ✓ **OPTION 2** – Momentum Health will bill the insurance company (if on our list of direct billing insurance companies)
  - You are responsible for any portion of the bill that the insurance company does not pay.
  - If the account is overdue by 3 months, you are responsible for the bill and will be reimbursed by the clinic if the insurance company pays.
  - **As Momentum Health may carry an outstanding patient balance for a period of time, a credit card in trust is required for security**. Credit card information/slips will be shredded upon request.
  - You will need to complete a Credit Card Billing Authorization below if you choose Option 2.
  - It can take up to 3 months for insurance companies to inform the clinic of any treatments or portions of treatment not covered.
- ✓ Please be aware that if your claim is denied, you are responsible for any and all charges accrued for your treatment at our facility.

Extended health insurance ** Please provide your policy and ID numbers		
Insurance Company:	Policy Number	Employee ID Number:
Physiotherapy Coverage:	Massage Therapy Coverage:	Chiropractic Coverage:
Yearly Max:	Yearly Max:	Yearly Max:
☐Doctor's note required?	☐Doctor's note required?	☐Doctor's note required?
Details:	Details:	Details:

I, _____, hereby authorize Momentum Health to debit my MasterCard/Visa for charges and all overdue accounts.

a. Credit card information

Card Type:

Card #:

Expiry Date (mm/dd/yyyy) :

b. Consent for Payment and Cancellation Policy

I agree that in the event I cannot attend my scheduled therapy appointment(s) that I will make every effort to notify and inform Momentum Health at least 24 hours prior to my scheduled appointment. If I am unable to give appropriate notice of cancellation, I agree to pay the **FULL VISIT FEE** for missed or late therapy cancellation. Treatment may be suspended until the account has been paid in full.

c. Signature

PLEASE BE AWARE THAT ALL ACCOUNTS NOT PAID BY THE INSURANCE COMPANY, WCB OR THIRD PARTY PAYER FOR WHICH DIRECT BILLING IS POSSIBLE IS THE RESPONSIBILITY OF THE PATIENT. WE ASK THAT YOU SIGN THE SPACE BELOW IN ACKNOWLEDGMENT AND UNDERSTANDING OF YOUR LIABILITY OF ANY COSTS INCURRED BY YOU AT THIS CLINIC.

Signature of Patient _____ Date _____

Printed Name of Patient _____ Date _____