Dr. Balwinder Badhan, ND

NATUROPATHIC PATIENT INTAKE

Date of Initial Appointment: ________________

Name: Birthday: Sex: Weight: Height:

Address:

City: Province: Postal Code:

Home Phone: Cell: Email:

How did you hear about us? Facebook Google Referral In-Store Other____________

Who is filling out this form if not self? (Name and relationship):

Occupation: Marital Status: Number of Children:

Pregnant: Y N If yes, how many weeks: Breastfeeding: Y N

Emergency Contact Name: Phone Number: Relationship:

Name of Medical Doctor: Phone Number:

Have you received *naturopathic* care previously? Y N If yes, when?

Name of practitioner: For what reason?

Health Concerns

What are your main health concerns in order of importance to you?

Vitamins and Supplements

Please list all vitamin/mineral/herbal supplements you are currently taking: **Please bring in all supplement's info (or photo) to initial visit**

Please list all prescription and non-prescription medication you are currently taking: **Please bring in all medications to initial visit**

Please list all prescription medications you have taken in the past for longer than 6 months. Indicate how long you have taken each for:

Family History

Is there a history of any of the following in your family?
Please check and then list relationship of family member beside the condition.

	Alcoholism		Cataracts		Kidney Disease
	Allergies		Celiac		Learning Disability
	Arteriosclerosis		Colitis		Mental Disease
	Arthritis		Depression		Multiple Sclerosis
	Asthma		Diabetes		Schizophrenia
	Bed Wetting		Epilepsy		Tuberculosis
	Candida Albicans		Heart Disease		Yeast Infections
	Cancer		Hyperactivity		

Allergies: Do you have any allergies to any medications/foods/supplements? Yes/No

If yes, please describe the type of medication/foods/supplements:

Medical History

Please list any major illnesses or diseases, any injuries and/or major surgery you have had and when they occurred.

Vaccinations (please check)

	DPT (Diphtheria, Pertussis, Tetanus)		Flu Shot		MMR (Measles, Mumps, Rubella)
	Hepatitis A		Hepatitis B		Chicken Pox
	Polio		Other		

Did you experience any symptoms from them? If yes, please explain.

Diet

	Non-Vegetarian		Vegetarian		Vegan
	For How Long?				
How many cups/bottles/glasses do you drink, on average, per day?					
	Coffee		Milk 2%		Fruit juice
	Tea		Skim milk		Soft drinks (diet)
	Water		Beer		Soft drinks (regular)
	Herbal tea		Wine		Vegetable juice

Review of Symptoms: Please check any of the following that apply to you or write "P" beside the box if you have experienced any in the past.

General

	Fatigue		Night sweats		Sleep problems
	Change in appetite		Allergies		Hours of sleep per night
	Change in thirst		Heat or cold intolerance		Sudden drop in energy (time?)
	Bleed or bruise easily		Cancer		

Skin

	Rashes/hives/itching		Hair changes (colour/quantity)		Skin ulcers/skin cancer
	Eczema/psoriasis		Changes in skin color		Warts
	Nail changes (strength/shape)		Excess dryness/moistness		Recent moles
	Acne/boils				

Head, eyes, ears, nose, and throat

	Headache		Blurred/double vision		Ringing in the ears
	Problems with jaw joint/TMJ		Use of glasses		Poor hearing
	Head injury		________Date of last eye exam		Sinus issues
	Migraines		Cataract		Frequent colds
	Dizziness		Floaters/blind spot		Mercury dental fillings
	Light-headedness		Earache/infection		Cold sore/ canker sore
	Eye pain		Excess ear wax		Swollen glands

Heart and circulation

	High blood pressure		Irregular heartbeat		Varicose veins
	High cholesterol		Palpitation/fluttering		Blood clots
	Heart disease		Chest pain		Cold hands and feet

Neurological

	Fainting/loss of consciousness		History of concussion		Twitching
	Seizures		Loss of sensation		Tremors
	Speech problems/slurring		Numbness/tingling		Memory problems

Endocrine

	Thyroid problems		Weight gain		Hormone replacement therapy
	Diabetes		Weight loss		

Musculoskeletal

	Joint pain / stiffness		Muscle weakness		Osteoporosis
	Sciatica		Muscle spasm / cramp		

Urinary

	Pain / burning while urinating		Urinary tract infections		Kidney problems
	Inability to hold urine		Blood in urine		Kidney stones/infection
	Urgency/hesitation				

Sexual Health

	Sexually active		Sexually transmitted infection		Contraception use

Informed Consent

Please note that this form must be signed prior to your first appointment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle techniques are generally used to stimulate the body's inherent healing capacity. Dr. Badhan, ND, will take a thorough case history, perform a physical examination, which can include a breast exam, and take blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate, or genital exams.

There are some slight potential risks associated with treatment by naturopathic medicine. These include but are not limited to:

- *Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.*
- *Some patients experience allergic reactions to certain supplements, herbs & IV ingredients. Please advise your clinician of any allergies you may have.*
- *Pain, bruising or injury from venipuncture or acupuncture or parental therapy.*

It is particularly important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient, you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

I understand:

- *That naturopathic treatments and conventional treatments are not mutually exclusive and therefore I am free to seek or continue medical care from a qualified physician.*
- *The clinic does not guarantee treatment results.*
- *That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.*
- *I am free to withdraw my consent and to discontinue treatment at any time.*

CANCELLATION POLICY

Please note a no-show appointment is a loss of income for our practitioners and delays our work and full visit charge will apply. When you must cancel, please give us at least 24 hours notice. We are rarely able to fill a cancelled session unless we know at least 24 hours in advance. If you are unable to provide at least 24 hours notice when you cancel, half of the total visit charge as cancellation fee will be applied.

____ ____________________

Patient or Lawful Representative Signature *Date signed*

____ *Full Name Printed*

Dr. Balwinder Badhan, N.D.

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

INTRAVENOUS THERAPY INFORMED CONSENT

1. The patients have the right to be informed of the intravenous procedure, any feasible alternative options, and the risks and benefits of the treatment.

   a) The IV procedure involves inserting a needle into your vein or muscle and injecting the formula described by your naturopathic doctor.
   b) Alternatives to IV therapy include oral supplementation and/or dietary and lifestyle changes.
   c) Risks of IV therapy include but not limited to:
      i) Discomfort, bruising, and pain at the injection site
      ii) Rarely: Inflammation of the vein used for injection (phlebitis), metabolic disturbance and injury
      iii) Extremely Rarely: Allergic reactions, severe anaphylaxis, infections, cardiac arrest and even death.
   d) Benefits of IV therapy include:
      i) Injectables are not affected by stomach or intestinal disease.
      ii) Total amount of infusion is available to the tissues.
      iii) Nutrients are forced into the cells by means of high concentration gradient.
      iv) Higher doses of nutrients can be given than is possible by mouth without causing intestinal irritation.

2. The patient has the right to consent to or refuse the proposed treatment at any time during the procedure. Your signature on this form affirms that you have given your consent to the procedure(s) described above with any different or further procedures, which, in the opinion of your naturopathic doctor, may be indicated.
3. The procedure will always be performed by or under the direction of a naturopathic doctor. I (patient) rely on Naturopathic doctor to exercise judgment during course of treatment.

I (patient) understand that all the nutrient infusions given by the Naturopathic Doctor at the Clinic are considered investigational/experimental. I am aware that other unforeseeable complications could occur. I do not expect the Naturopathic Doctor to anticipate or explain all the risks and possible complications. My signature below indicates the following:

a) I understand and acknowledge the information and risks explained on this form and agree to the proposed treatment.
b) The procedure(s) set forth has been adequately explained to me by my naturopathic doctor.
c) I have received all the information and explanation I desire the procedure.
d) I have been adequately informed & explained by Naturopathic Doctor that I need to eat well within 3 hours before starting IVs and to keep myself well hydrated during and after IVs to avoid any undesired side effects of IV therapy.
e) I understand and acknowledge the cancellation policy for IV treatments.

PLEASE NOTE that IV solutions need to be prepared the same concerning day of the treatment. If you must cancel your appointment for any reason, you must do so at least **3 hours before** your scheduled appointment time otherwise the IV bag/fluid in syringe will have to be discarded and you will be responsible for the cost of the treatment.

Patient Name: (Please print name): ____________________

Signature of Patient or Guardian: ____________________ Date: ____________________

Witness: ____________________