Patient Information

Date: _____ Alberta Health Care #: _____

Name: _____ Phone: _____ (H/W/C – circle)

Address: _____

Email: _____

Birth Date: _____ Age: _____ Country of Birth: _____ Gender: M F

Occupation: _____

Marital Status: _____ Name of Spouse: _____

# of Children (include age, gender): _____

Emergency Contact: _____ Phone: _____

Current Medical Doctor: _____ Phone: _____

Please list any other practitioners you currently seeing (e.g. Naturopaths, massage therapists, chiropractors, specialists, other):

Practitioner: _____ Phone: _____

Practitioner: _____ Phone: _____

Practitioner: _____ Phone: _____

Practitioner: _____ Phone: _____

Date of last physical exam: _____

How did you find out about the clinic: _____

Do you have extended Medical Coverage: Y N Insurer: _____

If yes, what services are covered: _____

Chief Health Concerns

What are your health concerns, in order of importance to you:

1. _____

2. _____

3. _____

List any other concerns you may want to discuss:

_____

_____

What are your short-term goals (within the next 6 – 12 months)?

_____

_____

What are your long-term goals (2 – 5 years)?

_____

_____

Medical History

How would you describe your general state of health?

Excellent Good Fair Poor

Please list all past & present injuries, surgeries and/or hospitalizations? Include approximate date(s) or age.

_____

_____

_____

Please list all allergies (medications, environmental, foods, other)?

_____

_____

Have you ever had a reaction to anesthetics? Y N (local or general)

List ALL current medications (prescription, over-the-counter, vitamins, herbs, etc), with dose and frequency that you take them:

_____
_____
_____
_____

Have you ever been treated with antibiotics, and if so approximately how many times?
_____

Do you frequently ingest any of the following?

			Details: What & How often?
Laxatives	Y	N	_____
Antacids	Y	N	_____
Aspirin/Tylenol/Advil	Y	N	_____
Caffeine	Y	N	_____
Alcohol	Y	N	_____
Cigarettes	Y	N	_____
Recreational Drugs	Y	N	_____
Dairy	Y	N	_____
Sweets/Sugar	Y	N	_____

Do you have regular screening tests done by a doctor? (Pap, blood tests, etc.) Y N

Date of last Pap: _____

Have you ever had an abnormal Pap result? Y N

Date of last blood tests: _____

Date of last prostate exam: _____

Height: _____

Weight: _____

Diet

Please list all known food allergies or intolerances? Do you avoid these foods?

_____
_____

Do you avoid any other foods for other reasons (e.g. vegetarian/vegan, etc)?

_____

Health History (present & past)

Indicate if you have or have had any of the following:

- ☐ Allergies
- ☐ Asthma
- ☐ Headaches/Migraines
- ☐ Sinusitis
- ☐ Osteoporosis/Osteopenia
- ☐ Gallstones
- ☐ Appendicitis
- ☐ Tonsillitis
- ☐ Kidney stones
- ☐ Kidney conditions
- ☐ Arthritis (any)
- ☐ Gout
- ☐ Heart condition
- ☐ Heart attack
- ☐ Anemia
- ☐ Blood disorders
- ☐ Malaria
- ☐ Stroke
- ☐ Thyroid condition
- ☐ High/Low Blood Pressure
- ☐ Eczema
- ☐ Psoriasis
- ☐ Skin Conditions
- ☐ Diabetes
- ☐ Obesity
- ☐ Multiple Sclerosis
- ☐ G6PD Deficiency
- ☐ Sexually Transmitted Infections
- ☐ Rubella/Measles/Mumps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Chicken Pox/Shingles
- ☐ Herpes (face or genital)
- ☐ Warts
- ☐ Tuberculosis
- ☐ Parasites
- ☐ Epilepsy
- ☐ Mental Illness/Depression/Anxiety
- ☐ Abuse
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ PMS
- ☐ Miscarriage or Abortion
- ☐ Erectile dysfunction
- ☐ Frequent Colds/Flu

Please list all other notable past & present medical conditions?

_____

_____

Do you exercise regularly? Y N

What type of exercise, how much, how often?

_____

_____

What are your hobbies and interests?

_____

Please list your primary sources of stress.

_____
_____

Is there anything that you feel that is important that hasn't been covered?

_____
_____
_____
_____

CONSENT TO TREATMENT

1. I understand that Lacey Gerbrandt, ND is a Naturopathic Doctor, and will primarily use natural, minimally-invasive methods of assessment and treatment.

2. I understand that any advice given to me as a patient from Lacey Gerbrandt, ND, is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.

3. I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in Canada.

4. I understand that the Naturopathic Doctor reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.

5. I understand that I am accepting or rejecting this care by my own free will.

6. I understand that no employee at Vita Sana Naturopathic Wellness Clinic including Lacey Gerbrandt, ND, is suggesting that I refrain from seeking the advice of another health care provider.

7. I understand that the services offered here are not typically covered by Alberta Health, and that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.

8. I understand that 48-hour notice is required for appointment cancellation. Cancellation fees may apply.

I _____ have read, understood and agree to the above statements.

Signature_____ Date_____