Integrated Health Clinic™
Cancer Care Centre FORT LANGLEY, BC

NEW Cancer PATIENT INTAKE FORM – **ADULT**

Today's Date: _____ /_____ /_____ Date of Birth: _____ /_____ /_____
MM DD YYYY MM DD YYYY

Patient Name: _____ Preferred Name: _____
(First) (Middle Initial) (Last)

Age: ____ Gender: ____ Wt: _____ Ht: _____ Marital status:_____ # Children & ages: _____

Care Card #: _____

Home Address: _____ City: _____ Prov/State: _____

Country: _____ Postal Code: _____ Email: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Emergency contact: Name: _____ Relationship: _____ Phone: _____

Family Doctor: _____ Specialists: _____

Other Health Care Provider(s): _____

How did you hear about us? _____

Medical Information

Allergies, if known (medical, environmental, foods):_____

Dietary Restrictions, if any (religious/vegetarian/vegan):_____

Current Medication/s & dosage: _____

(Prescription, over-the-counter, vitamins) _____

_____

Past prescription medications: _____

_____

Past serious conditions, illnesses, injuries and/or hospitalizations & dates:

_____

_____

Family Health History: Has a close relative (parent, grandparent, sibling) had any of the following?

- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Cancer / Type(s) _____
- ☐ Eczema
- ☐ Endometriosis
- ☐ Gallstones
- ☐ Heart Disease
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Multiple sclerosis
- ☐ Osteoporosis
- ☐ PMS
- ☐ Skin disease
- ☐ Stroke
- ☐ Tuberculosis

Other medical conditions? _____

Your general state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list your health concerns, in order of importance to you:

1. _____ 3. _____
2. _____ 4. _____

2nd Floor - 23242 Mavis Avenue | P.O. Box 39 | Fort Langley, BC, V1M 2R4 | phone: 604.888.8325 | fax: 604.888.8365
email: info@integratedhealthclinic.com | www.integratedhealthclinic.com

General Health Information

Do you use any of the following? List the type and frequency if applicable:

Alcohol: _____
Antacids: _____
Caffeine: _____
Laxatives: _____

Cigarettes: _____
Recreational drugs: _____
Tylenol/Aspirin/Advil: _____

Number of antibiotic treatments in last 5 yrs: _____

History of adverse reactions to immunizations: ☐ Yes ☐ No If Yes, please describe: _____

_____

Are you currently pregnant? ☐ Yes ☐ No
Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) ☐ Yes ☐ No
If Yes, please describe:

_____

Have you ever had an abnormal pap, if applicable? ☐ Yes ☐ No

Typical diet, very generally:

Breakfast:_____
Lunch:_____
Dinner: _____

Snacks:_____
Beverages (Type & Amount):_____
_____

Occupation: _____ Spiritual beliefs/Religion: _____

Hobbies _____

Do you exercise regularly? ☐ Yes ☐ No Type:_____ Frequency:_____

Are you regularly, or have you ever been exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____

_____

How would you describe the emotional climate of your home? (Indicate levels of stress if applicable)

_____

_____

How stressful is your work, or other aspects of your life? How do you manage stress?

_____

_____

Is there anything that you feel may be important for us to know?

_____

_____

_____

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Cancer Specific Information

Please identify in detail any symptoms you are currently experiencing (pain, nausea, diarrhea, headaches, etc.)

_____
_____
_____
_____
_____
_____

If you are currently undergoing any conventional cancer treatment, please identify below:

Chemotherapy: _____
Radiation Therapy: _____
Surgery: _____
Other: _____

If you are currently engaged in a form of alternative cancer treatment, please identify below:

_____
_____
_____
_____

Please assess the level of pain you may be experiencing and provided a rating based on the scale below _____.

Pain scale: provide a number between 1 & 10, 1 - being no pain, 10 – being extreme pain

Please assess your overall Quality of Life (QOL) and provide a rating based on the scale below _____.

Karnofsky QOL Scale

100	Normal no complaints; no evidence of disease.
90	Able to carry on normal activity; minor signs or symptoms of disease.
80	Normal activity with effort; some signs or symptoms of disease.
70	Cares for self; unable to carry on normal activity or to do active work.
60	Requires occasional assistance, but is able to care for most of his personal needs.
50	Requires considerable assistance and frequent medical care.
40	Disabled; requires special care and assistance.
30	Severely disabled; hospital admission is indicated although death not imminent.
20	Very sick; hospital admission necessary; active supportive treatment necessary.
10	Moribund; fatal processes progressing rapidly.
0	Unresponsive

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Informed Consent to Treatment

1. **I understand that the practitioners at this health centre are Naturopathic Physicians, and will use only natural, non-invasive methods of assessment and treatment.**
2. **I understand that any advice given to me as a patient at Integrated Health Clinic 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 qualified health care provider.**
4. **I understand that the Naturopathic Physician 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 or physician at Integrated Health Clinic is suggesting to me to refrain from seeking the advice of another health care provider.**
7. **I understand that the services offered here are not covered by MSP, and that fees are payable at the time of appointment, including fees for services, prescriptions, and laboratory tests.**
8. **I understand that a minimum of 24 hours' notice is required for appointment cancellations, otherwise I will be responsible for payment of a cancellation fee billed at 100% of the service fee.**
9. **I understand that any therapies recommended will be explained to me in full by the physician, and that I will give consent to treatment based on informed consent.**

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

Signature: _____

Date: ___/___/_____
MM DD YYYY

Integrated Health Clinic™
Cancer Care Centre FORT LANGLEY, BC

Informed Consent for Communication

We value our relationship with you and would like to send you information electronically relating to Integrated Health Clinic. In order to do this, we are collecting your consent to receive electronic messages from us in the form of *appointment reminders*, newsletters, upcoming events and other clinic information. Please take a moment to select either "OPT IN" or "OPT OUT". Opting in will provide Integrated Health Clinic consent to communicate with you electronically. Opting out will indicate that you do not wish to receive any electronic communication from us.

☐ **OPT IN** ☐ **OPT OUT**

Signature: _____

Date: ___/___/_____
MM DD YYYY

Thank you for taking the time to complete this intake form. We look forward to working with you to optimize your health and well being.

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Integrated Health Clinic™
working together for your health FORT LANGLEY, BC

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Records of Release Authorization for:

Patient's full name: _____

Date of Birth: ____/____/____ PHN: _____
MM DD YYYY

Requested Records Release Authority:

I authorize the receiving Doctor or Facility to fax a copy of my complete medical records to the Integrated Health Clinic at fax #: 604.888.8365. I release you from any and all legal responsibility or liability that may arise from this authorization.

Requested Records include the past six (6) months for:

X Lab Results **X** Pathology Report **X** Imaging Results

X Consultation Letters **X** Other records as necessary

Send To:

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Note to Patients: The BC Medical Association instated a $32.69 fee for the transfer of records between medical offices. If your Doctor or medical facility charges our clinic for the transfer, please be advised that you will be responsible for covering this fee.

Date Requested: ____/____/____ Signature: _____
MM DD YYYY