Integrated Health Clinic - Cancer Screening & Prevention Program (CS&PP)

We would like to welcome you as a new patient of the IHC CS&PP and thank you for choosing us for your cancer screening and prevention needs.

In order to help your doctor prepare for your upcoming visit we ask that you please complete the attached documents:

1. **New Patient Intake form:** This form captures important past & present personal and medical information. Pertinent details of your family medical history are also requested. Please complete to the best of your ability.
2. **Release of Records document:** This document provides your doctor with authorization to reach out to your other health care providers (family doctor, specialists, etc.) to request your medical history documentation.

This is a fillable PDF document that needs to be downloaded to your desktop, completed and saved to your desktop. Then it can be sent back to us as an email attachment. Please be advised that some fields are mandatory and must be completed to proceed. Others are optional based on your individual circumstance.

If you have **relevant medical history documentation** that you have already collected through your healthcare journey, please attach to the email as well. Documentation you may want to provide include:

1. Recent diagnostic imaging reports (copies of reports from CT, MRI, PET, etc.).
2. Recent lab tests (blood work).
3. Recent consultation notes from your health care provider or other specialists.
4. Surgical operative reports that may be pertinent to your discussion with the doctor.

Clinic Information

FORT LANGLEY LOCATION

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

WHITE ROCK LOCATION

Suite #101 – 13585 16th Avenue | Surrey, BC, V4A 1P6 | phone: 604.888.8325 | fax: 604.888.8365
email: cancercare@integratedhealthclinic.com | www.integratedhealthclinic.com

Personal Information

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

PHN / Care Card #: _____

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

Preferred Name: _____

Age: _____ **Gender:** _____ Wt: _____ Ht: _____

Marital status: _____ **# Children & ages:** _____

Home Address-1: _____

Home Address-2: _____

City: _____ **Prov/State:** _____

Country: _____ **Postal Code:** _____

Email: _____

Home Phone: _____ **Work Phone:** _____ **Cell:** _____

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

Family Doctor/Clinic: _____

Specialists/Location: _____

Other Health Care Provider(s): _____

How did you hear about us? _____

Personal Medical History Information

Please list your current primary health concerns

1._____

2._____

3._____

4._____

YES	NO	Condition	Comments
		FOR MEN & WOMEN	
☐	☐	A change in bowel habits, such as diarrhea, constipation, or narrowing of the stool, that lasts for more than a few days	
☐	☐	Rectal bleeding	
☐	☐	Dark stools, or blood in the stool (poop)	
☐	☐	Cramping or abdominal pain	
☐	☐	Weight loss	
☐	☐	Fatigue, lack of energy	
☐	☐	Changes to appetite	
☐	☐	Changes in appearance of one or both nipples and/or nipple discharge	
☐	☐	General pain in/on any part of the breast	
☐	☐	Irritated, peeling, flaking or itchy breasts	
☐	☐	Change in breast color, size, shape, or touch?	
☐	☐	Peeling or flaking of the nipple skin	

☐	☐	Any chest pain, chronic cough, or bloody sputum	
☐	☐	Drenching night sweats	
☐	☐	Severe headaches or seizure activity	
FOR WOMEN			
☐	☐	Vaginal bleeding	
☐	☐	Unusual vaginal discharge or odor	
☐	☐	Pelvic Pain	
FOR MEN			
☐	☐	Blood in urine or semen	
☐	☐	Changes to urination	
☐	☐	Pain on urination or ejaculation	

History of Cancer: ☐ Yes ☐ No

If yes, please describe

_____

_____

_____

Have you received any of the following conventional cancer treatments:

Chemotherapy: _____

Radiation Therapy: _____

Surgery: _____

Immunotherapy: _____

Other: _____

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

_____

_____

History of other Medical Conditions. Please select and describe to the best of your ability any of the following:

Skin

- ☐ Fair-skin, light eyes, freckles, red/blonde hair. _____
- ☐ Many moles. _____
- ☐ History of skin cancer(s). Type: _____
- ☐ History of sunburns. Estimated number of times:_____
- ☐ Suntanning beds. Estimated number of times:_____

Head/ears/eyes/nose/throat

- ☐ Head (concussions, brain injuries, mouth, etc.) _____
- ☐ Ears _____
- ☐ Eyes _____
- ☐ Nose _____
- ☐ Throat (thyroid, larynx, trachea, tongue, etc.) _____

Cardiovascular Conditions

- ☐ Heart related disease _____
- ☐ Coagulation disease (Clots, etc.) _____

Pulmonary Conditions

- ☐ COPD, emphysema, asthma, etc. _____
- ☐ TB, Chronic bronchitis, repeated lung infections, etc. _____

Smoking tobacco

- ☐ Never smoker (<100 cigarettes)
- ☐ Previous smoker (# of years) _____
- ☐ Current smoker (total # of years) _____

Abdominal Conditions

- ☐ Esophagus, stomach, pancreas, liver, spleen _____
- ☐ Intestines (small/large) _____

☐ Kidney, ureter _____

Pelvic Conditions (genitourinary)

☐ Sexual organs/reproductive tract. Explain: _____

☐ Urinary tract, bladder, urethra _____

☐ Rectum/sigmoid _____

Musculoskeletal Conditions

☐ Arthritis. Type: _____

☐ Autoimmune conditions. Type: _____

Mental Health Conditions (further questions included in the NCCN Distress Thermometer)

☐ Diagnosed condition. Please explain: _____

_____

☐ Current symptoms. Please explain: _____

_____

Family History Information

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

☐ Arthritis	☐ Endometriosis	☐ Mental illness	☐ Stroke
☐ Asthma/eczema	☐ Gallstones	☐ Multiple sclerosis	☐ Tuberculosis
☐ Diabetes	☐ Heart Disease	☐ Osteoporosis	
☐ MSK	☐ Lung disease	☐ PMS	
☐ Colitis/Crohn's	☐ Kidney disease	☐ Skin disease	

Family history of Cancer ☐ Yes ☐ No

Type(s): _____

Relationship(s): _____

Other medical conditions? _____

_____

Social History Information

Alcohol drinking

- ☐ Never or only during special occasions _____
- ☐ ≤ 4 drinks/week
- ☐ ≥ 5 drinks/week

Typical diet, very generally:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (Type & Amount):_____

Occupation: _____

Spiritual beliefs/Religion: _____

Hobbies: _____

Physical activity

- ☐ 7 days/week. Explain _____
- ☐ Active 3-5 days/week. Explain _____
- ☐ Active 1-2 days/week. Explain _____
- ☐ Sedentary. Explain _____

Sexual history

- ☐ Number of partners _____
- ☐ High risk behaviours. Explain _____
- ☐ STD history. Explain _____

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?

_____

_____

Other Medical Information

Current Medication/s & dosage: _____

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

_____

_____

Past prescription medications: _____

_____

_____

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

_____

_____

_____

_____

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

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

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

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 agreed to the above statements.

Signature: _____ Date: _____

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: _____

Release of Records Authorization for:

Patient's full name: _____

Date of Birth: _____ PHN: _____

Requested Records Release Authority:

Fax to: Doctor _____ Fax #_____

Faxed to: Facility _____Fax #_____

I authorize my 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 _____ months for:

☐ Lab Testing Results ☐ Diagnostic Imaging Results ☐ Pathology

☐ Consultation Letters ☐ Other applicable records

Please Send Requested Documentation To:

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or Email: cancercare@integratedhealthclinic.com
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Note to Patients: The BC Medical Association instituted 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: _____ Patient Signature: _____