Dr. Hayley Owens ND

Naturopathic/Acupuncture Adult Intake Form

Personal Information

Name:		Today's Date:	Gender: ○ M ○ F
How did you hear about Dr. Owens?		Age:	DOB:
Address:	City:	Province:	Postal Code:
Home Phone:	Marital Status: ○ Single ○ Married ○ Divorced		
Work Phone:	Occupation:		
Cell Phone:	Spouse/Partner:		
Email:	Emergency contact:		
Emergency relationship:	Emergency phone:		
Primary care doctor:	Phone:		
Address:			

Please list any other health care providers: _____
(name, title, phone #) _____

Where can we leave information concerning your health? ○ Work # ○ Cell # ○ Home # ○
Other:_____

Email Correspondence? ○ Yes ○ No Dr. Owens may correspond with me at the above email address.

Cancellation Policy: Dr. Owens requires a minimum of 24 hours notice for any cancellations or changes to your appointment. A fee will be charged to your account for missed appointments.

Signature: _____

Any life threatening allergies drug, food, other? ○ Yes ○ No To what?

If you are female, are you pregnant or breastfeeding? ○ Yes ○ No ○ Maybe

How many times have you been on antibiotics? _____	Date of Last Physical Exam? _____
Do you follow a special diet? _____	Date of Last Blood Work? _____

Present Health Concerns/Goals (Please begin with the most important)

1)	Is the condition: ○ Better ○ Worse ○ Same	For how long:
2)	Is the condition: ○ Better ○ Worse ○ Same	For how long:
3)	Is the condition: ○ Better ○ Worse ○ Same	For how long:
4)	Is the condition: ○ Better ○ Worse ○ Same	For how long:
5)	Is the condition: ○ Better ○ Worse ○ Same	For how long:

Have any these conditions been evaluated? ○ Yes ○ No **Condition:** ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Is your goal in receiving Naturopathic treatment to resolve just the issues presented above, or to achieve optimal health?

Medical History (Check all that apply in past 12 months)

General
- Allergies food Seasonal
- Chills
- Fainting or Dizziness
- Fatigue
- Fever
- Forgetfulness/Difficulty concentrating
- Headache
- Intolerant to exercise
- Change in appetite
- Loss of sleep
- Weight change loss gain
- Numbness
- Chemical/metal exposures
- Sweats (Night/Day)
- Cold Intolerance(Night/Day)
  - Whole body
  - Hands/Feet Other: _____
- Heat Intolerance(Night/Day)
  - Whole body
  - Hands/Feet
  - Other: _____

Muscle/joint/Bone
Pain, stiffness, weakness or numbness in
- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders
- Other: _____
- Pain or swelling in joints
- Loss of range of motion
- Bone pain

Genitourinary
- Blood in urine
- Color change in urine
- Frequent urination: day/night
- Lack of bladder control
- Painful Urination
- Difficulty Urinating
- Kidney Stones

Gastrointestinal
- Appetite, poor
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Cravings: _____
- Gas or Bloating
- Belching, excessive
- Hemorrhoids
- Indigestion
- Reflux or Heartburn
- Nausea
- Rectal bleeding
- Stomach Pain
- Vomiting
- Vomiting blood
- Blood or mucous in stool
- Other:_____
- # of bowel movements per day: _____

Cardiovascular
- Chest pain
- Heart flutters or skips
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Water retention
- Varicose veins
- Anemia

Pulmonary
- Persistent cough
- Spitting up blood/phlegm
- Shortness of breath
- Difficulty breathing
- Frequent colds/flu (>2/year): #_____

Eye/ Ear, Nose, Throat
- Painful/Bleeding gums
- Loss of taste
- Sore lip/tongue/mouth
- Metal fillings
- Difficulty swallowing
- Hoarseness
- Feeling of lump in throat
- Enlarged glands
- Dental problems
- Jaw pain
- Ear ache/plugged
- Ear discharge
- Ringing in the ears
- Loss of hearing
- Loss of balance
- Nasal congestion
- Post-nasal drip
- Nose bleeds
- Sinus problems
- Loss of smell
- Hay fever
- Crossed eyes
- Eye: pain, swelling, red, dry or itchy
- Double vision
- Vision-Blurry, Flashes or Halos
- Vision-Light Sensitivity

Skin/Hair/Nails
- Acne
- Bruise easily
- Discoloration of skin
- Hair loss or excess
- Excessive Dryness
- Hives
- Itching
- Change in moles
- Rash
- Scars / Stretch marks
- Sore that won't heal
- Weak: brittle nails/hair
- Eczema or Psoriasis

Men Only
- Urgency/frequency
- Erection difficulties
- Lump or pain in testicles
- Penis discharge
- Sore on penis
- Other

Last PSA:_____

Women Only
- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Breast Tenderness
- Extreme menstrual pain
- Hot flashes
- Irregular menses
- Miscarriages
- Nipple discharge
- Osteoporosis
- Vaginal discharge
- Vaginal itchiness
- Vaginal dryness

Other:_____

Last period:_____

Last PAP:_____

Last Mammogram:_____

Are you pregnant Y N

Number of children:_____

Sexual/Emotional
- Low or High sex drive
- Painful intercourse
- History STI (STD)
- Depression
- Anxiety or worry
- Irritability/Anger
- Any form of abuse
- Using contraception

Past surgeries, hospitalizations, accidents or major illnesses (including food poisoning etc.)	Medical Diagnosis	Date

Personal Health History

Smoker: ○ Y ○ N Quit what yr:	How many years:	Amount per day:
Alcohol: ○ Y ○ N	Type:	Frequency:
Recreational Drugs: ○ Y ○ N	Type:	Frequency:
Coffee/Soda/Tea ○ Y ○ N	Type:	Amount per day:

Typical diet:	Breakfast:_____ _____	Lunch:_____ _____	Dinner:_____ _____	Snack:_____ _____

Sleep: Restful ○ Y ○ N Time to bed: _____ Rise? _____	Hours per night: _____ Water consumption/day:_____
Regular exercise ○ Y ○ N	Type and frequency of activity:
Stress level 1(low)-----10(high): _____	Greatest cause of stress:
How do you manage stress?	Who do you have for support?
Please list the two most stressful events in your life:	
Have you had any travel related illnesses?	

Prescriptions Medications (Currently on)

Medication name	Reason for taking it?	Dose	Prescribing doctor	Start date	Does it work, any side effects?

Nutritional Supplementation (Currently on)

Supplement	Reason for taking it?	Dose	How long?	Response/Reactions

Family History (Please mark all that apply)					
Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart Disease Cancer Hypertension Diabetes					
Stroke Asthma					
Substance abuse					
Osteoporosis					
Depression					
Migraines					
Allergies Other: _____					

The information above is correct to the best of my knowledge

FINANCIAL POLICY

MSP POLICY FOR B.C RESIDENTS

Non-Insured Fee (Office Fee):
Naturopathic Doctors are registered with the College of Naturopathic Physicians of British Columbia. There is a fee charged for consultations based on the amount of time spent with the ND. Please review the information below for more details.

Insured Fee (MSP Fee):
If you have a valid BC Medical card and are receiving MSP premium assistance, you will be reimbursed $23 for each consultation (up to a combined maximum of 10 visits). Premium assistance patients are insured for a total of 10 visits per calendar year for any combination of services provided by the following licensed health professionals: Naturopathic Physicians, Chiropractors, Registered Massage Therapists, Physiotherapists, and Podiatrists. For example: 8 visits to a Naturopathic Doctor, 2 visits to a Chiropractor equals the 10 visits insured maximum limit. If you have used up your allowable visits for the year then no more reimbursements can be issued. You can fill out your MSP claims electronically online at http://www.health.gov.bc.ca/msp/infoben/benefits.html#permit, under opted-out services.

PLEASE NOTE: As of January 2002, only patients who have MSP Premium Assistance are eligible for reimbursement.

Extended Health Coverage:
Most extended health care plans cover naturopathic doctors, usually between $200-500 per year. Some plans also include lab and diagnostic testing coverage. Please verify with you Extended Healthcare provider whether consultations, testing, and/or treatments are covered under your plan. We will issue a receipt for you to submit to your extended health insurance carrier at each visit.

NATUROPATHIC SERVICES

Adult Consultation Fees	Duration	Fee
Initial visit	60 minutes	$185
Follow-up visit	60 minutes	$185
Follow-up visit	45 minutes	$135
Follow-up visit	30 minutes	$98
Follow-up visit	15 minutes	$60

Acupuncture	Duration	Fee
Follow-up visit	45 minutes	$75

Intravenous Vitamins		
IV Drip	30 minutes	$95
IV Push	15 minutes	$75

Additional charges may apply for medicines prescribed and/or labs tests recommended by Dr. Owens. You will be informed of the costs and have the right to refuse purchase.

CONSENT FOR TREATMENT

I hereby authorize Dr. Hayley Owens to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, radiography, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments)

Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions

Herbs/Natural Medicines: Prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical creams, pastes, plasters, washes, suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.

Dietary Advice and Therapeutic Nutrition: Use of foods, diet plans or nutritional supplements (Eastern/Western) for treatment—may include intramuscular vitamin injections.

Soft Tissue and Osseous Manipulation: Use of massage, cupping, Tui Na, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction and craniosacral therapy.

Acupuncture: The insertion of pre-sterilized, disposable needles through the skin into the underlying tissues at specific points on the surface of the body

Electromagnetic and Thermal Therapies: Includes the use of ultrasound, low and high volt electrical muscle stimulation, Electroacupuncture transcutaneous electrical stimulation, microcurrent stimulation, diathermy, and infrared and ultraviolet therapies or moxa—warming or indirect burning of an acupuncture point and hydrotherapies.

Vitamin Injection Therapies: Intramuscular (IM) and Intravenous (IV) injections involving high dose vitamins and minerals are used to treat deficiencies, aid in detoxification, support the immune system and improve overall energy.

Bioidentical Hormones: Structurally identical to hormones produced naturally by the human body, bioidentical hormones are a safer alternative to the synthetically modified hormones that have been used in the past with Hormone Replacement Therapy (HRT).

Prescriptive Medicines: In 2010, the BC government granted NDs prescriptive drug rights. Dr. Owens chooses to prescribe pharmaceutical medicines when required.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

Consultation Visits

Consultations with Dr. Owens will vary depending on your requirements and requests. Initial consultations usually require 60 minutes while most follow-up consultations are approximately 30 minutes. The initial consultation may include an extensive health history review, a detailed discussion of your main health concerns, physical examination as required, recommendation for lab testing as required, and a naturopathic treatment plan. You will be informed of the cost of all tests and supplements before they are performed/dispensed and have the right to refuse to purchase.

Dr. Owens may request information pertaining to your case from your healthcare providers (medical, doctor, chiropractor, etc.) in order to create a complete health profile. In these cases you will be asked to sign a release of records form, which will be sent to your healthcare provider to obtain your health records.

Potential Treatment Risks:

Naturopathic medicine utilizes primarily non-invasive and low-risk treatment modalities. You will be informed of the cost of all treatments before they are performed and have the right to refuse any treatment. All therapies are associated with some potential risk. Side effects from naturopathic treatments are relatively uncommon but can include (but not limited to):

Aggravation of symptoms, allergic reactions to herbs, supplements or allergy testing, complications from acupuncture (pain, bruising, bleeding, lightheadedness, fainting, nausea, vomiting, puncture of internal organs), injury to soft tissue and/or joints/bone/spine arising from the use of physical medicine, accidental burns associated with moxa, unforeseen interactions between recommended herbs/supplements and over the counter or prescription medications, or pain, bruising, infiltration, bleeding, lightheadedness or fainting arising from injection treatments.

Potential benefits:

Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Confidentiality

A record of all interactions with Dr. Owens, including health history, exams/tests performed and treatments recommended will be kept by Dr. Owens at Healing Cedar Wellness (8-3130 St. John's Street, Port Moody, BC). This record is kept strictly confidential and is not released to others without written consent provided by you or your representative or unless Dr. Owens is required to do so by law. In the event that you require naturopathic consultation and/or treatment and Dr. Owens is not available, the ND substituting for Dr. Owens will be permitted full access to your naturopathic health record for the purposes of providing you with appropriate advice and/or treatment.

Statement of Consent

I understand the description of the treatment modalities that Dr. Owens may recommend for me. I understand that there may be potential risks and side effects of naturopathic treatment and that Dr. Owens cannot anticipate and/or explain all risks and complications that may arise. I agree that any questions or concerns that I may have about naturopathic care will be addressed with Dr. Owens immediately. I understand that Dr. Owens, similarly for all medical professionals, cannot guarantee results. I further understand that advice and/or treatments offered to me by Dr. Owens are not intended to substitute for or replace advice and/or treatment provided by my other healthcare practitioners.

With this knowledge I voluntarily consent to the diagnostic and therapeutic procedures outlined above which may be recommended by Dr. Owens except for (please list exceptions, if any):

_____

This consent form is intended to apply to my entire course of my care by Dr. Owens (and/or the ND substituting for her). I understand that at any time I may withdraw my consent for any further treatment and discontinue at any time.

Signature of Patient or Guardian:_____Date:_____