INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

Personal Information

Today's Date	Name		Sex M F
Date of Birth (DD/MM/YYYY)	Age	Weight	Height
Address Email	Contact Information [h] [w] [c]	In case of emergency notify Contact number	
Innate Wellness will email you confirmation of your upcoming appointments. If you wish to be contacted by phone, please list the best number to contact you.			
Occupation	Employer		
How did you learn about Innate Wellness?			

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General Health Questionnaire

Please take the time to fill out this questionnaire carefully to help us provide you with a complete evaluation. If you have further questions, concerns, or comments, please bring them to our attention.

Please list your additional Health Care Providers (i.e. Medical Doctor, Medical Specialist, etc.)

Name Occupation Phone	Name Occupation Phone	Name Occupation Phone

If you are female, are you currently pregnant? Yes No

Please list **all** prescribed and over-the-counter medications, vitamins, minerals, herbs, and homeopathic remedies, which you are **presently** using.

Please list any chronic or major illnesses, traumas/injuries (car/home/work/sports, etc.) and any surgeries you have had and when.

Chronic/Major Illnesses	Traumas/Injuries	Surgeries

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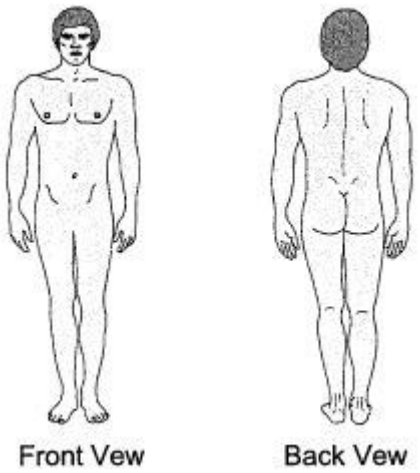
Are you here for: a general check up? _____ a specific health concern _____	
What is your main concern? _____ How long have you had it ? _____ D/W/M/Y How did it start? _____ Unsure of how it started? _____	
Is it: always there on and off	Is it: improving staying the same worsening
Is it: sharp/shooting dull/aching throbbing burning numb/tingling other	
What aggravates it?	What relieves it?
Have you had any spinal x-rays taken in the last 12 months? Yes No	

Please indicate on the diagram **and** check all illnesses/diagnoses by indicating "P" for Past or "C" for Current.



	Illness/Diagnosis	Past or Current
☐	Headaches/Migraines	_____
☐	Dizziness/Loss of Balance	_____
☐	Ringing/Buzzing in Ear	_____
☐	Menstrual Pain/Irregularity	_____
☐	Changed Bowel/Bladder Control	_____
☐	Indigestion/Heartburn	_____
☐	Other Digestive Problems	_____
☐	Blood Pressure Problems	_____
☐	Stroke or TIA	_____
☐	Pains/Sweats Waking You at Night	_____
☐	Recurrent/Persistent Sinusitis	_____

	Illness/Diagnosis	Past or Current
☐	Sudden/Recent Weight Loss	_____
☐	Sleeping Problems	_____
☐	Heart Disease	_____
☐	Blackouts/Blurry Vision	_____
☐	Increased Urinary Frequency	_____
☐	Other _____	_____

☐	Cancer: _____	_____
☐	Prolonged Steroid Use	_____
☐	Asthma	_____
☐	Neck Stiffness	_____
☐	Osteoporosis	_____
☐	Fatigue/Irritability	_____
☐	Recurrent Ear/Nose/Throat Infections	_____

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Informed Consent

We would like you to understand the services we provide, the costs involved, and what we do with the personal information we obtain about you. If you have any questions about this, please ask. This informed consent begins today and is between the Chiropractor (DC) and the person named at the end of this document.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. It is very important, therefore, that you inform your DC immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your DC immediately. You will be assessed and tested before any adjustments are applied. Health risks associated with Chiropractic Treatment include, but are not limited to:

- Aggravation of pre-existing symptoms during the healing process;
- Rare risk of damage to neck blood vessels which can arise in stroke or like symptoms;
- Muscle strains and sprains or disc injuries from spinal manipulation.

Please check the box (☑) to indicate you have read and understand the following:

<u>Disclaimer of Health Care Related Services</u>

☐ I understand that the Chiropractor (DC) will answer any questions that I have to the best of his ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I will rely on him to exercise judgment during the course of the procedure which he feels at the time is in my best interests, based upon the facts then known.

☐ I understand that any treatment or advice provided to me by my DC is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from a physician, surgeon, or any other licensed health care provider.

☐ I understand that I am at liberty to seek or may continue to seek treatment or advice from a physician, surgeon or any other licensed health care provider and it has not been suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

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Confidentiality

☐ I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

☐ I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy.

Payments & Appointment Etiquette

☐ I understand the fee schedule as stated below and I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand Innate Wellness' lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and I am ready for my appointment.

☐ I understand that I may purchase any recommended medicines or supplements from the dispensary at Innate Wellness or a pharmacy or retail store of my choice.

Patient Name _____ Signature _____ Date _____
(please print) (guardian if applicable)

Fee Schedule

New Patient Initial Assessment

First Assessment (30-45min.) 95.00
Your Chiropractor may suggest further testing as part of the initial assessment

Treatment Plan & Follow-up Appointments

Follow Up Visit (15min.) 45.00

Supplements and Remedies

Supplements and remedies are available from the office dispensary or from a naturopathic pharmacy of your choice.

Missed Appointment Fee (less than 24 hours business days' notice) **Full price of the appointment**

We accept Cash, Visa, MasterCard, and Interac Debit