Dr. Karen Wallace
| Your Local Naturopathic Doctor |

Adult Naturopathic Intake Form

Name: ____ Date: ______________________

Date of Birth (MM/DD/YY): ________________________ Age: _______ Gender: M / F (please circle)

Address: ____________________________ City: ______________ Province: ____ Postal code: __________

Preferred Phone: ________________________________ Home / Cell / Work (Please circle)

Email: ______________________________________ Can the clinic contact you via email? Y / N

How did you hear about Dr. Karen? ____

Marital Status: _________________ # of Children: ______ Occupation: _________________________

Name of Medical Doctor: _____________________________ Date of last physical exam: _____________

Emergency Contact: _______________________Phone #: _______________ Relationship: _____________

HEALTH HISTORY: (This is a confidential record. Information contained here will not be released to any person except when you have authorized us to do so. Please complete as thoroughly as possible.)

Main health concerns that brought you to Dr. Karen, in order of importance (include severity on a scale of 1-10, 10 being very severe):

1. ____ Severity: ___________
2. ____ Severity: ___________
3. ____ Severity: ___________

Other: ____

How much do these concerns interfere with your activities of daily living? (Please circle number)

(least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Have you received Naturopathic treatment in the past? Y / N (Please circle)

What expectations do you have for me as your ND and in the treatments provided?

How committed are you to addressing your health concerns and making changes in your lifestyle if necessary?

(not at all) 0 1 2 3 4 5 6 7 8 9 10 (very)

List of all **medications** you are currently taking:

Name	Dosage	Date started	Reason

Other: ____

List all **supplements** you are currently taking, including the brand and dosage:

____

____

____

Medical History
Please indicate any serious medical conditions, illnesses, injuries, surgeries, &/or hospitalizations that you have had in the past:

____

____

____

Any major mental/emotional traumas (loss of a loved one, divorce, career change, miscarriage, major disease, etc):

____

____

Please list any allergies you may have (environmental, food, drugs, supplements):

INSURANCE INFORMATION

Dr. Karen can direct bill several insurance companies for naturopathic services, however every plan is unique. Please circle your primary insurance company.

Blue Cross	Great West-Life	Sun-Life	Green Shield	Manulife
Standard Life	Industrial Alliance	Johnson	Other: ______________	

Name of insured: ____

Policy number: ___________________________ ID number: ____________________________

NATUROPATHIC TREATMENT INFORMED CONSENT

Dr. Karen utilizes the principles of naturopathic medicine to assist the body's natural ability to heal and improve quality of life. She will conduct a thorough case history, which may include a physical exam and laboratory testing.

As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Karen Wallace will discuss the potential benefits, risks and hazards involved.

I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions, in very young children, in pregnancy or in those on multiple medications. I acknowledge that the information I have provided is complete and inclusive of all health concerns, including risk of pregnancy, and all medications, including over the counter drugs, supplements and herbs.

I understand that medical records will be kept confidential and secure and will not be released without my personal consent or that of my representative, unless it is required by law. However, I understand that if being treated by multiple therapists in the clinic, I agree that my medical information and treatment plan can be discussed between therapists to ensure the best possible treatment.

To respect the time of Dr. Karen Wallace and all her patients, I acknowledge that a minimum of **24 hours notice** is required to **cancel or change an appointment**. I understand that failure to provide adequate notice will result in a **missed appointment fee of half the cost of the visit**.

After signing this consent form, I understand I am free to withdraw consent at any time.

With this knowledge I give my written consent for naturopathic evaluation and treatment. I intend this as a consent form for the entire course of treatment including any future conditions for which I seek treatment.

PRINTED NAME: _______________________________________ DATE: ____________________

SIGNATURE: ____

CREDIT CARD AUTHORIZATION

Considering our cancellation policy and in an attempt to streamline patient experience, credit card information will be taken and be used only if needed for missed appointments.
Credit card information will remain encrypted in our system and a copy of this authorization will be attached to your chart. No hard copies of this form will remain in our office. If you do miss an appointment, which I am sure you won't of course ;), and you choose not to pay by automatic transaction your payment, of 50% of the visit, is expected within the week.
I sincerely appreciate your cooperation. If you have any questions please let me know.

Card Type: Visa Mastercard

Name: ___________________________________

Card Number: ______________________________ Expiry Date: ___________

CSC Code (3 digits on back): ___ ___ ___

O - I do not wish to leave a copy of my credit card information on file. I promise to pay my invoice upon receipt the week of the missed appointment.

Signature: ____________________________ Date: _____________

Thank you,

Dr. Karen

Please email this form to info@drkarenfrackowiak.com or fax to the clinic at least one day before your appointment.
Symmetry Wellness Centre – 902-444-6554
Please bring any current prescriptions or lab results with you to the consultation.