PROACTIVE HEALTH GROUP
PROFESSIONAL HEALTH CARE FOR THE ACTIVE INDIVIDUAL

Date _____

Name _____ / _____ / _____
last first middle initial

Personal Health # _____ - _____ Male ☐ Female ☐

Home Address _____

City _____Postal Code_____Home Telephone #_____

Business Telephone # _____Cell #_____

E-Mail Address_____

Best way to contact you: ☐ Home # ☐ Work # ☐ Cell # ☐ Email

Birth Date _____/____/____ Marital Status ◯ M ◯ S ◯ W ◯ D
Y M D

Emergency Contact Name, Address, Phone#_____

_____

Occupation & Company Name _____

Physician's (G.P) Name, Address, Phone#_____

_____

Date of last physical examination _____/____/_____
Y M D

On occasion, our practitioners will communicate your clinical condition with your Physician.

Do you have health insurance other than Alberta Health Care? Yes ◯ No ◯

How did you first find out about the clinic?

☐ Patient Referral * ☐ Health Care Event ☐ Internet Search ☐ Physician Referral *

☐ Walk In ☐ Sport Team Referral * ☐ Trainer Referral * ☐ Website ☐ Other *

* Please specify the name of the person referring you: _____

120-602-12th Ave SW Calgary Ab. T2R 1J3 -- Tel: 403-225-3842 -- Fax: 403-225-3914
info@proactivehealthgroup.ca -- www.proactivehealthgroup.ca

Dr. Michael Hoffmann Dr. Mandy Milliquet
Naturopathic Physician

HISTORY OF PRESENT ILLNESS

What is the nature of the acute illness/complaint? Be as specific as possible:

How did this complaint develop? How long has it been occurring? Have you experienced this before? If due to an accident, please describe what happened in detail

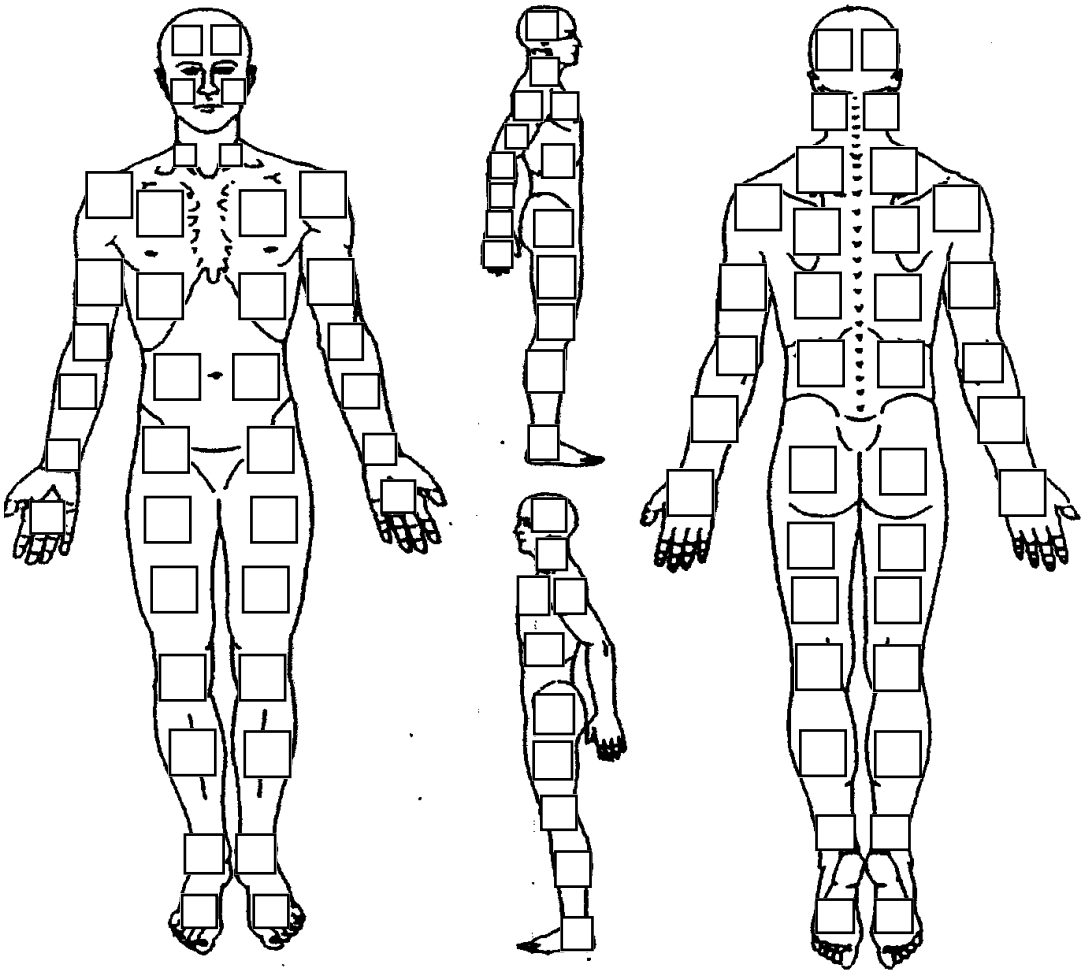
Have you noticed anything in particular that is making the complaint better or worse?

Have you been elsewhere for this complaint? If so, what was the diagnosis and suggested treatment?

Medications – List all your present medications both for the acute complaint and for chronic health concerns including drugs, vitamins, minerals, homeopathics, herbs and their dosages:

Are you allergic to any medicines or other substances? If yes, please list:

Please mark any problem or painful areas as exactly as possible with an X on the diagram bellow



Thank you for taking the time to complete this form

Dr. Michael Hoffmann **Dr. Mandy Milliquet**
Naturopathic Doctor

CONSENT FOR TREATMENT

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Prolotherapy is an established treatment technique used to tighten and strengthen weak and damaged ligaments and tendons which are believed to cause pain and instability. It is also used to decrease pain and improved function in some forms of arthritis. The technique requires the injection of local anesthetic (Procaine or Lidocaine) plus 15-25% Dextrose (sugar water). Occasionally, your own blood (autologous)is used. The sight of the injection is where the ligament or tendon attaches to the bone, at the joint capsule or inside the joint.

It is very important therefore that you inform your ND immediately of any disease process that you aresuffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your ND immediately.

* I understand that this procedure is not guaranteed to relieve my pain, partially or totally.

* I understand that there are potential complications which include increased pain, permanent numbness, infection, abscess, weakness, spinal headache, pneumothorax (collapse of the lung which may require hospitalization), allergic reactions, dizziness and nausea, and other disability.

* 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 of it by paying the appropriate fee.

* I understand that the Naturopathic Doctor 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 understand that charges are to be paid at the time of the visit. Payment for all dispensary items is due at the time of the visit.

* I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or latecancellations (less than 24 hours).

If I have coverage for naturopathic medicine, it is my responsibility to bill my insurance company. I have read and understood the above stated policies and information. 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.

Patient Name: (Please Print) _____

Signature of Patient or Guardian: _____Date:_____