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: _____

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Dr. Michael Hoffmann, B.Sc., N.D.
Naturopathic Physician

PLEASE COMPLETE THE FOLLOWING QUESTIONS

What are the most important health concerns that you are seeking treatment for or are currently being treated for? List as many in order of importance.

1. _____
2. _____
3. _____
4. _____

MEDICAL HISTORY

How is your health in general? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please indicate any serious conditions, illnesses, injuries, and hospitalizations, along with dates:

1. _____
2. _____
3. _____
4. _____

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking, the dosage and the reasons for taking them:

1. _____
2. _____
3. _____
4. _____

Are you hypersensitive or allergic to any of the following (please list):

Drugs? _____

Foods? _____

Environmental? (e.g. pollen, dust, perfume)

_____

Do you frequently use any of the following? (Circle)

Aspirin | Laxatives | Antacids | Diet pills | Birth control: pills / implants / injections

Alcohol: amount per day week_____

Tobacco: amount per day_____

Caffeine: form and amount per day_____

Recreational drugs: what and how often_____

How many times have you been treated with antibiotics?_____

Please indicate what immunization you have had:

☐ DPT (diphtheria, pertussis, tetanus)
☐ MMR (measles, mumps, rubella)
☐ Smallpox
☐ Other: _____
☐ Haemophilus influenza B
☐ "Flu"
☐ Polio
☐ Hepatitis A
☐ Hepatitis B

Please describe any adverse reaction: _____

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		High blood pressure	
Alcoholism		Kidney disease	
Asthma		Mental illness	
Arthritis		Mononucleosis	
Cancer (type)		Multiple Sclerosis	
Chronic Bronchitis		Osteoporosis	
Diabetes		Rheumatic Fever	
Depression		Skin diseases	
Drug abuse		Strep throat	
Emphysema		Stroke	
Hepatitis		Tuberculosis	
Heart disease		Other	

☐ I don't know my family medical history

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverage: _____

Cravings: _____

Aversions: _____

Do you have any dietary restrictions? _____

GENERAL

How many hours do you sleep per night?_____ Do you sleep well? Y / N

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____

How often do you (in a day): have a bowel movement?_____ Urinate?_____

What are your interests and hobbies?_____

_____

Describe the emotional climate at home and at work?_____

_____

What do you do to relax and cope with stress?_____

_____

Is there anything that you feel is important that has not been covered?

_____

_____

_____

Thank you for taking the time to complete this form

Dr. Michael Hoffmann, B.Sc., N.D.
Naturopathic Physician

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

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your naturopath will take a thorough case history, do a screening physical examination that may include a breast exam, blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important therefore that you inform your ND immediately of any disease process that you are suffering 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.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture, prolothreapy, neuralthreapy or mesotherapy
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa
- Muscle strains and sprains, disc injures from spinal manipulation

_____ 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
Initials 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
Initials 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.
Initials

_____ I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or late
Initials cancellations (less than 24 hours).

As the patient, you are responsible for the total charges incurred for each visit including costs of supplements. If I have coverage for naturopathic medicine, it is my responsibility to bill my insurance company. I understand that most insurance companies do not cover the cost of supplements. 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: _____