Port Moody Health
Integrative Medicine & Cancer Care

Dear New Patient:

Thank you for choosing Port Moody Health as your integrative health care provider. We are conveniently located in the scenic community of Port Moody. Free parking is available on the premises. Please note that our office is scent-free to respect those clients with allergies or sensitivities. The office accepts payment by debit, Visa, MasterCard, cash, and direct billing. Most extended health care providers cover Naturopathic visits. Please check with your provider to determine the amount that is covered under your policy.

Enclosed are a contact form and a detailed intake questionnaire. Please fill out the questionnaire and bring it with you to your appointment.

What to expect from your first visit:

- ✓ Please arrive **15 minutes prior** to your scheduled appointment in order to provide a urine sample prior to the start of your visit.
- ✓ The first visit with Dr. Gurm, ND, FABNO, is 60 minutes in length and involves a review of the detailed intake questionnaire, full health history, macroscopic urine analysis and, if necessary, may include a partial physical exam.
- ✓ Some laboratory tests, such as specific blood, urine or saliva analysis may also be recommended at this time **but are not included in the cost of the visit**.
- ✓ Subsequent visits vary from 15 minutes to 75 minutes in length.
- ✓ Treatments and therapies are an additional cost.

What we need before your first visit:

- ✓ Your completed new patient forms and Release of Records. Please fax or email these to us in advance so that we can upload your chart and request your medical records.
- ✓ Copies of any blood work or laboratory reports that are recent as of the last six months (or longer if appropriate) and any other pertinent documents.
- ✓ If possible, please bring medications or supplements that you are currently taking.

In the event that you must reschedule your appointment we do require 2 business days' notice or the full charge of the visit fee will be applied. Changes can only be made in person or via telephone, not e-mail.
Please note, all tests, product and treatment purchases are final. We do not issue returns or exchanges. Thank you for your cooperation.

Kindly give us a call at 604-949-0077 if you have any questions. We look forward to meeting you.

Yours in Health,

The Port Moody Health Team

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CONTACT INFORMATION

Full Name: _____ Preferred First Name: _____

Date of Birth: _____ Gender: ___ Male ___Female

Ethnicity:_____ Occupation: _____

Personal Health No. _____ BC Cancer Agency No. (if applicable):_____

Home Address: _____

City: _____ Postal Code: _____

Telephone: (home) _____ (work) _____ (mobile) _____

Preferred form of contact for reminder/follow-up calls: _____

Can we contact you via email? ___ Yes ___ No Initial: _____

Would you like to sign-up for our e-Newsletter? ___ Yes ___ No Initial: _____

Email: _____

Emergency Contact Name: _____

Relation: _____Telephone: _____

Name of Medical Doctor: _____

Address: _____ Telephone: _____

Specialists: _____ Telephone: _____

Other Health Care Providers: _____

How did you hear of us? _____

Were you referred by someone? If yes, whom? _____

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Cancer Intake Form

Please fill out this form to the best of your ability. It will help to assess your present state of health and assist in providing you with the best care possible.

Age: _____ Height: _____ Current Weight: _____

List all prescribed medications currently taken and include: **dose, frequency, and duration** (how long you have been taking them). If you need more room, provide the information on a separate sheet.

1.

2.

3.

Allergies (medical, environmental, foods): _____

List all over-the-counter medications that you take (eg. Aspirin, Tums, Acetamephenol) and include **dose and frequency**:

_____

_____

Has any close relative (parent, grandparent, or sibling) had any of the following?

	Arthritis		Allergies		High blood pressure		Skin Disease
	Asthma		Endometriosis		High Cholesterol		Stroke
	Diabetes		Gallstones		Kidney Disease		Tuberculosis
	Cancer Types:		Heart Disease		Osteoporosis		Other

List any serious conditions, illnesses, surgeries and/or hospitalizations, along with the dates (including dental surgeries, tooth extractions, root canals, etc.):

_____

_____

List any severe accidents or injuries in the past along with the dates:

_____

_____

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Dr. Sharon Gurm, ND, Integrated Health LTD.

List all vitamins, minerals, herbal medicines, Asian medicines, or homeopathics you are currently taking and include dosage and frequency:

_____

_____

_____

Do you use any of the following? List the type and frequency if applicable:

Alcohol: _____ Cigarettes: _____
Antacids: _____ Recreational Drugs: _____
Caffeine: _____ Tylenol/Aspirin/Advil: _____
Laxatives: _____ Other over-the-counter meds: _____

Are you currently pregnant? ___ Yes ___ No

Do you get regular screening tests done by another doctor? (PAP, blood tests, etc.) ___ Yes ___ No

Have you ever been screened for colon cancer (FIT test, colonoscopy) ___ Yes ___ No

List date(s), type of screening, and any findings/related procedures: _____

_____

Have you ever been on hormone therapies? Indicate what and when if applicable: _____

_____

Do you have any sexual difficulties or concerns around your sexual health? _____

_____

Please list any known past or present toxic exposures (occupational, residential, medical, environmental, etc.):

_____

Please list past regions of long-term residence (along with dates, duration) if different than your current residence: _____

Describe your general state of health as a child:

_____

Describe your general state of health as a teenager: _____

How would you describe your general state of health? ___ Excellent ___ Good ___ Fair ___ Poor

Do you have any dietary restrictions, or food sensitivities or allergies? If so, please describe:

_____

_____

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Please provide details about your average daily diet:

Breakfast:
Lunch:
Dinner:
Snacks:
Beverages:

Water Intake: litres per day _____ Source: ___Tap ___ Bottle ___ Filtered ___ Other: _____

Do you experience any gas, bloating, indigestion, or acid reflux? If yes, please describe:
_____

How often do you have a bowel movement? _____

Do you exercise? If so, indicate the type, frequency and duration: _____
_____

List your hobbies or interests: _____

Spiritual beliefs/religion: _____

How would you describe the emotional climate of your home? _____
_____

How stressful is your work, or other aspects of your life? How do you manage stress?
_____
_____

How would you describe your present support network? How do you rate your level of support from 0-10? (0=no support, 10=excellent support network of friends and/or family)
_____
_____

Who are the members of your support network? _____

Do you have difficulty falling and/or staying asleep? If yes, please explain:
_____

Do you wake up feeling refreshed? ___ Yes ___ No

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Cancer Specific Information

Please indicate which conventional treatments you have had, are presently receiving, or plan to receive?
Chemotherapy: _____
Radiation therapy: _____
Surgery: _____
Other: _____

Are you currently engaged in any form of complementary cancer treatment? If so, please describe:
_____
_____

Please describe your short-term and long-term goals for coming to Port Moody Health:
_____
_____
_____
_____

On the chart below, please indicate which statement best defines your level of physical performance:

GRADE	ECOG PERFORMANCE STATUS*	CHECK ONE
0	Fully active, able to carry on all pre-disease performance without restriction	
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work	
2	Ambulatory and capable of all selfcare but unable to carry out any work activities; up and about more than 50% of waking hours	
3	Capable of only limited selfcare; confined to bed or chair more than 50% of waking hours	
4	Completely disabled; cannot carry on any selfcare; totally confined to bed or chair	

*Developed by the Eastern Cooperative Oncology Group, Robert L. Comis, MD, Group Chair.

Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group.*Am J Clin Oncol.* 1982;5:649-655.

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Please assess the level of pain you may be experiencing and provide a rating between 1 & 10 (1 = no pain, 10 = extreme pain): _____

On the chart below, please indicate which statement best describes your overall Quality of Life (QOL).

GRADE	KARNOFSKY QOL SCALE	CHECK ONE
100	Normal, no complaints, no evidence of disease.	
90	Able to carry on normal activity; minor signs or symptoms of disease.	
80	Normal activity with effort; some signs or symptoms of disease.	
70	Cares for self; unable to carry on normal activity or to do active work.	
60	Requires occasional assistance, but is able to care for most of his personal needs.	
50	Requires considerable assistance and frequent medical care.	
40	Disabled; requires special care and assistance.	
30	Severely disabled; hospital admission is indicated although death not imminent.	
20	Very sick; hospital admission necessary; active supportive treatment necessary.	
10	Moribund; fatal process progressing rapidly.	
0	Unresponsive.	

Is there anything else that you feel may be important for us to know? _____
_____

Thank you for answering all the questions. Complete answers to all of the questions are to your benefit for the most effective naturopathic assessment, diagnosis and treatment.
This is a **confidential** record of your medical history and will be kept in this office.
Information contained here will not be released to any person except when you have authorized us to do so.

For research purposes, may we contact you for health updates? ___ Yes ___ No Please initial _____

May we use your information for research purposes? Your confidentiality will be strictly maintained.
___ Yes ___ No Please initial _____ /6

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Acknowledgement and Informed Consent

Port Moody Health would like to take this opportunity to welcome you. This health clinic utilizes the principles of integrative medicine to aid in the recovery from disease or illness, prevent disease or maintain overall health, and to improve quality of life by engaging the body's healing capacity. The naturopathic physician will conduct a detailed case history, a physical exam as needed and may utilize standard and/or specialized tests as part of assessment and the diagnostic work-up. Treatment recommendations are made based on a comprehensive assessment and are individualized to address your specific health concerns. Some treatments or procedures may include: vitamins, minerals, herbs, injections, IV therapy, nutritional and lifestyle counselling, and prescription medications, among others.

All female patients must alert the health care practitioners (mentioned above) if they know or suspect that they are pregnant, as some of the therapies used could present a risk to the pregnancy.

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1. 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 unless so directed by me or unless it is required by law. This privacy policy is in compliance with the CNPBC bylaws.
2. I understand that any advice given to me as a patient at Port Moody Health is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.
3. I understand that I am at liberty to seek, or to continue medical care with, another qualified health care provider.
4. I understand that as part of the comprehensive and team-oriented health care approach unique to this clinic, I may be seeing other clinic practitioners and information pertinent to my health and treatment outcome may be shared in order to facilitate the best health care provision possible.
5. I recognize the potential risk of some treatments that include but are not limited to: aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain, fainting or bruising from injection therapies or acupuncture, and inconvenience of lifestyle changes.
6. I understand that the Naturopathic Physician reserves the right to determine which cases fall outside their scope of practice, and that an appropriate referral will be recommended.
7. I understand that I am accepting or rejecting this care by my own free will and choice and that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without so stating.
8. I understand that no employee or physician at Port Moody Health is suggesting to me to refrain from seeking the advice of another health care provider.
9. I understand that the services offered here are not covered by MSP, and that fees are payable at the time of appointment, including fees for services, prescriptions, and laboratory tests.
10. I understand that any therapies recommended will be explained to me in full by the physician, and that I will give consent to treatment based on informed consent.

I understand that 2 full business days' notice is required for appointment cancellation or re-scheduling (via telephone or in person – not by email) or I will be responsible for the full cost of the missed appointment. X_____ *Initials*
Please note that ***ALL*** *testing and supplement purchases are final. We* ***DO NOT*** *accept returns or exchanges. Please check the box to verify you have read and understand our policy statement.* X _____ *Initials*

I, _____, have read, understood, and agree to the above statements.

Signature _____ Date: _____

Witness _____ Date: _____

Print parent/guardian's name_____

Signature of parent/guardian _____

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Port Moody Health
Integrative Medicine & Cancer Care

PATIENT RELEASE OF RECORDS

Physician(s) _____
_____
BCCA/Hospital: _____
Clinic Address: _____
Phone#: _____
Fax #: _____

Please accept this as a request for the following patient's clinical records/imaging results.

Specific requests:

□ All Clinical Records □ Other

□ All recent blood work results

Imaging / Radiology Reports: □ Mammogram □ Ultrasound □ X-Ray □MRI □CT □ Bone Scan

□PET scan □ Pathology / Biopsy Reports □ Other □ All Imaging

□ URGENT □ Routine

***** Please cc Port Moody Health on all future clinical notes for our records*****

Patient name: _____
PHN#: _____
BCCA#:_____
Address: _____
_____
Phone#: _____

Patient Signature: _____
Date: _____

Please Fax or Email Records To:
Dr. Sharon Gurm, ND, FABNO
Fax (604) 949-0017
E: info@portmoodyhealth.com