Port Moody Health
Integrative Medicine & Cancer Care

Healthcare Redefined

Dear New Patient:

Thank you for choosing Port Moody Health as your integrative health care provider.

Port Moody Health is 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 or cash. Most extended health care providers cover Naturopathic treatments. Please check with your provider to determine the amount that is covered under your policy.

Enclosed is a contact form and a detailed Child Intake questionnaire.
Please ensure this is completed and submitted one (1) week prior to your appointment.

What to expect from your first visit:

- ✓ Please arrive 15 minutes early for your scheduled appointment in order to provide a urine sample prior to the start of your visit.
- ✓ The first visit with your naturopathic physician is 30 to 45 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 and may include A.R.T. (Autonomic Response Testing). Treatment plans are generally established and discussed during the second visit. Treatments and therapies are an additional cost.

What to bring for your first visit:

- ✓ Your completed new patient forms should already be submitted one (1) week prior to this visit.
- ✓ 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.
- ✓ Please bring with you any reports from your oncologist and fill out our Cancer Intake Page if you have recently been diagnosed with cancer.
- ✓ If possible, please bring medications or supplements that you are currently taking.

***INITIAL CONSULTATION FEE is charged at time of booking and NON-REFUNDABLE.**
In the event that you must reschedule your appointment we do require 48 business hours 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 product purchases are final. We do not accept 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.

CONTACT INFORMATION

Full Name: _____

Name of Parent or Guardian if under age of 18: _____

Date of Birth: _____

Sex: Male / Female/ Transgender Male (FTM) / Transgender Female (MTF) / Decline to answer/ Other (please specify)

Ethnicity: _____

Occupation: _____

Full Address: _____

Postal Code: _____ Email: _____

Would you like to sign-up for our e-Newsletter? ☐YES ☐NO Initial: _____

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

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

☐Home Number ☐Work Number ☐Mobile Number

Emergency Contact Name: _____

Relation: _____ Telephone: _____

Name of Medical Doctor: _____

Address: _____

Telephone: _____ Date of last visit: _____

Did someone refer you? If yes, whom? _____

How did you hear of/research/find us? Please tick all that apply

- ☐ Google
- ☐ Facebook
- ☐ Twitter
- ☐ Tri-Cities Chamber of Commerce
- ☐ BCNA
- ☐ Website
- ☐ Yelp
- ☐ Listing (please specify) _____
- ☐ Other (please specify) _____

Infant/Child Intake Form

Please fill out this form to the best of your ability. It will help to assess your child's present health and will assist in facilitating the healing process.

Preferred First Name: _____ Last Name: _____

Age: _____ Height: _____ Weight: _____

What are your child's health concerns, in order of importance?

1.

2.

3.

How would you describe your child's general state of health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

IMMUNE SYSTEM HEALTH

Does your child have any allergies (medicines, environmental, etc.)?

_____

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

_____

_____

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

n	m	a	s	rubella (german measles)	n	m	a	s	roseola
n	m	a	s	measles	n	m	a	s	scarlet fever
n	m	a	s	chicken pox	n	m	a	s	mumps
n	m	a	s	whooping cough	n	m	a	s	strep throat
n	m	a	s	impetigo	n	m	a	s	mononucleosis
n	m	a	s	ear infections					

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics).

_____

Please list past prescription medications. _____

_____

How many times has your child been treated with antibiotics? _____

Please indicate what immunizations your child has indicate the date if possible.

- ☐Chicken pox (varicella)
- ☐MMR (measles/mumps/rubella)
- ☐DTP (diphtheria)
- ☐Tetanus booster; when? _____
- ☐Haemophilus influenza B
- ☐Influenza (flu)
- ☐Meningococcal (meningitis)
- ☐Polio
- ☐Hep A
- ☐Hep B

Other _____

Please indicate if any caused adverse reactions.

_____

What screening tests has your child had (blood, hearing, vision, etc.)?

_____

_____

Does your child visit the dentist? How frequently? _____

Describe your child's dental hygiene and dental history (indicate number of fillings and type, orthodontics, gum health, etc.):

_____

_____

Has your child ever traveled outside Canada? If yes, where? Did any illness develop?

_____

_____

Has the child ever lived anywhere outside of current place of residence? If yes, indicate when and where and duration:

_____

Has your child ever been exposed to highly toxic or hazardous substances? Please describe.

_____

PRENATAL HEALTH

What was the health of the parents at conception?

Mother	Poor	Fair	Good	Excellent	Unknown
Father	Poor	Fair	Good	Excellent	Unknown

What was the mother's age at child's birth? _____

What was the health of the mother during the pregnancy?

Poor	Fair	Good	Excellent	Unknown

Did the mother have any mercury ("silver") fillings prior to pregnancy? If so, how many? _____

Did the mother or father have any known toxic or hazardous exposures prior to or during pregnancy? Please describe. _____

How was the mother's diet during pregnancy?

Poor	Fair	Good	Excellent	Unknown

Did the mother receive prenatal medical care? Yes No Unknown

Did the mother experience any of the following during the pregnancy?

☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting ☐ Diabetes
☐ Thyroid Problems ☐ Physical or emotional trauma ☐ Other _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐ Supplements: _____
☐ Other: _____

BIRTH HISTORY

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Length of Labour: _____ Weight at birth: _____

Any complications? _____

Was the birth: Vaginal/C-Section Induced Forceps Anesthesia used
Did the child experience any of the following at or shortly after birth?
☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries _____
☐ Birth defects _____
☐ Other _____

DIET & DIGESTION

How was your infant fed?
☐ Breast milk. How long? _____ ☐ Formula: Cow'/Goat/Soy milk. _____
☐ Other: _____

Has your child ever been given acidophilus or some form of pro-biotic since birth? _____

What foods were introduced before six months? (Please list approximate month.)
_____
_____

6 – 12 months?
_____
_____
_____

Did your child experience colic? Y N
How severe was the colic? mild moderate severe

How many bowel movements does your child have in a day/week? ----------
Please describe the consistency, color and odor to the best of your knowledge.
_____
_____

Does your child have any food allergies or intolerances? Please list.
_____
_____

Does your child have any dietary restrictions (religious, vegetarian, vegan, etc.)?
_____
_____

Describe a typical day's diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages (and total quantity) _____Type of water (circle): tap filtered bottled

HEALTH AND DEVELOPMENT

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first:
Sit up _____ Crawl _____ Walk _____ Talk _____ Show teeth _____

Describe your child's sleep pattern. _____

How would you describe your child's temperament? _____

How would you describe your child's behaviour and performance at school (i.e. with friends, teachers)?
_____
_____

FAMILY HISTORY

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

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disorder	
Birth defects		Other	
Juvenile arthritis			

☐ I don't know the family history

Do either of the parents have a chronic illness? Y N Please describe _____
_____

ENVIRONMENT

Is the child in: school daycare home care other _____

What are you child's favourite activities? _____
_____

Does the child exercise regularly? Y N Indicate type and frequency _____

How much television does your child watch? _____ hours

How often does your child read (not for school), or is read to by someone?

☐ daily ☐ several times a week ☐ weekly ☐ less than weekly

Does anyone in the child's household smoke: Y N

Are there any animals in the home? Y N

How is the child's home heated? _____

What type of flooring does the child's home have (i.e. carpets, hardwood, etc.)?_____

Do you have a hepa-filter and/or humidifier in the child's bedroom? _____

Do live in (circle): apartment/condo basement suite house

How old is your home? _____

How would you describe the emotional climate of the child's home?

_____

_____

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

_____

_____

_____

Thank you for answering all the questions. Complete answers to all of the questions are to your child's benefit for the most effective naturopathic treatment. This is a confidential record of your child's medical history and will be kept in this office. Information contained here will not be released to any person except when you (the parents/guardians) have authorized us to do so.

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PATIENT RELEASE OF RECORDS

Physician: _____

Clinic Address: _____

_____

Phone#: _____

Fax #: _____

Please accept this as a request for the following patient's clinical records/imaging results. (within last 2 years):

☐ All recent blood work results

☑ All Imaging results

☑ Other

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

☐PET scan ☐ Pathology / Biopsy Reports ☐ Other

☐ **URGENT** ☐ **Routine**

*** Please note that the patient will be responsible for any processing fees associated with reproducing medical records.***

Patient name: _____
PHN#: _____
DOB: _____
Phone#: _____

Patient Signature: _____
Date: _____

Please Fax, Email or Mail Records To:

☐ **Dr. Sharon Gurm, ND, FABNO**
☐ **Dr. Lindsay Adrian, ND, FABNO**

Fax (604) 949-0017

E: info@portmoodyhealth.com