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. 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. We do offer directing billing for Chamber of Commerce, Cowan, Desjardins, Great-West Life, Industrial Alliance, Johnson Inc., Manulife, Maximum Benefit, Standard Life and Sun Life.

Enclosed are a contact form and a detailed Adult 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 prior** to 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 45 to 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 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.
- ✓ 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 <u>require 2 business days' notice or the full charge of the visit fee will be applied</u>. Changes can only be <u>made in person or via telephone</u>, not e-mail.
Please note, <u>all product purchases are final</u>. 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

CONTACT INFORMATION

Full Name: ____________________________ Preferred Pronoun: __________

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

Date of Birth: ______________ Sex: Male ☐ Female ☐

Ethnicity: __________________________ Occupation: ____________________

Personal Health Number: ______________________

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: ______________________

How did you hear of us?

____

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

Adult Intake Form

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

Legal name (on official documents) : ______________________________

Preferred Name: ___________________________ Preferred Pronoun: _________________________

Age: ____________ Height: ____________ Current Weight: ____________

Gender identity
☐Male ☐Female ☐Transgender Male ☐Transgender Female ☐Non-binary ☐Intersex
☐Two-spirit / Gender Fluid ☐Decline to answer ☐Another identity: __________________

Sex assigned at birth _________________ ☐Decline to answer

List all prescribed medications currently taken and include: **dose, frequency, and duration** (how long you have been taking them).

1.

2.

3.

List any medication allergies (for example penicillin):

____

List all over-the-counter medications that you take (for example: Aspirin, Tums, Tylenol) and include **dose and frequency**:

____

Please list any significant illness or health concerns pertaining to your immediate family members:

____

____

List any 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:

____

How many courses of antibiotics have you been on in the last 5 years? (Indicate the reason for prescription):

What are your health concerns, in order of importance?

1.

2.

3.

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

____

____

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

---

What type of vaccinations have you received? ______________________________

Have you ever experienced an adverse reaction to the above vaccinations? ______________________________

Do you drink alcohol? If yes, what type, and how often?

____

Do you smoke? If yes, since when, and how many a day? If you smoked in the past, please indicate the **frequency and duration**.

____

Do you currently or have you in the past used any recreational drugs? If yes, indicate type and frequency and duration of usage:

____

Do you presently have mercury (silver) fillings in your mouth? How many? ______________

Have you had any mercury fillings replaced? How many? __________

Did you receive chelation at the time of removal? ☐ YES ☐ NO

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: ______________________________

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

Please provide details about your average daily diet:

202-101 Klahanie Drive, Port Moody, BC | www.portmoodyhealth.com | T: 604 949 0077 F: 604 949 0017

Dr. Sharon Gurm, ND, Integrated Health LTD.

Breakfast:

Lunch:

Dinner:

Snacks:
Beverages:

Water Intake: litres per day _________ Source: ☐ Tap ☐ Bottle ☐ Filtered ☐ Other ____________________

Do you exercise? If so, indicate the type, frequency and duration that you have been exercising

____

List your hobbies or interests: ____

What level of personal stress are you experiencing at the present moment?

☐ Minimal ☐ Average ☐ Considerable ☐ Unbearable

What are the main stressors in your life? ____________________________________

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

Do you wake up feeling refreshed? ☐ Yes ☐ No

How would you rate your overall energy out of 10 (10 being the optimal level you would like to achieve)?

_______/10 If applicable, at what time(s) of the day do you experience the lowest energy?

____

Please circle 'Y' if you are currently experiencing the condition. Please circle 'P' if you had the condition in the past. **Write comments to the right as necessary to provide details/specifics.**

SKIN	**Y**	**P**	
Itching	☐	☐	
Dryness	☐	☐	
Hives (allergy)	☐	☐	
Eczema	☐	☐	
Psoriasis	☐	☐	
Boils	☐	☐	
Acne	☐	☐	
Rosacea	☐	☐	
Skin cancer	☐	☐	Type:
Change in moles	☐	☐	
Weak nails (of hands or feet)	☐	☐	
Nail fungus (of hands or feet)	☐	☐	

HEAD	**Y**	**P**	
Headaches	☐	☐	

	Y	P	
Migraines	☐	☐	
Head injury/trauma	☐	☐	
Dizziness	☐	☐	
Loss of hair	☐	☐	

EYES

	Y	P	
Date of last Optometrist Visit:			
Glasses/contact lenses	☐	☐	
Eye pain	☐	☐	
Tearing	☐	☐	
Dryness	☐	☐	
Floaters	☐	☐	
Double vision	☐	☐	
Blurring	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Bothered by sun	☐	☐	
Blind spot	☐	☐	
Night/colour blindness	☐	☐	

EARS

	Y	P	
Impaired hearing	☐	☐	
Earache	☐	☐	
Discharge	☐	☐	
Infections	☐	☐	
Tinnitis (ringing in the ears)	☐	☐	

NOSE

	Y	P	
Frequent colds	☐	☐	
Nose bleeds	☐	☐	
Stuffiness/Congestion	☐	☐	
Hay fever	☐	☐	
Sinus infections	☐	☐	

MOUTH AND THROAT

	Y	P	
Date of Last Dental Visit:			
Frequent sore throats	☐	☐	
Sore tongue/mouth	☐	☐	
Difficulty swallowing	☐	☐	
Gum Recession	☐	☐	
Gum Disease/Gingivitis	☐	☐	
Hoarse voice	☐	☐	
Loss of taste	☐	☐	
Dry mouth	☐	☐	
TMJ Syndrome (jaw clicking)	☐	☐	
Halitosis (bad breath)	☐	☐	

NECK	Y	P	
Pain or stiffness	☐	☐	
Enlarged thyroid	☐	☐	
Enlarged lymph nodes	☐	☐	

RESPIRATORY	Y	P	
Cough	☐	☐	
Sputum	☐	☐	
Wheezing	☐	☐	
Asthma	☐	☐	
Bronchitis	☐	☐	
Difficulty breathing	☐	☐	
Pain on breathing	☐	☐	
Shortness of breath (when?)	☐	☐	
Pressure or tightness in the chest	☐	☐	

CARDIOVASCULAR	Y	P	
Heart disease	☐	☐	
High blood pressure	☐	☐	
High cholesterol	☐	☐	
Chest pain	☐	☐	
Angina	☐	☐	
Swelling in ankles/feet	☐	☐	
Palpitations, fluttering	☐	☐	

GASTRO-INTESTINAL	Y	P	
Heartburn/reflux	☐	☐	
Change in thirst/appetite	☐	☐	
Nausea/vomiting	☐	☐	
Bowel movements - **how often?**			
Blood in stool	☐	☐	
Belching/passing gas/bloating	☐	☐	
Liver/gallbladder disease/stones	☐	☐	
Ulcer	☐	☐	
Indigestion	☐	☐	
Diarrhea	☐	☐	
Constipation	☐	☐	
Hemorrhoids	☐	☐	
Intestinal worms and/or parasites	☐	☐	

URINARY	Y	P	
Pain on urination	☐	☐	
Increased frequency	☐	☐	
Inability to hold urine	☐	☐	
Frequent urinary infections	☐	☐	
Kidney stones	☐	☐	
Blood in urine	☐	☐	

REPRODUCTIVE AND SEXUAL HEALTH	**Y**	**P**	
Testicular masses/pain	☐	☐	
Are you or have you been sexually active?	YES ☐	NO ☐	
Sexual difficulties	☐	☐	
Venereal disease	☐	☐	
Have you ever had a digital rectal (prostate) exam and/or PSA test?	☐	☐	
If so, please indicate your last evaluation and any pertinent details:			
Age menses began			
Average number of days of menses			
Average length of cycle			
Bleeding between periods	☐	☐	
Irregular cycles	☐	☐	
Pain during intercourse	☐	☐	
Painful menses	☐	☐	
PMS	☐	☐	
Excessive flow	☐	☐	
Breast tenderness	☐	☐	
Breast lumps/cysts/discharge	☐	☐	
Last menstrual period (date)			
Vaginal discharge	☐	☐	
Vaginal itching	☐	☐	
Are you or have you been sexually active?	YES ☐	NO ☐	
Difficulty conceiving	YES ☐	NO ☐	
Birth control?	CURRENTLY ☐	NEVER ☐	PAST ☐
What type? When?			
Number of pregnancies			
Number of live births			
Number of miscarriages			
Number of abortions			
Sexual difficulties	☐	☐	
Venereal disease	☐	☐	
Last PAP (date)			
History of abnormal PAP?	YES ☐	NO ☐	If yes, when?
Have you ever had a mammogram, breast ultrasound, pelvic or transvaginal ultrasound?	YES ☐	NO ☐	
Do you receive regular mammograms?	YES ☐	NO ☐	List any
Please indicate when, frequency of imaging (i.e. yearly) and any pertinent details			

MUSCULOSKELETAL	Y	P	
Joint pain and/or stiffness	☐	☐	
Arthritis	☐	☐	
Broken bones	☐	☐	
Muscle spasms or cramps	☐	☐	
Backache	☐	☐	
Foot pain	☐	☐	
Injury (tendon/ligament/joint)	☐	☐	
Significant joint swelling	☐	☐	

PERIPHERAL VASCULAR	Y	P	
Deep leg pain	☐	☐	
Cold hands/feet	☐	☐	
Varicose veins and/or spider veins	☐	☐	
Extremity numbness or tingling	☐	☐	

NEUROLOGICAL	Y	P	
Fainting	☐	☐	
Seizures/convulsions	☐	☐	
Paralysis	☐	☐	
Loss of memory	☐	☐	
Involuntary movement	☐	☐	
Loss of balance	☐	☐	
Speech problems	☐	☐	

ENDOCRINE (circle all that apply where necessary)	Y	P	
Heat and/or cold intolerance	☐	☐	
Thyroid abnormalities	☐	☐	
Excessive sweating or lack of	☐	☐	
Excessive thirst/hunger/urination	☐	☐	
Diabetes Type (I) or (II)	☐	☐	
Hypoglycemia/Hyperglycemia	☐	☐	
Hormone therapy (past or present)	☐	☐	

BLOOD/LYMPHATIC	Y	P	
Anemia	☐	☐	If yes, what type?
Easy bleeding/bruising	☐	☐	
Lymph node swelling	☐	☐	

EMOTIONAL	Y	P	
Depression	☐	☐	
Mood swings	☐	☐	
Anxiety or nervousness or tension	☐	☐	
Diagnosed mental illness	☐	☐	
Alcohol/Drug abuse	☐	☐	
Emotional Eating	☐	☐	
Insomnia	☐	☐	

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.

PATIENT CODE OF CONDUCT

In an effort to provide a safe and healthy environment for staff, patients and their families, Port Moody Health expects patients and accompanying family members to refrain from unacceptable behaviour that are disruptive or pose a threat to the rights or safety of others.

Patients and their families will:

- Treat staff & physicians with respect & honesty
- Refrain from making verbal threats to harm another individual
- Refrain from intentionally damaging equipment or property; throwing objects
- Refrain from making menacing gestures, physical assault, behaves violently in any real or perceived manner, inflict bodily harm
- Refrain from making harassing offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication, as well as in person interactions with physicians, employees or others.
- Refrain from discriminatory comments or actions in regard to sexism, racism, ableism, classism, homophobia, biphobia, transphobia and any other behavior that is derogatory
- Supervise children in their care so that they are not climbing on furniture and respect other people's property
- Be prepared to work with other Port Moody Health staff when your usual Doctor, Nurse or Support staff is not available
- Understand that Port Moody Health works with many individuals with many levels of needs, and staff may need to prioritize their time to deal with emergency or high need situations.
- Maintain confidentiality of other patients and staff
- Understand that posting comments on social media that harass, bully or defame a doctor, clinic staff, or patients is unacceptable and could result in immediate dismissal from Clinic and services

Refusal of Service

Patients and their families have a responsibility to be respectful and considerate of others and the employees of Port Moody Health. The decision to refuse service is usually made by the employee in consultation with the Clinical Director when anyone has contravened any of the above and is disruptive to the clinic's ability to function. Violators are subject to removal from the clinic and/or discharge from the practice. Wherever possible, if a patient is refused service, that service user is provided with a referral to other appropriate agencies.

Print Name ______________________________ Signature __________________________

Witness ________________________________ Date ______________________________

Print parent/guardian's name ____

Signature of parent/guardian ____

Port Moody Health
Integrative Medicine & Cancer Care

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**
□ **Dr. Paulina Domzal, ND**

Fax (604) 949-0017

E: info@portmoodyhealth.com