

Kingsway Naturopathic Clinic
#102-6983 Kingsway, Burnaby, BC V5E 1E5
Tel 604-525-0600
Fax 604-525-1969
Reception@drkim.ca
www.DrKim.ca

Name: _____

Date: _____

Please list your chief complaint: _____

Check the conditions that you are currently experiencing, or have experienced often in the past. If more space is required please use the reverse side of this sheet.

	Current	Previous		Current	Previous		Current	Previous
<u>GENERAL SYMPTOMS</u>			<u>CARDIOVASCULAR</u>			<u>INFECTIONS/ILLNESSES</u>		
Loss of Consciousness	í	í	High blood pressure	í	í	Herpes	í	í
Numbness/tingling	í	í	Low blood pressure	í	í	Hepatitis	í	í
Fever	í	í	Bleeding disorders	í	í	Plantar warts	í	í
Sweats	í	í	Chest pain	í	í	TB	í	í
Fainting	í	í	Stroke	í	í	HIV/AIDS	í	í
Dizziness	í	í	Artery Hardening	í	í	Cancer	í	í
Loss of Sleep/Insomnia	í	í	Varicose Veins	í	í	Allergies	í	í
Frequent colds/flu	í	í	Swelling of the ankles	í	í			
Loss of Weight	í	í	Poor circulation	í	í	<u>MUSCLES AND JOINTS</u>		
			Angina	í	í	Stiff neck	í	í
<u>HEAD / NECK</u>			Heart Disease	í	í	Backache	í	í
Headaches	í	í				Swollen joints	í	í
Type _____			<u>GENITOURINARY</u>			Painful tail bone	í	í
Vision problems	í	í	Trouble urinating	í	í	Foot trouble L / R	í	í
TMJ concerns	í	í	Blood in urine	í	í	Shoulder pain L / R	í	í
Earaches	í	í	Kidney infections	í	í	Elbow pain L / R	í	í
Decreased hearing	í	í	Bed wetting	í	í	Wrist pain L / R	í	í
Sinus problems	í	í	Prostate trouble	í	í	Hip pain L / R	í	í
Difficulty swallowing	í	í				Knee pain L / R	í	í
			<u>GASTROINTESTINAL</u>			Arthritis	í	í
<u>SKIN</u>			Poor digestion	í	í	Weakness/lost strength	í	í
Rashes/eczema	í	í	Indigestion	í	í			
Itching	í	í	Excessive hunger	í	í	<u>WOMANS HEALTH</u>		
Bruise easily	í	í	Belching or gas	í	í	Painful menstruation	í	í
Dryness	í	í	Nausea/vomiting	í	í	Excessive flow	í	í
Boils/hives	í	í	Abdominal pain	í	í	Irregular cycle	í	í
Contagious skin disease	í	í	Constipation	í	í	Hot flashes	í	í
			Diarrhea	í	í	Cramps or backache	í	í
<u>RESPIRATORY</u>			Hemorrhoids	í	í	Vaginal discharge	í	í
Chronic cough	í	í	Liver concerns	í	í	Swollen breasts	í	í
Shortness of breath	í	í	Gall bladder trouble	í	í	Lumps in the breast	í	í
Smoking	í	í	Ulcer	í	í	Are you pregnant	Y	N
Breathing problems	í	í	Diabetes	í	í	On birth control	Y	N
Asthma/Bronchitis	í	í						

of Pregnancies _____

of Children _____

Do you exercise? Yes No

Do you smoke? Yes No

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Do you consume alcohol or recreational drugs? If so, please list _____

Are you on any medications? Please list _____

Are you on any supplements? Please list _____

Have you ever had any accidents/fractures/falls/injuries/hospitalizations/surgeries: Yes No

INFORMED CONSENT

I would like to take this opportunity to welcome you to Kingsway Naturopathic Clinic. This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's ability to heal and to improve the quality of life and health through holistic means.

Your practitioner will conduct a thorough case history and hear your chief complaints and priorities. Please do not hesitate to inform your naturopathic doctor what you'd wish to achieve. Any practitioner in this clinic you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

Printed Name: _____

As a patient of this clinic I have read the information above and understand that the form of medical care is based on *Naturopathic*. As Kingsway Naturopathic Clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture, acupuncture or other injection therapies; and muscle strains and sprains, disc injuries from spinal manipulations.

I also confirm that I have the ability to accept or reject this care of *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. I accept full responsibility for any fees incurred during care and treatment.

Signature

Date

Witness

EXPLANATION OF FEES

The services of Naturopathic Physicians are covered by many extended health care providers, but are currently not covered under the BC Medical Services Plan. Please take note of the following office policies:

1. The cost of an initial consultation is \$90.00. Subsequent visits are \$90.00 and are booked at 25-minute increments; any time over this will be billed accordingly.
2. If you receive Assisted Premiums with the Medical Services Plan, please let the receptionist know and provide us with your MSP card number.
3. Payment is due when service is rendered. Credit cannot be extended without prior approval.
4. Appointments not cancelled with sufficient notice to be filled (24 hours) are charged a \$90.00 fee.
5. There is a \$30.00 charge on all NSF cheques.
6. Additional services (such as Prolotherapy injections, supplements, assisted treatments, blood tests, IV drip, etc.) will incur an additional fee.
7. Visits and testing are often covered under extended health insurance plans and can be reimbursed accordingly. I would strongly advise you to:
 - (a) Look for an extended medical coverage plan to reimburse the costs of your treatment.
 - (b) Write or lobby your MLA to get the government to create extended coverage for Preventative and Natural Health Care Services, so that they are more affordable and accessible for you.

We are continually looking for ways to make the costs of Naturopathic treatments affordable yet self-sustaining. I realize that our office policies may create some cash flow difficulties for some of you. If you anticipate a problem, please feel free to speak to myself or one of my staff so we may work with you to minimize any difficulties that might arise.

I have read the above information and understand that I am responsible for payment of all charges incurred.

Signature: _____

Witness: _____

Date: _____