Health By Intent
Dr. Kathleen Fyffe
Doctor of Naturopathic Medicine

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or
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Weyburn, SK
Phone: 1-306-584-1830

Name: _____ Date: _____

Address: _____City: _____ Postal Code: _____

Phone (Home): _____ (Work): _____ (Cell)

E-mail address: _____ Extended Health Care Carrier: _____

Age: _____ Birthdate (mm/dd/yy): _____ Place of Birth_____ Blood Type: _____

Occupation: _____ Employer_____

Emergency Contact: _____ ___Relationship to you: _____Contact's Phone: _____

How did you find out about me? _____

Medical doctor_____ Your last blood test? _____Your last physical exam? _____

List your health concerns:
_____

Do you have any known allergies to drugs, herbs, foods, animals or other? _____

Circle any of the following conditions you have or may have had:

Abcess	diabetes	hepatitis	multiple sclerosis	rheumatic fever	tuberculosis
Abortion	emphysema	HIV	mumps	rubella/German measles	typhoid fever
Alcoholism	epilepsy	influenza	parasites	scarlet fever	venereal warts
Anemia	frequent colds	kidney disease	peritonitis	sexual abuse	warts
Arthritis	gallstones	leukemia	pelvic inflam. dis.	skin issues	whooping cough
Asthma	genital herpes	blood press.	pleurisy	sinusitis	worms
Cancer	gonorrhea	malaria	pneumonia	stroke	yellow fever
chicken pox	gout	measles	PMS	strep throat	other:
cold sores	hayfever	miscarriages	prostatitis	syphilis	
depression	heart disease	mononucleosis	psychiatric illness	tonsilitis	

Do you take any medications? Name, dose, how long? _____

_____

_____

Do you take any supplements or herbs? Name, dose, how long?

_____

_____

Do you get sick often? _____ How frequently? _____

And on the average describe your energy level from 1 – 10 (10 = highest & 1 = lowest) _____

What time of day is your best energy? _____ Lowest energy of the day? _____

Current height? _____ Weight? _____ Ideal or desired weight? _____

Please list the 5 most traumatic or stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (yes or no)

1) _____ date _____

2) _____ date _____

3) _____ date _____

4) _____ date _____

5) _____ date _____

Please circle. Are you currently living with? Spouse, partner, parents, friends, children, alone

Are you currently: Married, separated, divorced, widowed, single, in a supportive relationship?

What is your current level of education? _____ Are you satisfied with this? Yes or No

Any children? _____ If so, how many? _____Have you been hospitalized or had surgeries? _____

Dates_____

_____

Do you exercise? If yes, how many times per week and what activities?

_____

Number of extreme toxic exposures in the past year (radiation, insecticides, chemicals, chemotherapy

treatments?_____

Diet

How much water do you drink daily? _____

What is a typical breakfast for you? _____

What is a typical lunch for you? _____

What is a typical dinner for you? _____

Family History Please list ages, health problems, and if deceased, cause of death:

	Living (age)	Health Problems	Died (age)	Cause
Mother				
Father				
Sisters				
Sisters				
Brothers				
Brothers				
Mother's Mom				
Mother's Dad				
Father's Mom				
Father's Dad				

What is your general outlook on life? _____

How committed are you to making changes in your life in order to improve your health? _____

Clinic Appointment Cancellation Policy
We request 24 hours notice be given when canceling an appointment. This excludes cancellations due to poor road or weather conditions, or in the event of a sudden family crisis. In the event that sufficient notice is not received, then the clinic may ask for a credit card number to secure the next appointment, and if missed again, then the credit card will be processed for the cost of the appointment.
Due to environmental sensitivities of many patients, please refrain from wearing colognes or perfumes.

Health History Summary
I ask that these forms be completed before arriving, and brought to the appointment. If you are unable to print these forms at home, please arrive 15 minutes early so you can fill out the paperwork without sacrificing your appointment time.

Disclaimer
While aiding in overall patient assessment, ETAscans and Applied Kinesiology do not diagnose, treat, cure or prevent any disease.

I the undersigned, hereby give my consent to naturopathic care and treatment from the naturopathic physician. Naturopathic care and treatment may include, but is not limited to, physical examination, naturopathic diagnosis, nutritional and dietary counselling, botanical medicine, homeopathy, acupuncture, and lifestyle counselling.

I understand that I am entitled to a full description and explanation of any procedure before it is performed and that I have the right to refuse treatment should I choose to do so.

I the undersigned understand the fees of Health By Intent are as follows:

Initial Visit $225

Followup Visit $110.00

Any supplements are additional.

I have read and understood the above.

_____ _____

Patient name (please print) Patient signature

_____ _____

Date Witness signature