TIMELESS HEALTH CLINIC
INTEGRATIVE MEDICINE

Patient Intake Form

Date: _____ **How did you find out about our clinic?** _____

General Information

First & Last Name of Patient:

_____

Age: _____ **Sex:** **M** **F**

Preferred Pronouns: She/Her He/Him They/Them

Date of Birth: _____

✉ Address: _____

✉ City: _____

✉ Province:_____

✉ Postal Code: _____

☎ Home: ( ) _____

☎ Work: ( ) _____

☎ Cell: ( ) _____

✉ Email: _____

In case of emergency contact:

First & Last name: _____

Relationship: _____

Emergency Contact Information (if different):

✉ Address: _____

✉ City: _____

✉ Province: _____

✉ Postal Code: _____

☎ Home: ( ) _____

☎ Work: ( ) _____

☎ Cell: ( ) _____

✉ Email: _____

Occupation: _____

Medical Doctor or Referral: _____ **☎ Tel:** ( ) _____

If you have work benefits or insurance coverage for Naturopathic Medicine, what is the yearly limit? $_____

Insurance Provider: _____

Does your family doctor and/or G.P. know that you are pursuing Naturopathic Medicine? **YES** **NO**

Have you ever seen a naturopathic physician before? **YES** **NO** If yes, who? _____

Major Health Complaint(s)

1. _____

2. _____

3. _____

Patient Initials:

TIMELESS HEALTH CLINIC
INTEGRATIVE MEDICINE

Patient Intake Form

Please relate any relevant history to the major complaint(s) (i.e. symptoms, previous treatments, prescribed medications, lab test results, other practitioner diagnosis etc.) in the space below.

Medical History

❍ *Please check off circles for any of the following conditions that **you** have experienced.*

- ❍ allergies
- ❍ cancer
- ❍ hypertension
- ❍ arthritis
- ❍ diabetes
- ❍ mental illness
- ❍ low immune system
- ❍ HIV/AIDS
- ❍ birth defects
- ❍ heart disease
- ❍ tuberculosis
- ❍ syphilis/venereal disease
- ❍ stomach or gastro-intestinal disorders
- ❍ epilepsy/seizures
- ❍ goiter/thyroid disease
- ❍ Alzheimer's disease
- ❍ Parkinson's disease
- ❍ atherosclerosis
- ❍ kidney disease
- ❍ hepatitis/liver disease
- ❍ high cholesterol or triglycerides
- ❍ skin disease
- ❍ asthma

❍ other conditions _____

Family Medical History

Mothers Medical History:_____

Fathers Medical History:_____

Siblings Medical History:_____

Maternal Grandparents Medical History:_____

Paternal Grandparents Medical History:_____

Other Medical History:_____

Patient Initials:

TIMELESS HEALTH CLINIC
INTEGRATIVE MEDICINE

Patient Intake Form

General Medical History

Past surgeries (within a year) _____ Ever had IV injections ? **YES** **NO**

How many times have you been treated with antibiotics during the last year? _____ times

What were the antibiotics used for? _____ Any side effects? **YES** **NO**

Any serious drug allergies? _____

Medications currently on and dosage:_____

Do you currently have an exercise program or regimen? **YES** **NO** Describe _____

What is the emotional climate of your home: ❍ stable ❍ stressful ❍ very stressful

Hours of sleep per day _____Quality of Sleep _____

Do you experience frequent anxiety **YES** **NO** If yes describe some triggers_____

Do you experience palpitations (noticeably fast heartbeat) **YES** **NO**

Trouble falling asleep **YES** **NO** Trouble staying asleep **YES** **NO**

Do you (❍) or any member (□) of your household use any of the following recreational drugs? *(Check all that apply.)*

❍ Smoking. Cigarettes per day ____ ❍ Marijuana. How often? _____

❍ Alcohol. Glasses per day _____ ❍ Other drugs. Specify _____

Primary source of food (i.e. supermarket) _____ Source of drinking water (i.e. bottled) _____

Describe appetite_____

Any Digestion problems (gas, constipation, etc)? _____

Number of Bowel movements per day _____ Describe stool quality _____

Previous parasite infection? **YES** **NO** If yes, when and what type? _____

Any food or chemical allergies/intolerances? If so, name them and where it was diagnosed from:

Supplements/Vitamins currently on and dose _____

Do you feel chilly, medium or hot all the time? _____ Affected by weather? _____

Fears (i.e. heights, ghosts): _____ Emotional state (i.e. anxious) _____

Has there ever been a traumatic event that happened to you in the past (i.e. accident, abuse, fighting)?

_____

Please describe your mood, personality and spirituality: _____

Patient Initials:

Patient Intake Form

Gender Specific Medical History

For Women Only:

Length of cycle _____ days; Days of menstruation _____ days; Irregular? YES NO

Clots in flow? YES NO Size of clots: _____ (i.e. dime or loonie size)

PMS symptoms? YES NO Please list: _____

Age of first menstruation ____ Birth control used? YES NO Type? _____Since? ____

Any uterine/ovarian problems (i.e. fibroids, endometriosis)? YES NO

If so, please list: _____

Any surgeries? _____ Incontinence? _____

History of breast or uterine cancer in family? YES NO What type? _____

Pap smear results and dates _____ Last Gynae exam _____

STDs? List _____ Candida/Yeast infection before? YES NO

For men only:

Any male-related conditions? **YES NO** If yes please specify _____

Circle if applicable: Lower Back Pain Dribbling Discharge

Referred Thigh Pain Enlarged Prostate High PSA

Last Prostate Exam _____ Last Full Medical _____

STDs? List _____ Sexual Dysfunction? _____

Patient Initials:

TIMELESS HEALTH CLINIC
INTEGRATIVE MEDICINE

Patient Intake Form

SYMPTOM POINT SCALE:
Use the point scale to rate your symptoms based on how you have been feeling over the past 30 days

0 = ***never or almost never*** have the symptom
1 = ***occasionally*** have it, effect is ***not severe***
2 = ***occasionally*** have it, effect is ***severe***
3 = ***frequently*** have it, effect is ***not severe***
4 = ***frequently*** have it, effect is ***severe***

HEAD
___ Headaches
___ Migraines
___ Faintness
___ Dizziness
___ Facial flushing
___ Insomnia
___ Sleep disorder (i.e. narcolepsy)

MIND
___ Poor memory
___ Difficulty completing projects
___ Difficulty with mathematics
___ Underachiever
___ Poor/short attention span
___ Confusion
___ Easily distracted
___ Difficulty making decisions
___ Learning disabilities (i.e. dyslexia)

DIGESTIVE TRACT
___ Nausea
___ Vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Stomach pains or cramps
___ Heart burn
___ Blood and/or mucous in stools

EYES
___ Watery or itchy eyes
___ Red, swollen or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision
___ Eye infection (i.e. stye, pinkeye)

EMOTIONS
___ Mood swings
___ Anxiety, fear, nervousness
___ Anger, irritability, aggressiveness
___ Argumentative
___ Frustrated, cries easily
___ Depression

WEIGHT
___ Binge eating
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Binge drinking
___ Water retention
___ Weight loss

EARS
___ Itchy ears
___ Ear aches, ear infections
___ Drainage from ear
___ Ringing in ears
___ Hearing loss
___ Reddening of ears

SKIN
___ Acne
___ Itching
___ Hives, rash, dry skin
___ Hair loss
___ Flushing or hot flashes
___ Weak nails
___ Other skin conditions (i.e. vitiligo)

JOINTS & MUSCLES
___ Pains or aches in joints
___ Arthritis
___ Stiffness or limited movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
___ Swollen tender joints
___ Growing pains in legs

NOSE
___ Stuffy nose
___ Chronically red, inflamed nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucous formation

LUNGS
___ Chest congestion
___ Asthma
___ Bronchitis
___ Shortness of breath
___ Difficulty in breathing
___ Persistent cough
___ Wheezing

ENERGY & ACTIVITY
___ Apathy, lethargy
___ Attention deficit
___ Fatigue
___ Hyperactivity or restlessness
___ Poor physical condition
___ Stuttering or stammering
___ Slurred speech

MOUTH & THROAT
___ Chronic coughing
___ Gagging, often clearing throat
___ Sore throat, hoarse, loss of voice
___ Difficulty in swallowing
___ Swollen or discolored tongue, lips
___ Canker sores or cold sores
___ Itching on roof of mouth

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
___ Chest tightness

OTHER
___ Frequent or urgent urination
___ Anal itching
___ Genital itch or discharge
___ Frequent illness
___ Other symptoms *(please specify below)*
___ _____
___ _____

Patient Initials:

Dr. Yelena Deshko, B.Sc., N.D.
Dr. Janice Chan, N.D.
Dr. Sukriti Bhardwaj, N.D.
Doctor of Naturopathic Medicine

Please read the following carefully and sign below if you agree to these terms and conditions:

1. **Free Will:** You confirm that you are seeking naturopathic care on your own free will and can terminate care at any time. At the same time, I, as the naturopathic doctor, can terminate care if I find that it is not in the best interest of either party to continue treatment. A referral may be recommended.

2. **Risks of Treatment:** As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, expected benefits, risks, side effects. Some of the risks may include, but are not limited to:

   - Aggravation of pre-existing conditions and symptoms
   - Allergic reactions to supplements and herbs. Please advise us of any allergies.
   - Pain, fainting, bruising, or injury from venipuncture or acupuncture
   - Muscle strains and sprains, and/or disc injuries from spinal manipulations
   - Small potential risk for stroke or emboli is a concern in cervical manipulation; proper pre-requisite tests will be done before such manipulations are performed to prevent such an outcome.
   - Bruising, fainting, pain, swelling, injury or allergic reaction from IM or IV injections.

3. **Right to Refuse Treatment:** Please be advised that the risks of Naturopathic treatment and know that you may ask the Naturopathic Doctor to explain any risks to specific treatments as they come up. Please be advised that you may refuse any treatment that is offered to at any time. Be advised that it is your responsibility to disclose in writing any and all medical conditions, medications and health related concerns to Timeless Health Clinic Inc. prior to receiving any consultation or treatment in order to prevent any possible health related or other risk to yourself.

4. **Collection of Samples:** To provide you with the best medical care, we may ask you to collect certain laboratory specimens for analysis. Laboratory specimens may include but are not limited to: blood, urine, saliva, stool. You will be informed of the sample collection purpose, cost, procedure and any risks involved prior to the collection of the specimen. You have the right to refuse any sample collection. The results of the sample analysis will be explained to you after they are available. Standard Naturopathic visit fees apply to any results discussion and explanation.

5. **Fees and Pricing:** As a patient, you have been notified of the fees charged by the Naturopathic Doctor which include but are not limited to:
   - **$240.00 for an initial assessment (approximately 1.5 hours)**
   - **$180.00 for a 1 hour visit**
   - **$140.00 for a 45 minute visit**
   - **$95.00 for a 30 minute visit**
   - **$50-$250 for Intravenous therapy treatments depending on dosages of ingredients used**

6. **Appointment Times:** As a patient you are aware that the length of appointments is an approximation and that appointment may take more or less time based on individual needs.

7. **Fees and Pricing Cont.:** Other fees will be applied based on treatments which may be recommended as part of the treatment plan and which may include fees for intravenous therapy, intramuscular injections, laboratory testing,...etc. GST/HST is applicable to some fees and supplement/product sales. You, the patient will be notified of the fees prior to commencement of any therapies. All prices are subject to change at the discretion of Timeless Health Clinic Inc. without notice.

8. **Financial Policy:** Please be advised that you as the patient, are obligated pay for the services rendered, in cash, debit, or by credit card at the time the service is rendered.

9. **Refund Policy**: Please note that rendered services, products or gift card purchases are **strictly non-refundable.**

10. **Insurance Coverage:** Although many insurance providers offer extended health coverage that includes Naturopathic Medicine, insurance plans vary widely in coverage levels. Timeless Health Clinic and Staff cannot provide any guarantee that services, treatments, consumables, or laboratory tests will be covered by the patient's insurance provider. It is the patient's responsibility to be aware of their insurance coverage and communicate with the insurance provider as may be necessary. No services rendered by Timeless Health Clinic or its Staff are covered through OHIP

Patient Initials:

11. **Product Purchases:** The Naturopathic Doctor may prescribe supplements/vitamins or other consumables as part of a course of treatment. The cost of these consumables is separate and is not included in the fees for any other consultation or treatment. The patient has the right to purchase consumables such as vitamins, supplements, herbal products, skincare products and others from Timeless Health Clinic Inc. or any other provider as they see fit. The patient is not obligated to purchase supplement/vitamins from Timeless Health Clinic Inc. **Any purchased supplements or products are non-refundable**.

12. **Disclaimer:** Please be aware that following the directions of me, the Naturopathic Doctor, will help you achieve your goals for better health and that not doing so may decrease the chances of success of these goals. Please be advised that successful progress is directly linked to an open and honest communication between both parties. However Timeless Health Clinic Inc. and all its Staff members do not guarantee any specific outcome from any advice, treatment, service or prescription recommended or administered.

13. **Confidentiality:** Please be advised that your patient file will be kept confidential. The information in your file will not be shared with anyone outside this clinic unless it is required by law, or written consent to share the information with another person (ie another health care practitioner) has been given by yourself. Your personal information may be used to contact you for matters regarding treatments, appointments, or any other activity as required for operation of the clinic.

14. **Consent to Communication:** By signing this form, you the patient consent to receive communications from Timeless Health Clinic Inc and its Staff. Communication includes but is not limited to telephone calls, voicemail, SMS text messaging, social media messaging, email and others. Communication may be used for the purpose of: appointment reminders, advertising, communication of medical information, and any other purpose as deemed necessary by Timeless Health Clinic Inc. and Staff. If you do not wish to receive such communication please submit a written request for exclusion from this policy.

15. **Consent to Photography:** To document treatment progress Timeless Health Clinic Inc or its Staff may take before, after and progress photography. The photographs may be used and distributed for educational, training, information, advertising, or other purposes at the discretion of Timeless Health Clinic Inc. and Staff. If used for advertising or public demonstration, steps will be taken to protect patient identity. If you do not wish photographs to be taken or distributed please inform Timeless Health Clinic Inc. and Staff in writing: Decline _____ (initials)

16. **Inter-referral policy:** At Timeless Health Clinic, Dr Janice Chan ND, Dr. Sukriti Bhardwaj ND, and Dr. Yelena Deshko ND all oversee patient procedures and have a mutual referral agreement. By signing this form you indicate that you are aware that your initial treating Naturopathic Doctor will review your health history, reasons for IV administration, and provide a suggested treatment plan. Other Naturopathic Doctors at Timeless Health Clinic will be made aware of your medical history and the full contents of your medical file. All of the Naturopathic Doctors shall be informed of any changes to medications/supplements/protocols in your medical file. You hereby provide consent that all the Naturopathic Doctors mentioned in this form have the right to review your medical history, provide treatment, conduct relevant physical examinations, administer IV or IM injections, recommend treatment protocols and administer medical care as they deem necessary for your goals and medical condition. All Naturopathic Doctors listed above have the right to delegate aspects of your care to other Staff as they see fit.

17. **Waiver:** I, my heirs, executors, administrators, successors and assigns, hereby release, waive and forever discharge Timeless Health Clinic Inc. and its directors, officers, shareholders, affiliates, associates, employees, agents, servants, contractors, representatives, successors and assigns (the Staff) of and from all claims, demands, damages, costs, expenses, actions and causes of action, whether in law or equity, in respect of death, injury, allergic reaction, illness, physical discomfort, loss or damage to my person or property however caused, arising or to arise by reason of the treatments or consultations, whether as a participant, or otherwise, whether prior to, during, or subsequent to the treatments, and notwithstanding the same may have been contributed to, or occasioned by, the negligence or misconduct of Timeless Health Clinic Inc. staff. I further hereby undertake to hold and save harmless and agree to indemnify Timeless Health Clinic Inc. or its Staff from or against any and all liability incurred by any of them as a result of, or in any way connected with the treatments, recommendations, or consultations.

By signing this form I indicate that all above medical information is correct to the best of my knowledge and I understand and agree to the terms and conditions outlined.

Name and Signature _____ **Date** _____

Witness or Guardian _____ **Date** _____

Patient Initials:

Cancellation and No Show Policy
Credit Card Authorization

Dear patient,

When you schedule an appointment, the time allotted for your visit is reserved especially for you. For this reason we ask that you respect the booking times and try not to be late for your appointments. Arriving late for an appointment may result in a shorter visit that is billed at the full rate. However we understand that things happen, and schedules do change. If you need to cancel or reschedule your appointment we ask that you provide us with a minimum of 24 hours notice in advance. Failure to provide adequate notice for a cancellation or re-booking will result in a missed appointment charge. **There will be a $50 charge that must be paid before another appointment can be booked.**

I, _____ hereby acknowledge and agree to abide by the Timeless Health Clinic Cancellation and No Show Policy. I understand that failure to provide 24 hours notice to Timeless Health Clinic by phone or e-mail of any appointment cancellation or re-booking will result in a $50 charge. I hereby authorize Timeless Health Clinic to charge my credit card in the event of any short term cancellation or no show. I understand that my credit card information will be kept confidential and shall not be used for any purpose other than stated above.

Type of Card ☐ Visa ☐ MasterCard

Credit Card Number: _____

Expiration Date: _____

Security Code: _____

Name of Cardholder: _____

Authorized Signature of Cardholder _____

Signing this, I acknowledge the charges described above and assume full responsibility for said charges and agree to honour and abide by the terms of the Timeless Health Clinic cancellation policy.

Signature: _____ Date: _____

Patient Initials: