Island Integrative Health
acupuncture . nutrition . weight loss

Victoria Office
550—2950 Douglas St, Victoria, BC V8T 4N4

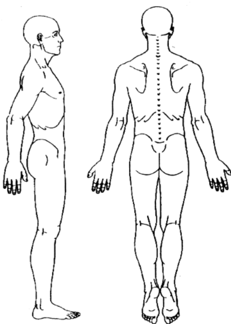
Sooke Office
Unit 2B, 6631 Sooke Rd, Sooke, BC V9Z 0A3

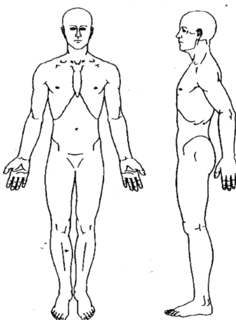
Name	**Date**
Address	**Height**
City / Postal Code	**Weight (lbs)**
Home Phone **Cell Phone ( )**	**Date of Birth** **Age**
Email	**Occupation**
Would you like to receive our Health & Wellness Newsletter? Y ( ) N ( )	**Referred By**

HEALTH ASSESEMENT **Please indicate if you have or have had any of the following conditions**

❑ AIDS / HIV	❑ Candida	❑ Epilepsy / Seizures	❑ Jaundice	❑ Obsessive Compulsive
❑ Alcoholism	❑ Digestive Disorder (bloating, gas, constipation, diarrhea, abdominal pain)	❑ Fibromyalgia	❑ Joint Pain	❑ Sinusitis
❑ Allergies or Sensitivities	❑ Circulatory Disorder	❑ Gall Bladder (stones)	❑ Kidney Disorders	❑ Thyroid Disorders
❑ Anemia (iron deficiency)	❑ Chronic Fatigue	❑ Gastric Reflux	❑ Liver Disorders	❑ Tinnitus
❑ Anxiety / Stress Disorder	❑ Chronic Pain	❑ Gout	❑ Low Blood Pressure	❑ Tonsillitis
❑ Arthritis	❑ Convulsions	❑ Heart Disease	❑ Lupus	❑ Urinary Tract Infections
❑ Asthma	❑ Depression	❑ Hepatitis A, B, or C	❑ Menstrual Disorders	❑ Ulcer
❑ Back Pain (Upper / Lower)	❑ Diabetes Type I , II	❑ Hernia	❑ Migraine Headaches	❑ Other: Please list:
❑ Blood Pressure (High / Low)	❑ Drug Dependencies	❑ Herpes Simplex I or II	❑ Memory (poor)	____________________
❑ Bronchitis	❑ Eczema / Psoriasis	❑ High Cholesterol	❑ Multiple Sclerosis	____________________
❑ Cancer of any kind	❑ Eating Disorder	❑ Hypoglycemia	❑ Neck /Pain (Cervical)	____________________

PLEASE INDICATE AREAS OF CONCERN





Briefly describe why you are seeking treatment today (ie. symptoms)

___

What other forms of treatment have you sought (ie. Chiropractic, Massage)

___

Please list any accidents, injuries, or hospitalizations in the past 10 years

___

ALLERGIES / SENSITIVITES
Please list any allergies &/or sensitivities:

___

MEDICATIONS
Please list any prescribed medications, or over-the-counter drugs you are currently taking and reason for taking:

___

NUTRITIONAL SUPPLEMENTS
Please list any natural health products, supplements, herbal, or homeopathic remedies you are currently taking:

___

DIETARY INTAKE Please list your average daily dietary intake

Breakfast	Lunch	Dinner	Snacks

DAILY FLUID INTAKE (cups/day)

Water	Fruit Juice	Vegetable Juice	Herbal Tea
Coffee	Caffeinated Tea	Soft Drink	Alcohol

PRIVACY POLICY

As an integrative healthcare facility, please be advised that your Practitioner may feel it is necessary to consult with Co-Practitioners regarding your wellness and treatment protocols. This is to ensure that you receive the most comprehensive treatment available at the clinic. By signing your name below, you agree to have information in your file shared among those practitioners relevant to your treatment strategy only.

CLIENT CONSENT

1. I, the undersigned, hereby request and consent to a variety of diagnostic and treatment methods that may include the following: Metabolic & Nutritional Profile Testing, Ortho-Molecular Testing, Allergy Testing, Hormonal Testing, Laser/Needle Acupuncture, Homeopathy, Nutritional Supplementation, Detoxification, Cleansing and other alternative therapies and recommendations required to treat my health concerns as outlined.
2. I understand there are no guarantees regarding cure or improvement of symptoms. I understand that in order to obtain maximum results, I will follow my personalized program as recommended and accept that success and progress is dependent on my individual compliance with the program, therefore my Healthcare Practitioner does not offer any guarantee as to success of treatment.
3. It is very important that you notify your Practitioner of any disease process currently going on in your body, if you are on any prescription medication, over-the-counter drugs, recreational drugs, if you are pregnant, suspect you are pregnant, or you are breast-feeding.
4. There are some slight health risks to treatment, including but not limited to: aggravation of pre-existing conditions and symptoms, or allergic reactions or sensitivities to supplements or botanical homeopathic prescriptions. If either of these occur, please inform your Practitioner.
5. The information that I have supplied is true and complete. I understand that any inaccurate information may impact on the effectiveness of my recommended treatment program. I further understand that my Practitioner cannot be held responsible for any adverse effects that may arise as a result of inaccurate or incomplete information being supplied to this clinic.
6. All tests and service fees must be paid when rendered, without refund after 14 days from purchase date. I do not expect my Practitioner to be able to anticipate and explain all risks and complications, and I will rely on my Practitioner to exercise caution and judgment in my best interest
7. I understand if I have any questions, I may ask them at any time prior to or during treatment, and intend for this consent to extend during the entire course of treatment.

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

Signature ______________________ **Date** ______________________

Witness ______________________ **Date** ______________________

In consideration to your fellow patients and practitioner, 24 hours cancellation notice is required or a fee will be charged.