Dr. Harmi Kaler
NATUROPATHIC DOCTOR

113 – 109 Southbank Blvd
Okotoks AB T1S 0G1
403 938 1138
www.drkaler.ca

ADULT INTAKE FORM

Our health is influenced by many different factors and you provide valuable information to understand your current health.

GENERAL CONTACT INFORMATION

Name _____
(Last name) *(First name)*

Birthdate (mm-dd-yy): _____ Gender: _____ Today's Date (mm-dd-yy): _____

Address: _____
Street *City* *Province* *Postal Code*

Phone (H): _____ (C): _____ E-mail: _____

May we leave you a message about your appointment: Y N Preference: Home Cell Email

Occupation: _____ How did you hear about the clinic? _____

Medical Doctor: _____ Last Physical Exam: _____
Name *Telephone* *(mm/yy)*

Emergency Contact: _____
Name *Phone Number* *Relationship*

Do you have health benefits? Y N Provider: _____

PERSONAL MEDICAL HISTORY

What are your health concerns, in order of importance?
1. _____
2. _____
3. _____

Please indicate any surgeries, health diagnoses and hospitalizations along with approximate dates:
_____
_____
_____

Do you have any allergies or hypersensitivities to any of the following?
Foods: _____
_____
Medicines/Supplement: _____
Environment: _____
Other: _____
Do you have any dietary restrictions? (Religious, Vegetarian, Vegan, etc.)? _____

Please list all prescription, over the counter medications, vitamins or supplements you are currently taking including brands:
_____
_____
_____

Please list any other Healthcare Providers you are currently seeing:
_____

FAMILY MEDICAL HISTORY

Indicate if any of your following relatives (F: Father; M: Mother; B: Brother; S: Sister; C: Children; Sp: Spouse; MGM: maternal grandmother; PGM: paternal grandmother; MGF: maternal grandfather; PGF: paternal grandfather) have any of the following:

Condition	Family Member	Condition	Family Member	Condition	Family Member
Allergies/ Hay Fever		Epilepsy		Multiple Sclerosis	
Alcoholism/ Drug Addictions		Fibromyalgia		Myasthenia gravis	
Alzheimer's / Parkinson's		Glaucoma		Osteoporosis	
Anemia		Headaches		Obesity	
Arthritis		Heart Disease		Skin Conditions	
Asthma		High Blood Pressure		Stroke	
Autoimmune Disease		High Cholesterol		Syphilis	
Cancer		Kidney Disease		Thyroid Conditions	
Celiac Disease		Liver Disease		Tuberculosis	
Diabetes		Lupus		Other	
Digestive (Crohn's, Colitis, etc)		Mental Illness			

LIFESTYLE HABITS

Drinks	How many/ week?		How many per week?	Have you quit?
Liquor		Cigarettes		
Beer		Cigars / Pipes		
Wine		Marijuana		
Caffeine		Recreational Drugs		
Soft Drinks		Others		

Are you exposed to significant tobacco smoke? (Work, Home, Etc.) Yes No
Are you frequently exposed to animals? (Pets, Work, etc.) Yes No

Do you exercise regularly? What do you do for exercise? How often? How long?

_____

_____

What are your hobbies? What do you do in your spare time?

_____

_____

How stressful is your work? Life? How do you handle your stresses?

_____

_____

REVIEW OF SYSTEMS

GENERAL

Height: _____ Weight: _____ Max weight: _____ Weight one year ago: _____

For the following check "YES" if you are experiencing the symptom now or have in the last year.
Check "PAST" if you've had the symptom more than a year ago. If you've never had the condition, leave it blank.

MUSCULOSKELETAL

	YES	PAST		YES	PAST		YES	PAST
Joint pain	☐	☐	Broken bones	☐	☐	Backache	☐	☐
Joint stiffness	☐	☐	Muscle spasms/ cramps	☐	☐	Muscle pain	☐	☐
Arthritis	☐	☐	Weakness	☐	☐	Reduced movement	☐	☐
Other: _____			Joint swelling	☐	☐	Decreased flexibility	☐	☐

RESPIRATORY

	YES	PAST		YES	PAST		YES	PAST
Emphysema	☐	☐	Sputum	☐	☐	Pain on breathing	☐	☐
Tuberculosis	☐	☐	SARS	☐	☐	Difficulty breathing	☐	☐
Tuberculin Test	☐	☐	Asthma	☐	☐	Shortness of breath (SOB)	☐	☐
Chronic cough	☐	☐	Bronchitis	☐	☐	SOB at night	☐	☐
Spitting up blood	☐	☐	Pneumonia	☐	☐	SOB lying down	☐	☐
Wheezing	☐	☐	Pleurisy	☐	☐	Last Chest-ray: _____		

GASTROINTESTINAL

	YES	PAST		YES	PAST		YES	PAST
Trouble swallowing	☐	☐	Heartburn	☐	☐			
Change in thirst	☐	☐	Jaundice (yellow skin)	☐	☐	Flatulence	☐	☐
Change in appetite	☐	☐	Liver disease	☐	☐	Rectal bleeding	☐	☐
Nausea	☐	☐	Gall bladder disease	☐	☐	Hemorrhoids	☐	☐
Vomiting	☐	☐	Ulcer	☐	☐	Black, tarry stool	☐	☐
Vomiting blood	☐	☐	Indigestion	☐	☐	Abdominal pain	☐	☐
Blood in stool	☐	☐	Constipation	☐	☐	Food allergy	☐	☐
Belching	☐	☐	Diarrhea	☐	☐	Hernias	☐	☐
Bowel movements	☐	☐						
-how often? _____			Is this a change?	Y	N			

SKIN/ HAIR/ NAILS

	YES	PAST		YES	PAST		YES	PAST
Frequent rashes	☐	☐	Dry Skin	☐	☐	Skin cancer	☐	☐
Hives	☐	☐	Eczema	☐	☐	Hair loss	☐	☐
Itching/Itchy Skin	☐	☐	Mole changes	☐	☐	Changes in hair growth	☐	☐
Boils	☐	☐	Lumps	☐	☐	Change in skin texture	☐	☐
Psoriasis	☐	☐	Night sweats	☐	☐	Nail changes	☐	☐
Acne	☐	☐	Other: _____					

URINARY

	YES	PAST		YES	PAST		YES	PAST
Pain on urination	☐	☐	Inability to hold urine	☐	☐	Blood in urine	☐	☐
Increased frequency	☐	☐	Frequent infections	☐	☐	Urgency	☐	☐
Frequency at night	☐	☐	Kidney stones	☐	☐	Hesitancy	☐	☐

MALE REPRODUCTIVE

	YES	PAST		YES	PAST		YES	PAST
Hernias	☐	☐	Sexual difficulties	☐	☐	Penile sores	☐	☐
Testicular masses	☐	☐	Venereal disease	☐	☐	STIs	☐	☐
Testicular pain	☐	☐	Penile discharge	☐	☐	Sexually active	☐	☐

FEMALE REPRODUCTIVE

	YES	PAST		YES	PAST		YES	PAST
Bleeding between periods	☐	☐	Difficulty conceiving	☐	☐	Vaginal itching	☐	☐
Regular periods	☐	☐	Sexually active	☐	☐	Breast lumps	☐	☐
Pain during intercourse	☐	☐	Sexual difficulties	☐	☐	Breast pain or tenderness	☐	☐
Painful menses	☐	☐	Venereal disease	☐	☐	Nipple discharge	☐	☐
Excessive flow	☐	☐	STIs	☐	☐	Breast Cancer	☐	☐
PMS	☐	☐	Vaginal discharge	☐	☐	Ovarian Cancer	☐	☐

Age menses began: _____ Last menstrual period: _____ Number of live births: _____
Average number of days: _____ Last PAP - (date): _____ Number of miscarriages: _____
Length of cycle: _____ Number of pregnancies: _____ Number of abortions: _____

HEAD/ EYES/ EARS/ NOSE/ MOUTH/ THROAT/ NECK

	YES	PAST		YES	PAST		YES	PAST
Impaired vision	☐	☐	Blind spot	☐	☐	Sinus problems	☐	☐
Glasses/contacts	☐	☐	Headaches	☐	☐	Frequent sore throat	☐	☐
Eye pain	☐	☐	Migraines	☐	☐	Sore tongue/mouth	☐	☐
Tearing	☐	☐	Head injury	☐	☐	Bleeding gums	☐	☐
Dryness	☐	☐	Dizziness	☐	☐	Hoarseness	☐	☐
Double vision	☐	☐	Impaired hearing	☐	☐	Dental cavities	☐	☐
Glaucoma	☐	☐	Earache	☐	☐	Mouth ulcers	☐	☐
Cataracts	☐	☐	Ear discharge	☐	☐	Loss of taste	☐	☐
Blurring	☐	☐	Ear infections	☐	☐	Neck Lumps	☐	☐
Light Sensitive	☐	☐	Frequent colds	☐	☐	Swollen glands	☐	☐
Itchy eyes	☐	☐	Nose bleeds	☐	☐	Goiter	☐	☐
Redness	☐	☐	Nose stuffiness	☐	☐	Neck Pain or stiffness	☐	☐
Eye discharge	☐	☐	Hay fever	☐	☐			

CARDIOVASCULAR

	YES	PAST		YES	PAST		YES	PAST
Thrombophlebitis	☐	☐	Varicose veins	☐	☐	Chest pain	☐	☐
Leg cramps	☐	☐	Heart disease	☐	☐	Swelling in ankles	☐	☐
Extremity numbness	☐	☐	Angina	☐	☐	Palpitations	☐	☐
Extremity coldness	☐	☐	High blood pressure	☐	☐	Fainting	☐	☐
Extremity swelling	☐	☐	Low blood pressure	☐	☐	Cyanosis	☐	☐
Extremity ulcers	☐	☐	Murmurs	☐	☐	Past ECG	☐	☐
Deep leg pain	☐	☐	Rheumatic fever	☐	☐	Other heart tests	☐	☐
Cold hands/feet	☐	☐						

Other: _____

PSYCHOLOGICAL/ NEUROLOGICAL

	YES	PAST		YES	PAST		YES	PAST
Fainting	☐	☐	Depression	☐	☐	Sexual difficulties	☐	☐
Seizures	☐	☐	Mood swings	☐	☐	Suicidal thoughts	☐	☐
Convulsions	☐	☐	Anxiety or nervousness	☐	☐	Recurrent thoughts	☐	☐
Paralysis	☐	☐	Tension	☐	☐	Binge eating	☐	☐
Tremor	☐	☐	Phobias	☐	☐	Eating Disorder	☐	☐
Muscle weakness	☐	☐	Hallucinations	☐	☐	Low Self Esteem	☐	☐
Numbness or tingling	☐	☐	Alcohol/drug abuse	☐	☐	PTSD	☐	☐
Loss of memory	☐	☐	Insomnia	☐	☐	Self-Injury	☐	☐
Loss of balance	☐	☐	Sadness	☐	☐	Poor Concentration	☐	☐
Loss of coordination	☐	☐	Grief	☐	☐	Memory difficulties	☐	☐
Speech problems	☐	☐	Anger	☐	☐	Hyperactivity	☐	☐

Is there anything related to your health that has not been covered?

_____

_____

_____

Thank you for completing this form. The info provided will be discussed in further detail during your initial visit.

Dr. Harmi Kaler
NATUROPATHIC DOCTOR

Informed Consent Form

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and perform a physical examination. Each patient seeking care in this clinic should understand that the practitioner is a Naturopathic Doctor, not a medical doctor.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. Treatments used in this clinic include nutrition, botanical medicine, lifestyle counseling, homeopathy, Traditional Chinese medicine (including acupuncture), hydrotherapy, physical medicine, laboratory testing and supplement recommendations.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by your Naturopathic Doctor prior to manipulating the neck.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

I have been informed and I understand that:

- I am free to withdraw my consent and to discontinue treatment at any time.
- My Naturopathic Doctor will explain the exact nature of any treatment provided and will answer any questions I may have.
- The clinic does not guarantee treatment results.
- I agree to pay my account in full at each visit. I am aware that Alberta Health Care does not cover these fees.
- I understand cancellations must be made with 24 hours notice or a missed appointment fee applies.

Patient Name (please print): _____

Signature of Patient or Guardian: _____ Date: _____

Dr. Harmi Kaler
NATUROPATHIC DOCTOR

PATIENT PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of providing you with quality naturopathic care. Dr. Harmi Kaler understands the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly.

We strive to ensure that:

- Only necessary information is collected about you;
- We only share your information with your written consent;
- Storage, retention, and destruction of your personal information complies with existing privacy legislation and privacy protection protocols of our regulatory body, The College of Naturopathic Doctors of Alberta.

Information is collected, used and disclosed about you for the following purposes:

- To assess your health concerns and advise you of treatment options;
- To establish and maintain contact with you and remind you of upcoming appointments;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up for treatment, care and billing;
- To comply with legal and regulatory requirements;

I have read and understand how Dr. Harmi Kaler will use my personal information and the steps taken to protect my information. I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

Signature of Patient or Guardian: _____ Date: _____

EMAIL CONSENT FORM

Name: _____E-mail: _____

I hereby acknowledge that I consent to email communications about my care. It is my responsibility to inform Dr. Kaler if my email address changes. I understand that I am exposing myself to certain risks, which include but are not limited to:

- The privacy and security of email communication cannot be guaranteed.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Backup copies of Email may exist even after sender or recipients have deleted their copy.
- Email senders can easily misaddress an Email or be received by unintended recipients
- Email is easier to falsify than handwritten or signed documents.

Dr. Kaler will use reasonable means to protect the security and confidentiality of emails. Due to the risks above, Dr. Kaler cannot guarantee the security and confidentiality of emails and will not be liable for improper disclosure of confidential information that is not caused by Dr. Kaler's intentional misconduct.

Dr. Kaler will try to read and respond to emails. No one shall use Email for medical emergencies or other time-sensitive matters. It is the patient's responsibility to follow up with Dr. Kaler if a response has not been received within a reasonable time period.

Please be advised all Emails to or from Dr. Kaler will be made part of your medical record. It is your responsibility to inform Dr. Kaler of any types of information you do not want sent by Email. Dr. Kaler will not forward Emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

I acknowledge that I have read and fully understood this consent. I understand the risks associated with email communications between Dr. Kaler and myself, and consent to the conditions outlined. In addition, I agree to the instructions for communicating by Email, as well as any other instructions that Dr. Kaler may impose.

Signature of Patient or Guardian: _____ Date: _____

Harmony Health
INTEGRATIVE CENTRE

DIRECT BILLING AND CANCELLATION POLICY

If I am unable to make a scheduled appointment I must provide 24 hours advance notice to avoid being charged a missed appointment fee of 100% of my scheduled visit. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements, cost of laboratory tests, administrative fees as well as any other applicable fees.

Anyone who either forgets or consciously choses to forgo their appointment for whatever reason will be considered a “no-show”. They will be charged for their “missed” appointment and all future services will be denied until the account is settled.

In the event that an appointment is cancelled or rescheduled with less than 24 hours’ notice you are subject to a late cancellation fee of $50.

Credit card information provided below will only be used in the event that less than 24 hours’ notice was provided for cancellations or changes, no show appointments or if insurance direct billing does not pay Harmony Health Integrative Centre the amount authorized. In the event the credit card does not work, the balance owing must be paid within 5 business days of being advised. Harmony Health Integrative Centre reserves the right to cancel any future appointments until this is done.

Signature of Patient or Guardian: _____ Date: _____

Credit Card information: Visa MasterCard

Patient(s) Name: _____

Name on Card (please print): _____

Credit Card Number: _____

Expiration Date (Month/ Year): _____ CVV:_____

Cardholder’s Full signature: _____ Today’s Date: _____