Dr. Harmi Kaler
NATUROPATHIC DOCTOR

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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* *(M/Y)*

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 to you?

1. ____
2. ____
3. ____

Please indicate any health conditions, illnesses, injuries, and any hospitalizations along with approximate dates:

____

____

____

Do you have any allergies or hypersensitivities to any of the following?

Foods: ____

____

Medicines / Supplements: ____

Environment: ____

Other: ____

Do you have any dietary restrictions? (Religious, Vegetarian, Vegan, etc.)? __________________________

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

LIFESTYLE HABITS

Drinks	How many/ week?	Have you quit?		How many / week?	Have you quit?
Alcohol			Cigarettes		
Caffeine			Cigars / Pipes / Vaping		
Soft Drinks			Marijuana		
Juice			Recreational Drugs		

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

SKIN/ HAIR/ NAILS

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

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: _____________
Avg number of days of flow: _______
Length of cycle: _________________

Last menstrual period: ___________
Last PAP - (date): _______________
Number of pregnancies: __________

Number of live births: ____________
Number of miscarriages: __________
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	☐	☐	Swelling in ankles	☐	☐
Leg cramps	☐	☐	Heart disease	☐	☐	Palpitations	☐	☐
Extremity numbness	☐	☐	Angina	☐	☐	Fainting	☐	☐
Extremity coldness	☐	☐	High blood pressure	☐	☐	Cyanosis	☐	☐
Extremity swelling	☐	☐	Low blood pressure	☐	☐	Past ECG	☐	☐
Extremity ulcers	☐	☐	Murmurs	☐	☐	Other heart tests	☐	☐
Deep leg pain	☐	☐	Rheumatic fever	☐	☐	Other: ______________________		
Cold hands/feet	☐	☐	Chest pain	☐	☐			

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.

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 injections, IV therapy, IV Chelation, Prolotherapy, Ozone therapy, nutrition, botanical medicine, lifestyle counseling, homeopathy, Traditional Chinese medicine (including acupuncture), hydrotherapy, physical medicine, and 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 Intravenous therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa

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. Kaler understands the importance of protecting your personal information. She is 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. 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 Guardian or Patient: ____________________________________ Date: ____________________

EMAIL CONSENT FORM

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.

Please be advised all Emails to or from Dr. Kaler will be made part of your medical record. Dr. Kaler will not forward Emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

Email is not the primary method of contact. It will not be used for medical emergencies or other time-sensitive matters. I realize that no medical advice will be provided over email and that email is **only** to clarify matters already discussed in appointments with Dr. Kaler. All new concerns require me to book a follow-up appointment.

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: ____________________

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 that can be either $50 or the full cost of the 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 chooses 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.

Patient(s) Name:____

Signature of Patient or Guardian: _______________________________ Date: __________

DIRECT BILLING AND CREDIT CARD POLICY

Direct Billing with insurance provides a preauthorization for payment. However, in some cases the amount authorized can change when payment is received or the payment may be sent to the plan member instead. Therefore, it is clinic policy in order to direct bill any insurance company that a valid credit card must be provided and kept on file. The 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, supplement refills or if insurance 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. The credit card must be updated in order to direct bill in the future as well.

Credit Card information: Visa MasterCard

Name on Card (please print): ____

Credit Card Number: ____

Expiration Date (Month/ Year): ______________________ CVV:_____________________

Cardholder’s Full signature: ___________________________ Today’s Date: ____________