PROACTIVE HEALTH GROUP
PROFESSIONAL HEALTH CARE FOR THE ACTIVE INDIVIDUAL

Date _____

Name _____ / _____ / _____
last first middle initial

Personal Health # _____ - _____ Male ☐ Female ☐

Home Address _____

City _____Postal Code_____Home Telephone #_____

Business Telephone # _____Cell #_____

E-Mail Address_____

Best way to contact you: ☐ Home # ☐ Work # ☐ Cell # ☐ Email

Birth Date _____/____/____ Marital Status ☐ M ☐ S ☐ W ☐ D
Y M D

Emergency Contact Name, Address, Phone#_____

_____

Occupation & Company Name _____

Physician's (G.P) Name, Address, Phone#_____

_____

Date of last physical examination _____/____/_____
Y M D

On occasion, our practitioners will communicate your clinical condition with your Physician.

Do you have health insurance other than Alberta Health Care? Yes ☐ No ☐

How did you first find out about the clinic?

☐ Patient Referral * ☐ Health Care Event ☐ Internet Search ☐ Physician Referral *

☐ Walk In ☐ Sport Team Referral * ☐ Trainer Referral * ☐ Website ☐ Other *

* Please specify the name of the person referring you: _____

120-602-12th Ave SW Calgary Ab. T2R 1J3 -- Tel: 403-225-3842 -- Fax: 403-225-3914
info@proactivehealthgroup.ca -- www.proactivehealthgroup.ca

Dr. Michael Hoffmann, B.Sc., N.D.
Naturopathic Physician

HISTORY OF PRESENT ILLNESS

What is the nature of the acute illness/complaint? Be as specific as possible:

How did this complaint develop? How long has it been occurring? Have you experienced this before? If due to an accident, please describe what happened in detail

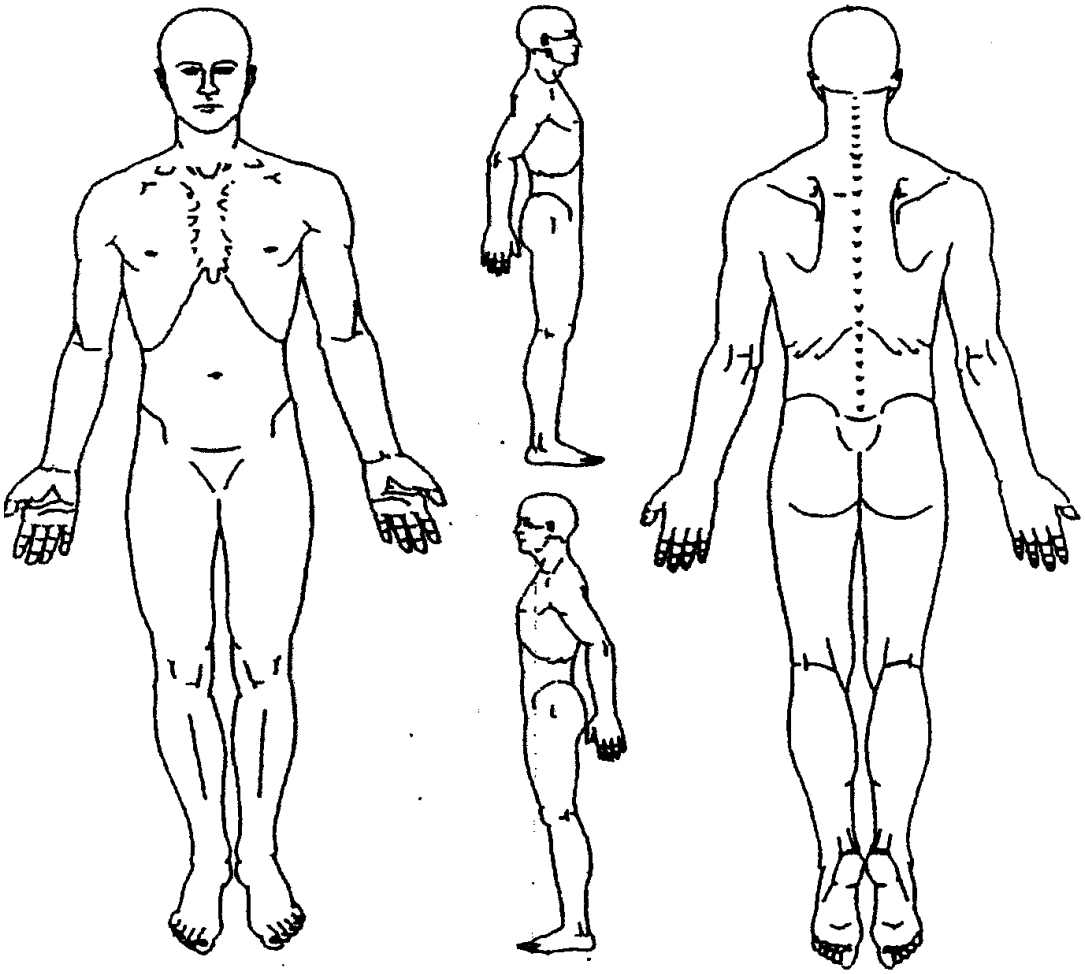
Have you noticed anything in particular that is making the complaint better or worse?

Have you been elsewhere for this complaint? If so, what was the diagnosis and suggested treatment?

Medications – List all your present medications both for the acute complaint and for chronic health concerns including drugs, vitamins, minerals, homeopathics, herbs and their dosages:

Are you allergic to any medicines or other substances? If yes, please list:

Please mark any problem or painful areas as exactly as possible with an X on the diagram bellow



Thank you for taking the time to complete this form

Dr. Michael Hoffmann, B.Sc., N.D.
Naturopathic Physician

CONSENT FOR TREATMENT

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT
Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopaths 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 naturopath will take a thorough case history, do a screening physical examination that may include a breast exam, blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important therefore that you inform your ND immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your ND immediately.

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

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture, prolothreapy, neuralthreapy or mesotherapy
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa
- Muscle strains and sprains, disc injures from spinal manipulation

_____ Initials I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____ Initials I understand that the Naturopathic Doctor will answer any questions that I have to the best of his ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications.

_____ Initials I understand that charges are to be paid at the time of the visit. Payment for all dispensary items is due at the time of the visit.

_____ Initials I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or late cancellations (less than 24 hours).

As the patient, you are responsible for the total charges incurred for each visit including costs of supplements. If I have coverage for naturopathic medicine, it is my responsibility to bill my insurance company. I understand that most insurance companies do not cover the cost of supplements. I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (Please Print) _____

Signature of Patient or Guardian: _____Date:_____