PYATT HEALTH CENTRE
NATUROPATHIC FAMILY MEDICINE & ONCOLOGY CARE

PATIENT INFORMATION

Name _____ Date of Birth _____ / _____ / _____ Age ____
DD MMM YY

Address _____
STREET NAME & # CITY, PROV POSTAL CODE

Phone # _( )_ - _____ Alt phone # _( )_ - _____
HOME WORK CELL HOME WORK CELL

Email address _____

Emergency contact: _____ _( )_ - _____

How did you hear about our clinic? _____

MEDICAL INFORMATION

Family Doctor _____ _( )_ - _____
NAME PHONE #

Medical Oncologist _____ _( )_ - _____
NAME PHONE #

Radiation Oncologist _____ _( )_ - _____
NAME PHONE #

Surgeon _____ _( )_ - _____
NAME PHONE #

Date of last physical exam _____ Date of last blood work _____

Are you pregnant or may you become pregnant? Y / N Are you breastfeeding? Y / N

Allergies _____

_____

Patient name:_____

Chief Health Concern:

Cancer Diagnosis:_____

Primary Occurrence -Y / N , Recurrence- Y / N

Metastatic -Y/ N, Lymph Node Involvement Y / N

Chemotherapy: Past Y / N Currently Undergoing Y / N Awaiting Y / N

Type(s) Of Chemotherapy:_____

_____

Radiation: Past Y / N Currently Undergoing Y / N Awaiting Y / N

Number of Treatments:_____

Hormone Therapy: Past Y / N Currently Undergoing Y / N Awaiting Y / N

Please List: _____

_____

Diagnostic Imaging: CT Scan - Y / N PET Scan - Y / N MRI - Y / N

Ultrasound - Y / N Mammogram - Y / N Colonoscopy - Y / N

Bone Scan - Y / N Mugga Scan - Y / N X-Ray - Y / N

Hospitalizations and Surgeries: _____

_____

_____

Other Prescribed Medications:_____

_____

_____

Over the Counter Medications and Supplements :_____

_____

_____

Patient Name _____

PERSONAL HEALTH HISTORY:

Side effects of conventional care:

Nausea - Y / N Vomiting - Y / N Diarrhea - Y / N Constipation Y / N

Neuropathy - Y / N Brain Fog - Y / N Chronic Fatigue - Y / N Mouth Sores Y / N

Please Rate the Following Where 1 = Very Poor and 10 = Your Ideal State.

Appetite ___/10 Strength ___/10 Pain ___/10 Overall Health ___/10

Energy ___/10 Sleep ___/10 Stress Tolerance ___/10

Please Circle Your Exposure to the Following:

Cigarette Smoke: Past Y / N Current Y / N

Other Potential Harmful Chemicals : Past Y / N

List: _____

_____

FAMILY HEALTH HISTORY:

Past Y / N Past Y / N

Father's

_____

_____

_____

Mother's Family

_____

_____

_____

Patient Name _____

REVIEW OF SYSTEMS:

Please state any health issues in the following categories that are not already mentioned above, including any significant past issues as well, indicated by a (P) after the condition:

Skin, Hair, Nails:_____

Digestive:_____

Respiratory:_____

Eyes, Ears, Nose, Throat:_____

Immune System:_____

Cardiovascular:_____

Nervous System:_____

Hormones:_____

Weight:_____

Urinary:_____

Musculoskeletal:_____

Mental Emotional:_____

Other:_____

PYATT HEALTH CENTRE
NATUROPATHIC FAMILY MEDICINE & ONCOLOGY CARE

If you wish to leave your credit card information here to allow for easier transactions please fill out the following form

Credit Card Information:

Card Type: ____ Master Card ____ Visa

Card Holder Name _____
(As Shown on Card)

Card Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Expiration Date: __ __ / __ __ (MM / YY) C.C.V.: __ __ __ (On Back Of Card) Postal Code _____ (associated with Card)

I, _____ authorize
Printed Name

Pyatt Health Centre to charge my credit card listed above for agreed upon purchases. I understand that my information will be saved to an encrypted file for future transactions on my account.

X_____ Date : _____ / _____ / _____
Signature Day Month Year

PYATT HEALTH CENTRE
NATUROPATHIC FAMILY MEDICINE & ONCOLOGY CARE

CONSENT TO TREAT & PATIENT RESPONSIBILITY

The Undersigned patient and/or responsible relative or person hereby consents to the following:

I authorize Pyatt Health Centre naturopathic doctors and medical personnel to administer and perform medical examinations, investigations, and medical treatments during the course of my care that are deemed advisable or necessary.

I consent to Pyatt Health Centre contacting me by telephone if needed regarding appointments and follow-up needs.

I am responsible for making my own appointments and notifying Pyatt Health Centre with sufficient notice (one business day prior to my appointment) should I be unable to attend a scheduled appointment. Appointments missed or rescheduled without sufficient notice may carry a financial penalty.

I understand that should I be later than half the length of my appointment I will likely need to reschedule. Though every attempt will be made to accommodate late clients, Pyatt Health Centre is unable to make guarantees in this regard.

I realize that I am responsible for all costs associated with my care at Pyatt Health Centre. This includes, but is not limited to, consultations, treatments, evaluations & labs, supplementation, professional letters/ correspondences and courier & shipping costs. I also know that I will be duly informed by a member of Pyatt Health Centre of any cost prior to my incurring them.

I understand that it is my responsibility to follow-up with my care provider at Pyatt Health Centre via a phone or clinic consult, should phone messages or email not be answered in a timely fashion. Inquiries regarding changes or continuation of my treatment plan will require a follow-up appointment. Email may be used to clarify existing treatment plans and general questions or or notify practitioners of adverse reactions.

I will familiarize myself with all instructions or guidance for testing or visits provided by Pyatt Health Centre prior to the scheduled appointment.

Out of respect for the healing environment at Pyatt Health Centre I will refrain from wearing any toiletries and cosmetics that are heavily scented.

_____ _____

Patient Signature Date