LIBERTY CLINIC

PATIENT INTAKE FORM

Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Phone (H): _____ (Bus.): _____ (Cell)_____
E-mail: _____
Male: ❒ Female: ❒ Date of Birth: _____
Occupation: _____ Employed By: _____
Marital Status: _____ Number of children: _____
Do you require any mobility equipments? If yes, please name_____
Emergency Contact: _____ Phone: _____ Relation: _____
Name of Medical Doctor: _____
Address: _____ Phone: _____

How did you hear about us? ❒ Radio ❒ T.V. ❒ Newspaper ❒ Website ❒ Friends ❒ Family ❒ Other: _____

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Health Concerns

What are your main health concerns in order of importance to you?

_____
_____

Vitamins and Supplements

Are you taking any vitamins/ mineral/ herbal supplements? Y N
If yes, what and indicate the total dosage taken in one day (i.e. if you take two tablets of Vitamin C 500mg/day, then the total daily is 1000mg)

_____
_____

Prescription Drugs

List all prescription drugs that you are currently taking. Indicate present dose and how long you have been on each medication.

_____
_____

List all prescription drugs you have taken in the past for longer than six months. Indicate how long you were on each medication.

_____
_____

Family History

Please put an "L" for living and "D" for deceased, and present age or age at the time of death. Please indicate if the family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis.

Relationship	L/D	Age	Diseases Suffered/ Cause of Death
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Mother			
Brother(s)			
Sister(s)			
Paternal Uncles			
Paternal Aunts			
Maternal Uncles			
Maternal Aunts			

Medical History

List any surgery or injury or cosmetic procedure and when it happened?

_____

_____

Are you seeing any other Health Care Providers for any type of treatments? If yes, what is it?

_____

_____

Have you had a massage before? Y N

Visual Pain Rating Scale

Make a mark (X) along the line which you think represents your current level of pain

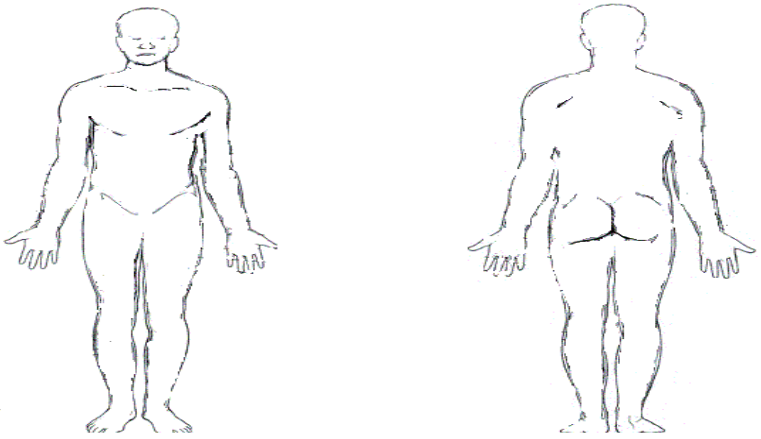
No pain at all _____As bad as it could be

Pain Diagram

On the following diagrams, indicate all areas of:

Pain – xxxx Stiffness - //// Numbness – 0000

Other(Specify)_____



Medical History

In the lists below, check all major illnesses that you have experienced.

Measles		Stomach/Duodenum Ulcers		Genital Herpes		Heart Problems	
German Measles		Hiatal Hernia		Genital Warts		Heart attack, angina	
Chicken Pox		Constipation		Gonorrhea		Palpitation	
Mononucleosis		Crohn's Disease		Spleen Disease		Circulation Problems	
Mumps		Appendicitis		Hypoglycemia		Varicose Veins	
Whooping Cough		Rheumatoid Arthritis		Jaundice		Anemia	
Scarlet Fever		Osteoarthritis		Hepatitis		Raynaud's Disease	
Polio		Rheumatism		Liver Disease		Platelet Disorders	
Reye's Syndrome		Back pain/Sciatica		Pancreatic Disease		Miscarriage	
Worms/Parasites		Fibromylagia		Bladder Problems		Abortion	
Cholera		Gout		Prostate Problems		Gestational Diabetes	
Malaria		Strep Throat		Diabetes		Uterine Prolapse	
Food Poisoning		Sinusitis		Gall Bladder Disease		Pre-eclampsia	
Typhoid		Allergies (Environmental)		Eye Problems		Other Pregnancy Related Illness	
Diarrhea		Hay Fever		Kidney Problems		Fibrocystic Breast Disease	
Acne, Boils, Impetigo		Bronchitis		Cushing's Disease		PMS	
Shingles		Pneumonia, Pleurisy		Addison's Disease		Uterine Fibroids	
Eczema		Asthma		Hypothyroid		Endometriosis	
Keloids		Tuberculosis		Hyperthyroid		Ovarian Cysts	
Psoriasis		Malnutrition		Eating Disorder		Vaginitis (recurrent)	
Warts		Rickets		Schizophrenia		Painful Periods	
Herpes (cold sores)		Osteoporosis		Bipolar Disease		Infertility	
Urticara		Wilson's Disease		Clinical Depression		Migraine Headaches	
Ulcers		Chronic Fatigue Syndrome		Suicidal Tendencies		Dizziness	
Skin Cancer		Environmental Illness		Multiple Sclerosis		Numbness	
Candida (yeast syndrome)		Human Papillovirus (HPV)		Lupus		Cramps	
Irritable Bowel Syndrome		Chlamydia		Myasthenia Gravis		Epilepsy	
Colitis		Syphilis		High Blood Pressure		Meningitis	
Diverticulitis		HIV		Low Blood Pressure		Cosmetic procedure	
Cancer, specify type:		Cancer, specify type:		Fainting		Other:	

Vaccinations (please check)

- ❑ DPT (Diptheria, Pertussis, Tetanus)
- ❑ MMR (Measles, Mumps, Rubella)
- ❑ Chicken Pox
- ❑ Polio
- ❑ Flu Shot
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Other _____

Did you experience any adverse effects from them? If yes, please explain

_____

_____

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Please check "√" if you are experiencing the following symptoms or write "**P**" beside the box if you have experienced these symptoms in the past.

General

- ❑ Poor/Change in appetite
- ❑ Nervousness
- ❑ Weight gain
- ❑ Weight loss
- ❑ Cancer
- ❑ Diabetes
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Allergies
- ❑ Chills and fevers
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Cravings
- ❑ Strong thirst

Skin and Hair

- ❑ Rash
- ❑ Itching
- ❑ Eczema
- ❑ Acne
- ❑ Loss of hair
- ❑ Thinning hair
- ❑ Dandruff
- ❑ Recent moles
- ❑ Dryness
- ❑ Hives or allergy reaction
- ❑ Boils
- ❑ Other skin problem(s)

Eyes Ears Nose Throat

- ❑ Ear aches
- ❑ Ear infections
- ❑ Ringing in ears
- ❑ Sinus infections
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Recurrent sore throat
- ❑ Tonsillitis
- ❑ Nasal obstruction
- ❑ Post nasal drip
- ❑ Nosebleeds
- ❑ Headaches
- ❑ Loss of taste/smell
- ❑ Eye pain
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Vertigo
- ❑ Impaired vision
- ❑ Cataracts
- ❑ Facial pain/tics
- ❑ Jaw pain or clicks
- ❑ Mercury fillings
- ❑ Sores in mouth

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis
- ❑ Stroke/cardiovascular accident
- ❑ Pacemaker or similar device
- ❑ Artificial valve
- ❑ Irregular heartbeat
- ❑ Dizziness
- ❑ Fainting
- ❑ Chest pain
- ❑ Varicose veins
- ❑ Cold hands or feet
- ❑ Swelling of limbs

Respiratory

- ❑ Difficulty breathing
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Shortness of breath
- ❑ Coughing blood
- ❑ Throat phlegm
- ❑ Wheezing

Muscle, Bone & Jointsl

- ❑ Neck pain
- ❑ Back pain
- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Arthritis
- ❑ Bursitis
- ❑ Other pain
- ❑ Artificial joint

Gastrointestinal

- ❑ Indigestion
- ❑ Gas or burping
- ❑ Bad breath
- ❑ Constipation
- ❑ Diarrhea
- ❑ Incomplete bowel movements
- ❑ Abdominal pain or cramps
- ❑ Nausea
- ❑ Vomiting
- ❑ Chronic laxative use
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Blood in stool
- ❑ Constant hunger
- ❑ Colon trouble
- ❑ Bloating
- ❑ Gall bladder trouble
- ❑ Intestinal worms
- ❑ Jaundice

Neurological

- ❑ Loss of balance
- ❑ Irritable
- ❑ Poor memory
- ❑ Anxiety
- ❑ Depression
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Seizures/Epilepsy
- ❑ Concussion
- ❑ Loss of sensation
- ❑ Emotional problems
- ❑ Other psychological problem

Infections

- ❑ Hepatitis

- ❑ Tuberculosis
- ❑ HIV/AIDS

Genito-Urinary

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Pain on urination
- ❑ Wake up at night to urinate
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Kidney infection
- ❑ Blood in urine

Male

- ❑ Prostate problem
- ❑ Impotence
- ❑ Sores on genitals
- ❑ Pain
- ❑ Infertility/low sperm count
- ❑ STD
- ❑ Hernia

Female

- ❑ Irregular periods
  - ❑ Heavy
  - ❑ Light
  - ❑ Clots
- ❑ Painful periods
- ❑ Vaginal discharge
- ❑ Pregnant
- ❑ Infertility
- ❑ Vaginal sores
- ❑ Sore breasts
- ❑ STD

Date of last Pap _____
Age of first menses _____
Menopausal Y□ N□
Age of last menses _____
Pregnant Y □ N□
Do you practice birth control? Y□ N□
Type _____

Number of:

- Pregnancies_____
- Abortions_____
- miscarriages _____
- births_____

Personal Habits and Lifestyle

How many cups/bottles/glasses do you drink on average per day?

Coffee		Milk 2%		Fruit Juice	
Tea		Skim Milk		Soft Drinks (diet)	
Water		Beer		Soft Drinks (regular)	
Herbal Tea		Wine		Vegetable Juice	
		Liquor			

What is the source of your drinking water?

Tap (city)		Well		Bottled (spring)		Filtered		Distilled	

Do you smoke? Y N If yes, how many per day? _____
Do you use recreational drugs? Y N

How frequently do you move your bowels? _____ (# of movements) per day or week?
How many hours of sleep do you get on average? _____
Do you feel refreshed in the morning? Y N

How many hours do you work each day? _____
Do you often feel overworked? Y N

Do you exercise? Y N If yes, How often?_____
What do you do for exercise? (indicate frequency, intensity and duration)

_____

_____

Do you frequently use any of the following? Please check and indicate amount.

- ❑ Aspirin
- ❑ Laxatives
- ❑ Antacids
- ❑ Diet pills
- ❑ Sleeping pills
- ❑ Pain pills

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Diet

Diet: Non Vegetarian ❒ Vegetarian ❒ Vegan ❒ For how long? _____

Known Food Allergies/Intolerance:

_____

Known Environmental or Drug Allergies/Sensitivities:

_____

_____

Please describe a typical day's diet

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Physical Activity Readiness Questionnaire (PAR-Q)

Yes No	1. Has your doctor ever said you have heart trouble and that you should only do physical activity recommended by a doctor?
Yes No	2. Do you feel pain in your chest when you do physical exercise?
Yes No	3. In the past month, have you had chest pain when you were not doing physical activity?
Yes No	4. Do you lose your balance because of dizziness or do you ever lose consciousness?
Yes No	5. Do you have a bone or joint problem that could be made worse by a change in your physical activity?
Yes No	6. Is your doctor currently prescribing drugs (e.g. water pills) for your blood pressure or heart condition?
Yes No	7. Do you know of any other reason why you should not do physical activity?

SIGNATURE

I attest that the information provided is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

Thank you for taking the time to fill out this questionnaire.
It will help greatly in our study of your present health concerns
and in our understanding of your health goals.
Your responses will assist us in choosing the appropriate treatment that will
bring about your return to optimal health.

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info@libertyclinic.com www.libertyclinic

DECLARATION AND CONSENT TO TREATMENT

I would like to take this opportunity to welcome you to our clinic. The Liberty Clinic utilizes the principles of *Vis medicatrix naturae* (the healing power of nature) and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

A health professional, will conduct a thorough case history, conduct a physical exam and may utilize specific blood, urinary or other laboratory tests as part of the treatment work-up.

Health professional you will be seeing:

❒ Dr. Jean-Jacques Dugoua ND PhD
❒ Dr. Lindsey Campbell ND
❒ Dr. Simona Scurtu ND
❒ Dr. Crystal Draper DC
❒ Dr. Donald Littlewood DC
❒ Mary-Margaret Heron DO(mp)
❒ Pierre Boachon DO (mp)
❒ Takayoshi Munemoto RMT RAc

Statement of Acknowledgement

Printed name: _____

As a patient of the Liberty Clinic, I have read the information and understand that the form of medical care is based on complementary and alternative medicine and other supportive therapies. As the **Liberty Clinic** is an integrated health clinic, I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications. The information I have provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs. The slight health risks of some treatments include, but are not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture, muscle strains and spasms, rib fractures, and disk injuries.

I also recognize the following:

- **Any treatment** or advice provided to me as a patient of the Clinic is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider.

- I am at **liberty to seek or continue medical care from a medical doctor or other healthcare provider licensed to practice in Ontario.**

- I am aware that **no part of my treatment is covered by OHIP** and that I am solely responsible for **payment at the time services are rendered.**

- I am aware that **48 hours notice** must be given for all cancelled appointments or a **cancellation fee (100% of the service fee)** will be applied.

- I understand that the health professional reserves the right to determine which cases fall outside of his/her scope of practice, in which event the **appropriate referral will be recommended.**

I am aware that the Liberty Clinic is an integrated clinic. In order to provide optimal care, our health professionals may confidentially request information from your medical doctor, e.g. medications, lab results and imaging (X-rays, MRI, CT, ultra-sound, bone density, etc.), in order to analyze all the components of your case. A "Patient information release form" would need to be signed in this case.

I confirm that I have the ability to accept or reject this care of my own free will. I have had an opportunity to ask questions about this form and they have been answered to my satisfaction. I accept full responsibility for any fees incurred during care and treatment.

I confirm that I am not an agent nor acting on behalf of an agent of an individual or organization (private, for-profit, non-for-profit, institutional, academic, media, municipal, provincial or federal) to gather information without stating. I also confirm that there is no such agent attending this appointment with me.

Initial here

I may receive a monthly newsletter from Liberty Clinic regarding announcements at the clinic and general health information/tips. I may unsubscribe from this newsletter at any time.

Signature: _____ Date: _____ (dd/mm/yyyy)