

Dear New Patient:

Thank you for choosing Port Moody Health as your integrative health care provider. We are conveniently located in the scenic community of Port Moody. Free parking is available on the premises. Please note that our office is scent-free to respect those clients with allergies or sensitivities. The office accepts payment by Debit, Visa, MasterCard, Amex, and direct billing. Most extended health care providers cover Naturopathic visits. Please check with your provider to determine the amount that is covered under your policy.

Enclosed are a contact form and a detailed intake questionnaire.

Please ensure this is completed and submitted at least one (1) week prior to your appointment.

What to expect from your first visit:

- ✓ Please arrive **15 minutes prior** to your scheduled appointment to provide a urine sample prior to the start of your visit.
- ✓ The first visit with Dr. Paulina Domzal, ND is 75-90 minutes in length and involves a review of the detailed intake questionnaire, full health history, macroscopic urinalysis and, if necessary, may include a partial physical exam.
- ✓ Some laboratory tests, such as specific blood, urine or saliva analysis may also be recommended at this time, **but are not included in the cost of the visit.**
- ✓ Subsequent visits vary from 15 minutes to 75 minutes in length.
- ✓ Treatments and therapies are an additional cost.

What we need before your first visit:

- ✓ Your completed new patient forms and Release of Records. Please fax or email these to us in advance so that we can upload your chart and request your medical records.
- ✓ Copies of any blood work or laboratory reports that are recent as of the last six months (or longer if appropriate) and any other pertinent documents.
- ✓ If possible, please bring medications or supplements that you are currently taking.

***INITIAL CONSULTATION FEE is charged at the time of booking and is NON-REFUNDABLE.**

- While we deeply empathize with the unexpected difficulties that can arise, including the loss of a loved one, we want to inform you that our policy is non-refundable for initial consultations, and unfortunately, we are unable to provide a refund for the consultation fee in such circumstances. Thank you for your cooperation.

- In the event that you must reschedule your appointment we do require 2 business days' notice or the full charge of the visit fee will be applied. Changes can only be made in person or via telephone, not e-mail.

Please note, all tests, product and treatment purchases are final. We do not issue returns or exchanges. Thank you for your cooperation.

Kindly give us a call at 604-949-0077 if you have any questions.

We look forward to meeting you.

CONTACT INFORMATION

Full Name: _____ Preferred Pronoun: _____

Name of Parent or Guardian if under the age of 18: _____

Date of Birth: _____ Sex: Male ☐ Female ☐

Ethnicity: _____ Occupation: _____

Personal Health Number: _____

Full Address: _____

Postal Code: _____ Email: _____

Would you like to be informed about upcoming news and events? Yes ☐ No ☐ Initial: _____

Telephone: (home) _____ (work) _____ (mobile) _____

Preferred form of contact for reminder/follow-up calls:

☐ Home Number ☐ Work Number ☐ Mobile Number

Emergency Contact Name: _____

Relation: _____ Telephone: _____

Name of Medical Doctor: _____

Address: _____

Telephone: _____ Date of last visit: _____

How did you hear of us?

Were you referred by someone? If yes, whom? _____

Adult Intake Form

Please fill out this form to the best of your ability. It will help to assess your present health and will assist in facilitating the healing process.

Legal name: _____

Preferred Name: _____ Preferred Pronoun: _____

Age: _____ Height: _____ Current Weight: _____

Gender identity

☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ non-binary ☐ intersex
☐ Two-spirit / Gender Fluid ☐ Decline to answer ☐ Another identity: _____

Sex assigned at birth _____ ☐ Decline to answer

List all prescribed medications currently taken and include **dose, frequency, and duration** (how long you have been taking them).

1.

2.

3.

List any medication allergies (for example penicillin):

List all over-the-counter medications that you take (for example: Aspirin, Tums, Tylenol) and include **dose and frequency**:

Please list any significant illness or health concerns pertaining to your immediate family members:

List any surgeries and/or hospitalizations along with the dates (including dental surgeries, tooth extractions, root canals, etc.):

List any severe accidents or injuries in the past along with the dates:

How many courses of antibiotics have you been on in the last 5 years? (Indicate the reason for prescription):

What are your health concerns, in order of importance?

- 1.
- 2.
- 3.

List all vitamins, minerals, herbal medicines, Asian medicines, or homeopathies you are currently taking and include dosage and frequency:

How would you describe your general state of health?

☐

Excellent

☐

Good

☐

Fair

☐

Poor

What type of vaccinations have you received?

Have you ever experienced an adverse reaction to the above vaccinations?

Do you drink alcohol? If yes, what type, and how often?

Do you smoke? If yes, since when, and how many a day? If you smoked in the past, please indicate the **frequency and duration**.

Do you currently or have you in the past used any recreational drugs? If yes, indicate type and frequency and duration of usage:

Do you presently have mercury (silver) fillings in your mouth?

How many? _____

Have you had any mercury fillings replaced?

How many? _____

Did you receive chelation at the time of removal?

☐

YES

☐

NO

Please list any known past or present toxic exposures (occupational, residential, medical, environmental, etc.):

Please list past regions of long-term residence (along with dates, duration) if different than your current residence:

Describe your general state of health as a child:

Describe your general state of health as a teenager:

Do you have any dietary restrictions, food sensitivities or allergies? If so, please describe:

Please provide details about your average daily diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Water Intake: liters per day _____ Source: ☐ Tap ☐ Bottle ☐ Filtered ☐ Other _____

Do you exercise? If so, indicate the type, frequency and duration that you have been exercising.

List your hobbies or interests: _____

What level of personal stress are you experiencing currently?

☐ Minimal ☐ Average ☐ Considerable ☐ Unbearable

What are the main stressors in your life? _____

Do you have difficulty falling and/or staying asleep? If yes, please explain: _____

Do you wake up feeling refreshed? ☐ Yes ☐ No

How would you rate your overall energy out of 10 (10 being the optimal level you would like to achieve)?
_____/10 If applicable, at what time(s) of the day do you experience the lowest energy?

Please circle 'Y' if you are currently experiencing the condition. Please circle 'P' if you had the condition in the past. **Write comments to the right as necessary to provide details/specifics.**

SKIN	Y	P	
Itching	☐	☐	
Dryness	☐	☐	
Hives (Allergy)	☐	☐	
Eczema	☐	☐	
Psoriasis	☐	☐	
Boils	☐	☐	
Acne	☐	☐	
Rosacea	☐	☐	
Skin Cancer	☐	☐	Type:
Changes in moles	☐	☐	
Weak Nails (of hands or feet)	☐	☐	
Nail Fungus (of hands or feet)	☐	☐	

HEAD

Y

P

Headaches	☐	☐	
Migraines	☐	☐	
Head injury/ trauma	☐	☐	
Dizziness	☐	☐	
Loss of Hair	☐	☐	

EYES

Y

P

Date of Last Optometrist Visit			
Glasses/ Contact lenses	☐	☐	
Eye Pain	☐	☐	
Tearing	☐	☐	
Dryness	☐	☐	
Double Vision	☐	☐	
Blurring	☐	☐	
Cataracts	☐	☐	
Glaucoma	☐	☐	
Bothered by sun	☐	☐	
Blind Spot	☐	☐	
Night/ Color blindness	☐	☐	

EARS

Y

P

Impaired Hearing	☐	☐	
Earache	☐	☐	
Discharge	☐	☐	
Infections	☐	☐	
Tinnitus (ringing in the ears)	☐	☐	

NOSE

Y

P

Frequent Colds	☐	☐	
Nose bleeds	☐	☐	
Stuffiness/ Congestion	☐	☐	
Hay Fever	☐	☐	
Sinus Infections	☐	☐	

MOUTH & THROAT

Y

P

Date of last dental visit			
Frequent sore throats	☐	☐	
Sore tongue/ mouth	☐	☐	
Difficulty swallowing	☐	☐	
Dry mouth	☐	☐	
Gum disease/ Gingivitis	☐	☐	
Hoarse voice	☐	☐	
Loss of Taste	☐	☐	
TMJ Syndrome (Jaw Clicking)	☐	☐	
Halitosis (Bad Breath)	☐	☐	

NECK

Y

P

Pain or Stiffness	☐	☐	
Enlarged Thyroid	☐	☐	
Enlarged Lymph nodes	☐	☐	

RESPIRATORY

Y

P

Cough	☐	☐	
Sputum	☐	☐	
Wheezing	☐	☐	
Asthma	☐	☐	
Bronchitis	☐	☐	
Difficulty breathing	☐	☐	
Pain on breathing	☐	☐	
Shortness of Breath (when?)	☐	☐	
Pressure or tightness in chest	☐	☐	

CARDIOVASCULAR

Y

P

Heart disease	☐	☐	
High blood pressure	☐	☐	
High cholesterol	☐	☐	
Chest pain	☐	☐	
Angina	☐	☐	
Swelling in ankles/ feet	☐	☐	
Palpitations, fluttering	☐	☐	

GASTRO-INTESTINAL

Y

P

Heartburn/ reflux	☐	☐	
Change in thirst/ appetite	☐	☐	
Nausea/ Vomiting	☐	☐	
Bowel movements- How often	☐	☐	
Blood in stool	☐	☐	
Belching/ Passing Gas/ Bloating	☐	☐	
Liver/ Gallbladder/ Stones	☐	☐	
Ulcer	☐	☐	
Indigestion	☐	☐	
Diarrhea	☐	☐	
Constipation	☐	☐	
Hemorrhoids	☐	☐	
Intestinal worms and/or parasites	☐	☐	

URINARY

Y

P

Pain on urination	☐	☐	
Increased frequency	☐	☐	
Inability to hold urine	☐	☐	
Frequent urinary infections	☐	☐	
Kidney stones	☐	☐	
Blood in urine	☐	☐	

REPRODUCTIVE & SEXUAL HEALTH	Y	P	
Are you or have been sexually active?	☐ YES	☐ NO	
Sexual Difficulties	☐	☐	
Venereal disease	☐	☐	
Male:			
Testicular masses/ pain	☐	☐	
Have you ever had a digital rectal (prostate) exam and/ or PSA test?	☐	☐	
If so, pls indicate your last evaluation and pertinent details			
Female:			
Age menses began			
Average number of days of menses			
Average length of cycle			
Bleeding between periods	☐	☐	
Irregular periods	☐	☐	
Pain during intercourse	☐	☐	
Painful period	☐	☐	
PMS	☐	☐	
Excessive flow	☐	☐	
Breast tenderness	☐	☐	
Breast Lumps/ cysts/ discharge	☐	☐	
Last Menstrual period date			
Vaginal discharge	☐	☐	
Vaginal itching	☐	☐	
Difficulty conceiving	☐ Yes	☐ No	
Birth Control	Currently/ Never/ Past		
If so, what type and when			
Number of pregnancies			
Number of live births			
Number of miscarriages			
Number of abortions			
Last PAP (Date)			
History of abnormal PAP	☐ Yes	☐ No	If yes, details:
Have you ever had a mammogram, breast ultrasound, pelvic or transvaginal ultrasound?	☐ Yes	☐ No	If yes, details:
Do you receive regular mammograms?	☐ Yes	☐ No	If yes, details:

MUSCULOSKELETAL

	Y	P	
Joint pain and/ or stiffness	☐	☐	
Arthritis	☐	☐	
Broken bones	☐	☐	
Muscle spasms or cramps	☐	☐	
Backache	☐	☐	
Foot Pain	☐	☐	
Injury (Tendon/ Ligament/ Joint)	☐	☐	
Significant joint swelling	☐	☐	

PERIPHERAL VASCULAR

	Y	P	
Deep leg pain	☐	☐	
Cold hands/ feet	☐	☐	
Varicose veins and/or spider veins	☐	☐	
Extremity numbness or tingling	☐	☐	

NEUROLOGICAL

	Y	P	
Fainting	☐	☐	
Seizures/ Convulsions	☐	☐	
Loss of memory	☐	☐	
Paralysis	☐	☐	
Involuntary movement	☐	☐	
Loss of balance	☐	☐	
Speech problems	☐	☐	

ENDOCRINE

	Y	P	
Heat and/ or cold intolerance	☐	☐	
Thyroid abnormalities	☐	☐	
Excessive sweating	☐	☐	
Lack of sweating	☐	☐	
Excessive thirst	☐	☐	
Excessive urination	☐	☐	
Excessive hunger	☐	☐	
Diabetes- Type I or II	☐	☐	
Hypoglycemia/ Hyperglycemia	☐	☐	
Hormone therapy	☐	☐	

BLOOD/LYMPHATIC

	Y	P	
Anemia	☐	☐	If yes, what type
Easy bleeding/ bruising	☐	☐	
Lymph node swelling	☐	☐	

EMOTIONAL

	Y	P	
Depression	☐	☐	
Mood swings	☐	☐	
Anxiety or nervousness or tension	☐	☐	
Diagnosed mental illness	☐	☐	
Alcohol/ Drug abuse	☐	☐	
Emotional Eating	☐	☐	
Insomnia	☐	☐	



Thank you for answering all the questions. Complete answers to all the questions are to your benefit for the most effective naturopathic assessment, diagnosis and treatment.

This is a **confidential** record of your medical history and will be kept in this office.

The information contained here will not be released to any person except when you have authorized us to do so.

Print Name _____ Signature _____

Witness _____ Date _____

Print parent/guardian's name _____

Signature of parent/guardian _____

PATIENT CODE OF CONDUCT

To provide a safe and healthy environment for staff, patients and their families, Port Moody Health expects patients and accompanying family members to refrain from unacceptable behavior that are disruptive or pose a threat to the rights or safety of others.

Patients and their families will:

- Treat staff & physicians with respect & honesty
- Refrain from making verbal threats to harm another individual
- Refrain from intentionally damaging equipment or property; throwing objects
- Refrain from making menacing gestures, physical assault, behaves violently in any real or perceived manner, inflict bodily harm
- Refrain from making harassing offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication, as well as in person interactions with physicians, employees or others.
- Refrain from discriminatory comments or actions in regard to sexism, racism, ableism, classism, homophobia, biphobia, transphobia and any other behavior that is derogatory
- Supervise children in their care so that they are not climbing on furniture and respect other people's property
- Be prepared to work with other Port Moody Health staff when your usual Doctor, Nurse or Support staff is not available
- Understand that Port Moody Health works with many individuals with many levels of needs, and staff may need to prioritize their time to deal with emergency or high need situations.
- Maintain confidentiality of other patients and staff
- Understand that posting comments on social media that harass, bully or defame a doctor, clinic staff, or patients is unacceptable and could result in immediate dismissal from Clinic and services

Refusal of Service

Patients and their families have a responsibility to be respectful and considerate of others and the employees of Port Moody Health. The decision to refuse service is usually made by the employee in consultation with the Clinical Director when anyone has contravened any of the above and is disruptive to the clinic's ability to function. Violators are subject to removal from the clinic and/or discharge from the practice. Wherever possible, if a patient is refused service, that service user is provided with a referral to other appropriate agencies.

Print Name _____ Signature _____

Witness _____ Date _____

Print parent/guardian's name _____

Signature of parent/guardian _____

PATIENT RELEASE OF RECORDS

Physician: _____

Clinic Address: _____

Phone#: _____

Fax #: _____

**Please accept this as a request for the following patient's clinical records/imaging results.
(within last 2 years):**

*** Please note that this is not a transfer of records request. ***

☐ All recent blood work results

☐ All Imaging results

☐ All Specialist consultations

☐ Other

Imaging / Radiology Reports: ☒ Mammogram ☐ Ultrasound ☐ X-Ray ☐ MRI ☐ CT ☐ Bone

☐ PET scan ☐ Pathology / Biopsy Reports ☐ Other

☐ **URGENT**

☐ **Routine**

*** Please note that the patient will be responsible for any processing fees associated with reproducing medical records. ***

Patient name: _____

PHN#: _____

DOB: _____

Phone#: _____

Patient Signature: _____

Date: _____

Please Fax, Email or Mail Records To:

☐ **Dr. Sharon Gurm, ND, FABNO**

☐ **Dr. Paulina Domzal, ND**

Fax (604) 949-0017

E: info@portmoodyhealth.com