**A: Contact Information**

Last name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M/F

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Street City Province Postal Code

Preferred Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ # of Children: \_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Care Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can Dr. Ariel Jones contact you via email?

Would you like to receive our monthly newsletter about clinic specials, medical news and new retreats?

**Emergency Contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about me?

☐ Walk-in ☐ Dr. Ariel’s website ☐ Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Newspaper ☐ Social media ☐ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any healthcare providers you are currently seeing:**

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ specialty \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last physical/annual exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last blood tests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_

**B: Health history**

Please list your main health concerns in order of importance

|  |  |  |
| --- | --- | --- |
| Concern | When it began? | Severity 1-10 |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |
| 5. |  |  |

Please list the treatments you have tried for the above mentioned concerns:

What led you to wanting to do a water fast?

What are your intentions with this water fast? What are you hoping to accomplish?

Do you have any emotional issues that you would like to address in this fast?

Do you have any sexual issues that you would like to address in this fast?

Do you have any social issues that you would like to address in this fast?

Do you have any family issues that you would like to address in this fast?

**Official Medical Diagnoses** (Name, When it was diagnosed, and by whom)

1.

2.

3.

4.

**Review of Systems -** Are you are having issues with any of these systems?  
  
**Head** (eyes, ears, nose, throat):  
**Respiratory system** (lungs):  
**Digestive system** (stomach, intestines, bowel movements):   
**Urinary system** (kidneys, urine):   
**Sexual system** (any body parts or sexual health, libido):  
**Nervous system** (nerves, tremors, brain problems, shooting pains):  
**Cardiovascular** (heart, veins):  
**Skin**:  
**Endocrine system** (sweating, body odor, fatigue, mood):  
**Musculoskeletal** (Muscles, body, aches pains):  
**General Markers of Health:**  
Sleep (how many hours do you get each night, difficulty falling asleep, waking in the night):

Energy (level, duration throughout the day):

Appetite-

Mood-   
Menses-

Length of cycle:

How heavy is the flow:

How many days of flow:

PMS:

Prostate Health:

Stress-what are your biggest stressors in life, how intense is your stress (1-10):

**Allergies** (drugs, herbs, foods, environmental):

**Smoking**- (Cigarettes, marijuana, other + How often/many):

**Hospitalizations**:

**Surgeries**:

**Any and All Supplements & current Medications**:

How many times have you taken anti-biotics?

Did you do a round of probiotics?

**Family history** (cancer, heart attack, diabetes, anxiety disorder etc. for your parents and grandparents:

Congratulations! You have completed the first step in our registration process. I look forward to our journey together,

Dr. Ariel Jones, ND

Thank you for completing this intake

Please read the following and indicate that you have read and understand the following. By submitting you will have indicated that you have read and understand the following:

**Cancellation policy**

* All fees are due 30 days prior to the first day of the program.
* You are free to cancel your attendance at the water fasting program at any time. Refunds are only available 30 days prior to the first day of the retreat.
* No refunds will be offered less than 30 days before the first day of the program.

**We require a credit card on file and to begin your process of administration.**

**Name on Card:**

**Credit Card Number:**

**Expiry Date:**

**Number on the back:**

**Postal code or Zip code the card is registered to:**

PLEASE READ THIS ENTIRE SECTION AND SIGN AT THE BOTTOM

INFORMED CONSENT **FOR NATUROPATHIC MEDICINE & WATER FASTING**

Naturopathic Medicine is considered a primary health care service in British Columbia, which focuses on individualized treatment, the prevention of disease, and the choice of less harmful (or more “natural”) treatments. Naturopathic physicians assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Naturopathic physicians are licensed to diagnose and treat illness. We provide a wide range of treatment options, including, but not limited to nutritional and lifestyle counselling, botanical medicine, physical therapies, acupuncture, spinal manipulation, homeopathy, laboratory diagnosis, supplements, vitamins, water fasting and pharmaceutical prescriptions in order to stimulate the body’s inherent healing capacity. We are governed by the Health Professions Act of BC and the Canadian College of Naturopathic Physicians of British Columbia (CNPBC).

Naturopathic Physician’s like to take time with people to cultivate a doctor-patient relationship that is built on mutual trust and respect. While it is possible for some treatments to be rapid and effective on the first visit, naturopathic often requires repeated visits. The course of treatment is always discussed and individualized to your needs.

**Informed Consent for Specialised Treatments:**

For specialised or invasive treatments, your physician may have you sign a consent form and/or have you verbally agree to the proposed treatment options. Scheduling an appointment for a specific treatment will be considered consent to that treatment. Prior to treatment, your physician will ensure you are informed of the risks, beneﬁts, cost, adverse effects and alternatives of the proposed treatment as well as the risks of not treating the diagnosed condition. You always have the right to refuse or withdraw consent to any treatment at any time with no consequences for other future treatments.

***Please check each box below to indicate you have read and understood the following:***

❑ I understand that the practice of naturopathic medicine requires taking a thorough case history, and may require a physical exam. In some cases, diagnostic testing, including the collection of blood, urine and/or saliva may be required.

❑ I understand that if my case requires specific examinations or diagnostic imaging not available in office, an appropriate referral will be made to another health professional.

❑ I will inform my doctor if I am pregnant, suspect I am pregnant, having unprotected sex or breastfeeding.

❑ I will inform my doctor of any disease process that I am suffering from, or have been diagnosed with in the past, and any medications/over the counter drugs that I am currently taking.

❑ I understand that a record of my visits and medical history will be kept electronically, that this record will be strictly confidential and will not be released to any persons without my written consent.

❑ I understand that the details of my case may be discussed between the doctor and other medical professionals, with no identifying information being given, for the purpose of giving me the best medical care possible.

❑ I understand there are no guaranteed treatment results.

❑ I confirm that I have the ability to accept or reject the recommended treatment at my own free will.

❑ I understand that I have the ability to seek and/or continue medical care from another qualified health care practitioner

***I understand that some treatments carry the following risks and adverse effects:***

❑ Allergic reactions from supplements, intravenous/injection therapy or botanical medicine.

❑ Pain, bruising, fainting or injury from blood tests, injections or acupuncture.

❑ Muscle strains, sprains, disc injuries, or stroke (rare) from spinal manipulation or other physical therapies.

❑ Aggravation of pre-existing symptoms.

❑ Punctured lung or other organ during insertion of needles for prolotherapy, neural therapy, acupuncture, and other techniques involving needles.

❑ Dizziness, nausea, vomiting, fainting, lethargy, body and headaches during water fasting.

**Dr. Jones thanks you for taking the time to read and fill out this form.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature