Dr. Karina Wickland
NATUROPATHIC PHYSICIAN

Dr. Karina Wickland, B Sc, ND
Valleyview Centre
44 – 1400 Cowichan Bay Rd
Cobble Hill, BC
V0R 1L3
www.drwickland.com

Adult Intake Form

General Information

Name: _____ Date of First Visit:_____
PHN # (care card #)_____ Extended Health:_____
Address: _____
Telephone # (home): _____ Telephone # (work or cell):_____
Email address: _____ Birthday: _____
Occupation: _____

Emergency Contact
Name:_____ Relationship: _____
Phone #: _____

How did you hear about Dr. Wickland? _____
Do you currently have an active ICBC or WCB claim? _____
Are you on Premium Assistance (MSP)? _____

List your **current health care providers** including **designation** (e.g. medical doctors, chiropractors, counselors, massage, physiotherapist, acupuncturist)

_____
_____
_____
_____
_____
_____

Do you have any known contagious diseases at this time?
No Yes: _____

Do you have any known life-threatening allergies?
No Yes: _____

Email Correspondence (your email will never be sold, shared or traded)
Would you like to receive a copy of my newsletter via email? __ No __ Yes

Health Overview – *Comprehensive health care requires a complete picture of your health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during the visit.*

Current Health Concerns – please list in order of priority

Past Medical History – please list any previous accidents, surgeries or significant illnesses

Family History

___ - I don't know my family history (skip to next section)

Do you have a family history of any of the following:

- ❑ Diabetes
- ❑ Heart disease
- ❑ Stroke
- ❑ Cancer – type:___
- ❑ Seizures
- ❑ Asthma
- ❑ Allergies
- ❑ High blood pressure
- ❑ Arthritis - type:__
- ❑ Kidney disease
- ❑ Depression
- ❑ Autoimmune Disease – type:__
- ❑ Glaucoma
- ❑ Celiac disease
- ❑ Bleeding disorder
- ❑ Other:_____

Medications – please list all prescription and over-the-counter medications

Supplements and remedies – please list all supplements that you use (vitamins, minerals, herbs, homeopathy)

Is there anything else you would like to add or comment on?

Why did you choose to come to this clinic?

What long-term expectations do you have?

What expectations do you have of me as your naturopathic physician?

What is your current level of commitment to addressing your health issues?

- ❑ I am willing to make any changes and do whatever is necessary
- ❑ I am willing to make some changes in my lifestyle to feel better
- ❑ I may consider change if absolutely necessary to feel better
- ❑ I am specifically looking for a medication/surgical alternative
- ❑ I am here to learn more about my healthcare options and what you offer

What behaviors or lifestyle habits do you currently engage in regularly that you believe **support** your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **unhealthy** for you: (please list)

Dr. Karina Wickland
NATUROPATHIC PHYSICIAN

Declaration and Consent for Naturopathic Care

I would like to take this opportunity to welcome you to my clinic. As a naturopathic doctor (ND) I will conduct a thorough case history, a physical exam and **may** utilize specific blood, urinary or other laboratory reports as part of the treatment work-up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

Statement of Acknowledgement
Printed name of patient: _____

As a patient of Dr. Karina Wickland, I have read the information and understand that the form of medical care is based on **naturopathic** and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. **Slight** health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture or injections

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient of Dr. Wickland 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 providers. I understand results are not guaranteed.
- I understand that a record will be kept of my visits. This record will be kept confidential and **will not be released** without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for **payment at the time services are rendered.** Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.
- I understand that Dr. Wickland reserves the right to determine which cases fall outside of her scope of practice, in which case the **appropriate referral will be recommended.**

I consent to receive naturopathic treatment from Dr. Karina Wickland. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: _____ Date: _____