15 - 1860 appleby line burlington ontario L7L 0B7
905.332.2828 info@imbuir.ca imbuir.ca
imbuir
integrative medicine + iV therapy

ONCOLOGY INTAKE FORM

This intake form is a *confidential* health assessment tool designed to gain insight into your personal health status. When embarking on an individualized health plan it is important to begin with a thorough understanding of where you are currently, your personal and family history, as well as your habits, concerns, and thoughts with respect to your health. Please take the time to answer the questions on this form as genuinely and as accurately as possible.

Patient Contact Information

First Name _____ Last Name _____ Gender **Male / Female**

Birthday: ____/___/____ Current Age ____ Height _____ Weight _____ Frame **S /M/ L**

Day / Month / Year

Address: _____

Street City Postal Code Country

Home Phone # _____ Mobile # _____ Work # _____

Email _____ Preferred Contact _____

Marital Status Single / Married/ Partnered # of Children _____ Occupation _____

Referred by _____ (Please let us know how you found out about **imbuir,** so that we can say thank you)

Emergency Contact

Name _____ Relationship _____

Phone Number _____

Current Health Concerns: What is your exact diagnosis (type of cancer and staging) along with any other diagnoses? Please list in the order of importance to you:

_____

_____

_____

_____

Is this a primary (first time diagnosis) or recurrent cancer? _____

Is the disease localized or spread (metastasis)? _____

Are you currently receiving any oncology treatments or do you have future treatments scheduled:

Surgery _____

Chemotherapy_____

Radiation_____

Are you experiencing side effects? If so which:

_____

_____

Have you received any conventional oncology treatments in the past? If so, please provide details.

_____

_____

Have you received any naturopathic medical care? If so, please provide details.

_____

_____

What goals do you have for the integrative natural treatment of your cancer?

_____

_____

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Supporting Documentation: Please send the following if available:

Reports	emailed/faxed	Reports	emailed/faxed
Blood Work		Genetic Markers	
Pathology Reports		Ultrasound	
PET scan report		Mammogram	
X Ray Reports		Bone Scan	
CT Reports		Medical History and Exam	
MRI Reports			
Chemo/Radiation Schedule			

Medical History

Current /past illnesses and hospitalizations (please include dates)

_____
_____
_____
_____

Allergies/Sensitivities (medications, foods, environmental)

_____
_____
_____

(♀) Are you currently pregnant: **YES / NO**
Have you received all vaccinations? **YES / NO**
Date of last - Physical exam / Blood test _____
Date of last - Antibiotic use _____
If yes, were there any complications?_____

LIST OF MEDICATIONS AND SUPPLEMENTS

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Family Physician _____Phone number_____Address_____

Oncologist_____ Phone number_____ Address_____

Other Health Care Practitioners, including past Naturopathic Doctor(s).

_____ Phone number_____ Address_____

_____Phone number_____ Address_____

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Family Medical History

Please indicate current/past medical conditions (cancer, diabetes, heart disease, chronic disease, mental illness, etc)

Father		Mother	
P. Grandfather		M. Grandmother	
P. Grandmother		M. Grandfather	

Diet + Lifestyle

Do you eat or use any of the following? ✓ Please check all that apply.

☐	Aluminum pans	☐	Microwave	☐	Margarine
☐	Refined sugars	☐	Fried foods	☐	Processed foods
☐	Luncheon meats	☐	Plastic Tupperware/Water bottles	☐	Artificial sweetener
☐	Fast foods	☐	Air Fresheners	☐	Scented body products

How would you describe your eating habits, any dietary restrictions: ✓ Please check one

- ☐ A meat eater
- ☐ Vegan – Eat no animal foods of any type
- ☐ Other - gluten free
- ☐ Other - dairy free
- ☐ Other - kosher
- ☐ Lacto-ovo-vegetarian – Eat dairy, eggs, but exclude animal meat
- ☐ Ovo-vegetarian – Eat eggs, but no dairy or animal meat
- ☐ Lacto-vegetarian – Eat dairy, but no eggs or animal meat
- ☐ Pesca-tarian – Eat dairy, eggs, and fish, but avoid red meat, poultry and fish
- ☐ Flexi-tarian – Eat dairy, eggs, fish and poultry, with some vegetarian meals

How do you eat?

- ☐ Around the table with family
- ☐ In front of the TV
- ☐ On the run
- ☐ Alone
- ☐ Restaurant How often? _____
- ☐ Fast food How often? _____
- ☐ At the computer
- ☐ In the car

Please describe what you typically eat in a day

Breakfast _____ Time _____ Water (cups/day) _____
Lunch _____ Time _____ Caffeine (cups/day) _____
Dinner _____ Time _____ Juice/pop (x/day) _____
Snacks _____ Time _____ Alcohol (x/day) _____
Other _____

Digestion

Do you have a bowel movement every day? **YES / NO** Do you Strain? **YES / NO**
Acid reflux/bloating/gas? _____
Food Cravings/Aversions _____

Lifestyle

Do you smoke? Yes / No Cigarettes/day _____ How long have you been smoking? _____
Do you use recreation drugs Yes / No What type? _____
Do you exercise? Yes / No What type? _____ How often? _____
Describe your stress levels: Low / Moderate / High
How many hours do you sleep daily? (Include naps) _____
Do you wake feeling rested? (Please circle one) Yes / No / Sometimes

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Female Health

Do you have regular menstrual cycles? Yes / No Cycle Length _____
When was the date of your last menstrual cycle? _____
Describe your PMS symptoms _____
How many days do you menstruate for? _____
Are you concerned about heavy menstrual flow or clotting? Yes / No
Do you have a history of estrogen positive cancer in your family? Yes / No
Do you have uterine fibroids/polyps/ovarian cysts? _____
Are you concerned about low libido? Yes / No
Do you have a Sexually Transmitted Infection (STI)? Yes / No

Male Health

Are you concerned about low libido? Yes / No
Do you have concerns with erectile dysfunction? Yes / No
Do you have difficulty with increasing muscle mass, despite exercise? Yes / No
Do you experience concerns with urination or rectal pain? Yes / No
Do you have a Sexually Transmitted Infection (STI)? Yes / No

Additional Health Information

If there is any additional information that you feel is important for our practitioners to know, please indicate this in the space provided below

_____
_____
_____
_____
_____
_____
_____
_____
_____

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ONCOLOGY INTAKE FORM

imbuir™ PRIVACY POLICY

At imbuir - integrative medicine + iV therapy we understand the importance of protecting your/the minor's personal information. Below is an outline of how our office is using and disclosing your/the minor's information.

The office will collect, use and disclose only necessary information about you/the minor for the following purposes:
(Please ✓ if interested)

- **To collect information for assessments conducted by our practitioners**
- **To collect fees for services and dispensary purchases**

☐ Subscription to monthly newsletters via email or mail (Optional)

☐ Emailing of continuing education, wellness, and health related topics (Optional)

☐ Seminars, workshops and surveys to promote patient education (Optional)

Your/the minor's information will be disclosed to the following individuals

- **To all health professionals employed by imbuir - integrative medicine + iV therapy**
- **To any emergency service personnel dispatched if one's life is endangered**

We will only share your/the minor's information with your consent. Storage, retention and destruction of your/the minor's personal information complies with existing legislation, and privacy protocols set out by the Board of Drugless Therapies Naturopathy (BDDT-N) and Ontario's Personal Health Information Protection Act (PHIPA).

At imbuir, we value the time we get to spend with you and strive to offer the best customer service possible, even if that is to schedule you a last minute appointment. Thus, in order to serve you better we enforce a strict 24 hour cancellation policy. If something comes up and you cannot make your appointment, please call us right away. If we do not receive a phone call or voice message, a cancellation fee of $75 will apply. We hope you will appreciate this service as your time here at imbuir is valuable.

I have reviewed the above information that explains how imbuir - integrative medicine + iV therapy will use my/the minor's personal information, and the steps that will be taken to protect my/the minor's personal information. I agree that imbuir- integrative medicine + iV therapy can collect, use, and disclose my/the minor's personal information as set out above in the privacy policy and consent to treatment.

_____	_____	_____
Signature of Patient or Guardian	Print Name	Date

CONSENT TO NATUROPATHIC TREATMENT/IV THERAPY

I understand and acknowledge that my attending Naturopathic Doctor or IV certified practitioner has explained verbally the nature of the naturopathic treatment or parenteral therapy I/the minor is to receive including benefits, risks, and any medical alternatives to the prescribed treatment. I hereby consent to the treatment as set out above. I may withdraw my consent to this treatment at any time.

_____	_____	_____
Signature of Patient or Guardian	Print Name	Date

For Office Purposes Only

☐ Verbal consent acquired and witnessed. Patient/Guardian understands and acknowledges risks and benefits to treatment explained.

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CREDIT CARD PRE-AUTHORIZATION FORM
FOR MISSED APPOINTMENTS, AND PAST DUE STATEMENTS

We require your credit card information for several reasons:

1) If you miss an appointment without calling 24 hours in advance, then we charge your card a missed appointment fee of $75.00. This fee cannot be submitted to insurance.
2) If you miss an iV/injection appointment without calling prior to 9 am on the day of the appointment, then we charge your card a missed appointment fee of $75.00 for infusions and $25 for injections. This fee cannot be submitted to insurance.
3) In the event that you have an outstanding balance past 30 days, then we will notify you in writing that your card will be charged for the outstanding balance within 15 days if you do not call our office to make partial or full arrangements for payment.

Please complete the following:

◯ I authorize imbuir – naturopathic medicine + iV therapy to keep my signature on file and to charge my Visa, Mastercard, or American Express account for an initial or recurring charge of $75.00 for any missed appointment in which I have not called 24 hours in advance to cancel and for any outstanding balances past 30 days. I realize I will only be charged for outstanding balances past 30 days if I have not made any payment arrangements with the billing department.

◯ I authorize imbuir – naturopathic medicine + iV therapy to keep my signature on file and to charge my Visa, Mastercard, or American Express for an initial or reoccurring charge of $75 for any missed iV appointments and $25 for any missed injection appointments that are NOT cancelled prior to 9 am on the date of the appointment.

◯ I understand this form is valid for one year unless I cancel the authorization in writing. I promise not to dispute charges (“charge back”) for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize imbuir – naturopathic medicine + iV therapy to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge.

_____
Client Name

_____
Cardholder Name

_____
Cardholder Billing Address City Province Postal Code

_____ _____
Account Number Expiration Date

_____ _____
Cardholder Signature Date