Dr. Kathryn Harbun

Naturopathic Physician

Intake form

Arc Integrated Medicine

personal information

NAME: _____ PREFERRED NAME:_____ SEX: _____

DATE OF BIRTH: mm/dd/yr ____/____/____ AGE:_____ HEIGHT:_____ WEIGHT:_____

STREET ADDRESS:_____ CITY:_____ POSTAL CODE:_____

PHONE NUMBERS:_____ EMAIL ADDRESS:_____

PREFERRED METHOD OF CONTACT (appointments, results etc): _____

PHN:_____ DO YOU HAVE EXTENDED INSURANCE?: Y / N

OCCUPATION:_____ DO YOU HAVE AN OPEN ICBC CLAIM?: Y / N

medical contact information

FAMILY PHYSICIAN:_____ OTHER PRACTITIONERS: _____

ADDRESS: _____ ADDRESS: _____

PHONE:_____ FAX:_____ PHONE:_____ FAX: _____

EMERGENCY CONTACT:_____ RELATION:_____ PHONE NUMBER:_____

PLEASE LIST YOUR MAIN HEALTH CONCERNS: SEVERITY (0-10) WHEN DID IT START; HAS IT CHANGED?

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

WHAT ARE 3 EXPECTATIONS YOU HAVE OF ME?

1. _____
2. _____
3. _____

LIST 3 HEALTH GOALS YOU'D LIKE TO ACHIEVE

1. _____
2. _____
3. _____

medical history

DIAGNOSED MEDICAL CONDITIONS, INJURIES, SURGERIES, HOSPITALISATIONS	DATE	ALLERGIES	WHAT HAPPENS? *If reaction is life threatening, please circle*
1.		1.	
2.		2.	
3.		3.	

medications, supplements

please list all medications and supplements you are currently taking (prescription and non-prescription)

MEDICATION/SUPPLEMENT/HERB	DOSE	PRESCRIBED BY	REASON FOR TAKING IT
1.			
2.			
3.			
4.			
5.			
6.			
WHERE DO YOU GET YOUR INFORMATION ABOUT THE SUPPLEMENTS YOU TAKE?			
HAVE YOU RECEIVED ALL CHILDHOOD VACCINATIONS? Y / N		OTHERS (specify):	

HAVE YOU HAD LAB WORK WITHIN THE LAST 6 MONTHS? Y / N

If yes, please attach a copy of the results or bring them to your appointment

lifestyle

please indicate your usage of the following both currently (C), and in the past (P):

	C / P	FREQUENCY/DURATION
alcohol		
tobacco		
recreational drugs		
coffee		
antacids		
pain killers (eg. aspirin, ibuprofen)		
laxatives		
energy drinks		
antibiotics (topical)		
antibiotics (internal)		

SLEEP	
hrs/night:	sleep quality (0-10):
do you feel rested on waking? Y / N	do you sleep through the night? Y / N
EXERCISE (for each, indicate frequency)	
cardio	yoga/palates
weightlifting	walking
team sport	other
ENERGY	
energy level (0-10)	are you satisfied with your energy level? Y / N
When are you the most energized?	When are you the most fatigued?
STRESS	
current stress level: *(please circle)* none low average high intolerable	sources of stress: *(please circle)* career financial health relationship family emotional other *(please specify)*
how does your stress present itself?	what are your strategies for managing stress?

WHAT HABITS OR THOUGHT PATTERNS DO YOU HAVE THAT PREVENT/CONTRIBUTE TO YOU BEING HEALTHY?

_____

_____

_____

WHAT BRINGS YOU JOY? _____

_____

living situation

WHAT TYPE OF HOME DO YOU LIVE IN?_____

URBAN OR RURAL AREA? _____

DO YOU LIVE WITH ANYONE? _____

DO YOU HAVE ANY PETS?_____

DO YOU WORK WITH ANY HAZARDOUS CHEMICALS EITHER AT WORK OR AS PART OF YOUR HOBBIES?

_____

family history

PLEASE INDICATE ANY SIGNIFICANT CONDITIONS A FAMILY MEMBER HAS EXPERIENCED, AND INCLUDE YOUR RELATION TO THAT PERSON:

_____

_____

_____

_____

WHAT IS YOUR ETHNIC HERITAGE? _____

dietary habits

DO YOU FOLLOW A SPECIFIC DIET? (please specify)

_____

ARE THERE ANY FOODS YOU AVOID? WHY?

_____

_____

HOW OFTEN DO YOU EAT OUT/TAKE OUT? _____

_____

ARE YOU SATISFIED WITH THE QUALITY OF YOUR DIET? (Y / N), IF NOT, ARE YOU WILLING TO MAKE CHANGES? (Y / N)

MEALS PER DAY
0 1 2 3 4 5+

SNACKS PER DAY
0 1 2 3 4+

CRAVINGS *(circle all that apply)*

sugar chocolate salt dairy carbs (bread/pasta/starch)

other:_____

please indicate which of the following you consume, and how often

water		tuna	
juice		milk/dairy	
pop/soda		refined sugar	
black tea		canned goods	
green tea		deli meats	
fresh vegetables		processed food	
fresh fruit		fast food	
fish		artificial sweetener	
red meat		fermented foods	

symptom tracker

please indicate if you have experienced any of the following symptoms or conditions. If you are not currently experiencing a symptom, but you have in the past, please indicate with a (P). If never experienced, please leave blank

SYMPTOM	Y//P	SYMPTOM	Y/P	SYMPTOM	Y/P	SYMPTOM	Y/P
head/eye/ear/nose/ throat/ neck		**skin**		**respiratory**		colon polyps	
headaches/migraines		eczema		frequent cold/flu		Crohn's/colotis	
jaw clicking/locking		dry skin		chronic cough		hemorrhoids/fissures	
teeth grinding		hives/rashes		asthma/wheezing		**urinary**	
head trauma		psoriasis		pneumonia		frequency/urgency	
dizziness/vertigo		acne		bronchitis/copd		burning/pain	
changes in vision		dark circles under eyes		difficulty breathing		kidney/bladder infections	
blind spots/blurring		difficulty healing wounds		pain on breathing		inability to urinate	
light sensitivity		dandruff		coughing blood		coloured/bloody urine	
colour blindness		lice/scabies/mites		tuburculosis		kidney stones	
eye pain		warts		**cardiovascular**		excess thirst	
glasses/contact lenses		bacterial skin infections		heart disease		**sexual/reproductive**	
ear ringing		ringworm/athlete's foot		stroke		sexually active	
ear infections		skin discolourations		chest pain		change in sex drive	
earaches		new.changing moles		murmurs		sexual difficulties	
hearing loss		sun spots		arrhythmia		pain with intercourse	
neurological/endocrine		itchy skin		high blood pressure		genital warts/growths	
sinus problems		**musculoskeletal**		easy bruising/bleeds		infection/sti	
congestion/phlegm		loss of height		cold extremities		HIV+/AIDS	
loss of smell		joint pain/stiffness		ankle swelling		**male reproductive**	
nasal obstructions		fractures		varicose veins		testicular pain/masses	
nosebleeds		muscle cramps/spasms		anemia		discharge/sores	
hoarse voice		muscle weakness		rheumatic fever		prostate issues; last exam	
dental cavities		muscle pain		**gastrointestinal**		erectile dysfunction	
mercury fillings		**neurological/endocrine**		change in appetite		premature ejaculation	
dental/Gum issues		numbness/tingling		difficulty swallowing		**female reproductive**	
mouth/lip/tongue sores		fainting		spitting up blood		age of first period	
frequent sore throat		involuntary movements		nausea/vomiting		duration of cycle (days)	
neck pain/stiffness		change in coordination		burping		duration of flow (days)	
swollen lymph nodes		memory loss		heartburn/GERD		regular cycles?	
goiter		loss of balance		jaundice/hepatitis		spotting/clots/heavy flow	
psychological		speech difficulties		gallbladder issues		birth control	
anxiety		cannot concentrate		abdominal pain		# pregnancies	
depression		excess hunger/thirst		gas/bloating		#miscarriages/abortions	
irritbility		fatigue		appendicitis		age of menopause	
mood swings		hair loss/brittle nails		hernias		date of last PAP	
emotional outbursts		feeling too cold/hot		constipation/diarrhea		vaginal discharge	
schizophrenia		**breast**		black or bloody stool		endometriosis/cysts	
phobias		pain/tenderness		mucous in stool		yeast/other infections	
attempted suicide		lumps/fibrous tissue		changes in BMs		pain/PMS	
alcoholism/drug use		nipple discharge		# BMs per day		cervical dysplasia	

systemic	
fever/chills	
night sweating	
rapid weight change	

ANYTHING WE'VE MISSED? PLEASE INCLUDE IT HERE: _____

_____

_____

INFORMED CONSENT TO TREATMENT
TERMS & CONDITIONS

Thank you for your interest in Dr. Kathryn Harbun, ND, and Arc Integrated Medicine as your naturopathic health care provider, and guide towards living a healthier, more vibrant life.

Throughout this letter agreement the terms "you", "I", "me" and "my" shall refer to you the undersigned individual or your child (as applicable), specified at the end of this letter agreement.

DISCLOSURE OF QUALIFICATIONS

I understand and acknowledge that Dr. Kathryn Harbun is a fully licenses naturopathic physician who has completed both a bachelor's degree, and a four-year diploma in naturopathic medicine. She is fully licenses by the CNPBC, and holds multiple college-approved certifications for additional therapies. As a member of the college, Dr. Harbun is governed by the Health Professions Act, as are all other licensed health care professionals.

TREATMENTS AND TESTING

I understand that naturopathic physicians may employ a variety of testing measures and treatment options including but not limited to:

- General diagnostic procedures which may include blood work, urine and stool testing, physical exams, radiography, testing through both public and private laboratories etc)
- Intravenous therapies, which may include injecting vitamins, amino acids, antioxidants, chelating agents, etc
- Nutritional interventions including dietary advice and therapeutic nutrition
- Lifestyle recommendations and psychological counselling
- Supplement or pharmaceutical prescription: Prescribing therapeutic substances which may include plants/herbs, minerals, vitamins, animal materials or pharmaceuticals. Medicine may be suggested in various forms (teas, pills, tinctures containing alcohol, creams, washes, suppositories etc)
- Traditional Chinese medicine and acupuncture: The use of the principles of Chinese medicine to approach a treatment protocol, and the sue of acupuncture to support a comprehensive treatment plan.

No testing or treatment will be administered without my (the patient's) knowledge and consent. I also understand that not all therapies or testing will be covered by the BC medical services plan, and unless my extended insurance agrees to reimburse me for these tests/treatments I am responsible for covering the cost. I understand that naturopathic physicians are currently unable to refer for imaging studies, or to specialists in BC.

I hereby acknowledge and agree that the Treatment may lead to certain unforeseen complications, including but not limited to: aggravation of pre-existing symptoms; allergic reactions to pharmaceuticals, supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations. I also acknowledge that I have the right to accept or reject this medical care of my own free will and choice.

PATIENT EXPECTATIONS

I understand that it is very important for me to inform my naturopathic doctor of any condition I currently have and if I am taking any medication or over-the-counter drugs. If I am pregnant, suspect pregnancy or am breast-feeding, I will advise my ND immediately, as some therapies may present a risk to the baby.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time with proper notification. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees of results have been given to me by Dr. Kathryn Harbun.

I understand that I am expected to be honest with Dr. Harbun about my health history, and what I can and cannot do as part of a treatment protocol. I agree to keep an open mind and hear/try all treatment recommendations and their reasoning before declining a therapy. I understand that if I do not adhere to treatments as recommended, they may be less effective, and therefore my results will not be as substantial. I will always do the best I can, and I understand that Dr. Harbun is available to help me with struggles along the way.

ATTENDANCE AND CALCELLATION

I will arrive early or on time to my appointments to the best of my ability, and if I need to cancel my appointment I will notify Arc Integrated Medicine front desk staff at least 24 hours in advance. If I fail to cancel my appointment sooner than 24 hours prior, or I no show without explanation, I will be charged the full fee for my visit.

I further agree and acknowledge that Dr. Harbun has the right to stop providing treatment to me at any time effective immediately, without any compensation to me whatsoever. This agreement will cover the entire course of my treatment and I am free to withdraw my consent and to discontinue participation in my treatment at any time.

CONFIDENTIALITY

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of my health history and the health services provided to me. This record will be kept confidential and will not be released to others unless I give consent or unless required by law. I understand that all staff and NDs at Arc Integrated Medicine are legally obligated to override confidentiality agreements if they become aware of any current child abuse, neglect, threats to harm any individual, or serious threats of suicide relating to my case. I understand that I may view my medical records at any time and I may request a copy of it by paying the appropriate fees.

I, (please print) _____ hereby agree to the terms and conditions set fourth in this agreement, and I certify that I have read all terms and conditions. I consent to the treatments as described above which will be provided by Dr. Harbun, or another doctor at Arc Integrated Medicine so long as I am made aware of the change in physician.

Signature _____ Date _____

(patient or legal guardian if under 18)