Lody Health Klinik
8400 Jane Street
Building D, Suite 104
Vaughan, ON L4K 4L8
T: (905)597-5639 F: (905)597-5637

New Patient Intake Form

First Name: _____ **Last Name:** _____ **Gender:** ☐ Male ☐ Female **Wt:** _____ **Ht:** _____

Address: _____ **City:** _____ **Province:** _____ **Postal Code:** _____

Phone: _____ **Work:** _____ **Email:** _____

Date of Birth: MM | DD | YYYY **Health Card #:** _____ **Marital Status:** _____ **How Did You Hear About Us?:** _____

Emergency Contact: _____ (NAME) _____ (PHONE) _____ (RELATIONSHIP) **Children & Ages:** _____

Family Doctor: _____ **Specialists:** _____ **Other Healthcare Providers:** _____

Known Allergies: _____ (Medical, Environmental, Food etc.) **Dietary Restrictions:** _____ (Religious, Vegetarian, Vegan)

Current Medications: _____
Prescriptions, Over the Counter, Vitamins With dosage

Past Medications: _____
Prescriptions Only

Past Serious Conditions: _____
Illnesses, Injuries, Hospitalizations with Dates

Has a Close Relative (Parent, Grandparent, Sibling) Had Any of the Following?:

☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Cancer Type: _____ ☐ Eczema ☐ Endometriosis
☐ Gallstones ☐ Heart Disease ☐ Hypertension ☐ Kidney Disease ☐ Mental Illness ☐ Multiple Sclerosis
☐ Osteoporosis ☐ Heart Disease ☐ PMS ☐ Skin Disease ☐ Stroke ☐ TB
☐ Other: _____

Your General State of Health:
☐ Excellent ☐ Good
☐ Fair ☐ Poor

List Your Health Concerns:
In Order Of Importance
1: _____
2: _____
3: _____
4: _____

Your Occupation: _____

Do You Use Any of the Following?:
List the type & frequency if applicable

☐ Alcohol _____ ☐ Antacids _____ ☐ Caffeine _____ ☐ Laxatives _____ ☐ Cigarettes _____ ☐ Rec. Drugs _____

Antibiotic Treatments in Past 5 Years: _____ **History of Adverse Reaction to Immunizations:** ☐ Yes ☐ No **Are You Pregnant?:** ☐ Yes ☐ No

Do You Regularly Get Screening Tests Done?: ☐ Yes ☐ No
Pap, Blood Tests etc.

Ever Had An Abnormal Pap Test?: ☐ Yes ☐ No

Typical Diet (Generally):

Breakfast: _____ **Snacks:** _____ **Lunch:** _____

Dinner: _____ **Beverages:** _____
Type & Amount

Hobbies: _____

Do You Exercise Regularly?: ☐ Yes ☐ No _____
If Yes, Type & Frequency

Exposure to Toxins or Hazards?: ☐ Yes ☐ No _____
Work, Home, Hobbies etc. If Yes, Please, Describe

Climate at Home: _____
Indicate Levels of Stress if Applicable

How Stressful is Your Work or Other Aspects of Your Life?: _____

How Do You Manage Stress?: _____

Anything Important That We Should Know?: _____

Reason For Your Visit: _____
What would you want to achieve with our treatments?

Informed Consent For Treatment:

1. I understand that the costs of consultations/treatments offered at Lody Health Klinik are not covered by Ontario Health and are my responsibility.
2. I understand that the practitioners at Lody Health Klinik will use only natural, non-invasive methods of assessment and treatment.
3. I understand that any advice given to me as a patient at this clinic is not mutually exclusive from any treatment or advice I may now or in the future be receiving from another health care provider.
4. I understand that I am at the liberty to seek or to continue any medical care from any other qualified health care provider.
5. I understand that the advisors at this clinic reserve the right to determine which cases fall outside of their scope of practice and/or an appropriate referral could be recommended as per guidelines.
6. I understand that I am accepting or rejecting this care by my own free will.
7. I understand that no employee or physician at Lody Health Klinik is suggesting to me to refrain from seeking the advice of another health care provider.
8. I understand that the services offered here are not covered by OHIP, and that fees are payable at the time of appointment, including if applicable, fees for services, prescriptions, and laboratory tests.
9. I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the payment of a cancellation fee.
10. I understand that any therapies recommended will be explained to me in full by the physician, and that I will give consent to treatment based on informed consent.

I, _____ have read, understand and agree to the above statements.

Signature: _____ Date:_____

Informed Consent for Communication:

We value our relationship with you and would like to send you information electronically related to Lody Health Klinik. In order to do this, we are collecting your consent to receive electronic messages from us in the form of appointment reminders, newsletters, upcoming events and other clinic information. By signing below, you consent to Lody Health Klinik's electronic communications. Please note, you can opt out anytime you want. All electronic messages will provide a way for you to opt out whenever you want.

Signature: _____ Date:_____

Thank you for taking the time to complete this intake form. We look forward to working with you to optimize your health and well-being.