kelowna wellness clinic

move better. feel better.

Dr. Brent Barlow, ND #201 1433 St. Paul St. Kelowna, BC V1Y 2E4 Phone: 250-448-5610

PATIENT ENTRANCE FORM

Name: _____ Date: _____

Address: _____

City, Province: _____ Postal Code: _____

Contact Number Home: _____ Business/Cell: _____

Email: _____ Care Card #: _____

Date of Birth(M/D/Year): _____ Age: _____

Family Doctor: _____ Marital status: _____

Spouse Name: _____ Children: _____

Occupation: _____ Name of Company: _____

Emergency contact: _____ Phone: _____

How did you hear about our office? _____

How would you like to receive appointment reminders (circle one)? Email Phone Call None

Major Health Concerns (in order of priority): 1)_____

2)_____

3)_____

Allergies

Drugs _____

Food _____

Chemical _____

Environmental _____

Animal _____

HABITS OF LIFESTYLE

Do you smoke: Y N

Do you consume Alcohol: Y N

Do you exercise: Y N If yes, what type of exercise and how much: _____

_____

Rate your sleep, hours per night: 4-6 6-8 8-10 12+

Do you wake rested: Yes No

Do you often feel fatigued during the day: Yes No

How often do you eat meals: 1-2 meals 2-3 meals 5+meals

Describe the type of food that you eat regularly: _____

_____

_____

SUPPLEMENTS/MEDICINE & MEDICAL HISTORY

Please list any Vitamins or Supplements that you are currently using including dose and start date:

	Name	Dose	Start Date
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

List any current medications and the reason for taking them:

	Name	Dose	Start Date
1			
2			
3			
4			
5			
6			
7			
8			

Hospitalizations and Surgeries:

	Condition	Date	Procedure
1			
2			
3			
4			
5			
6			
7			
8			

Previous lab test Results:

	Month and/or Year	Type of Test and Result
1		
2		
3		
4		
5		
6		
7		
8		

PATIENT PAST HISTORY FORM

Please check the appropriate box for any of the following symptoms that you have had in the past year.

C = Constant F = Frequent (weekly) O = Occasional (monthly/yearly)

NEUROLOGICAL	C	F	O
Allergy	( )	( )	( )
Chills	( )	( )	( )
Convulsions	( )	( )	( )
Dizziness	( )	( )	( )
Fainting	( )	( )	( )
Fevers	( )	( )	( )
Headache	( )	( )	( )
Loss of sleep	( )	( )	( )
Nervousness	( )	( )	( )
Depression	( )	( )	( )
Neuralgia	( )	( )	( )
Numbness	( )	( )	( )
Sweats	( )	( )	( )
Loss of weight	( )	( )	( )
Tremors	( )	( )	( )

RESPIRATORY	C	F	O
Chest pain	( )	( )	( )
Chronic cough	( )	( )	( )
Difficulty breathing	( )	( )	( )
Spitting blood	( )	( )	( )
Excess phlegm	( )	( )	( )
Wheezing	( )	( )	( )
Fever	( )	( )	( )

CARDIOVASCULAR	C	F	O
Rapid heart rate	( )	( )	( )
Slow heart rate	( )	( )	( )
Swelling of ankle	( )	( )	( )
Hardening of arteries	( )	( )	( )
High blood pressure	( )	( )	( )
Low blood pressure	( )	( )	( )
Pain over heart	( )	( )	( )
Poor circulation	( )	( )	( )

MUSCLES AND JOINTS	C	F	O
Arthritis	( )	( )	( )
Bursitis	( )	( )	( )
Foot Trouble	( )	( )	( )
Hernia	( )	( )	( )
Low back pain	( )	( )	( )
Neck pain	( )	( )	( )
Neck stiffness	( )	( )	( )
Pain between shoulders	( )	( )	( )

EYES, EARS, NOSE, THROAT	C	F	O
Crossed eyes	( )	( )	( )
Eye pain	( )	( )	( )
Failing vision	( )	( )	( )
Far sighted	( )	( )	( )
Near sighted	( )	( )	( )
Deafness	( )	( )	( )
Ear aches	( )	( )	( )
Ear noises	( )	( )	( )
Colds	( )	( )	( )
Asthma	( )	( )	( )
Sinus infections	( )	( )	( )
Nasal obstruction	( )	( )	( )
Nose bleeds	( )	( )	( )
Enlarged glands	( )	( )	( )
Enlarged thyroid	( )	( )	( )
Sore throat	( )	( )	( )
Tonsilitis	( )	( )	( )
Hay fever	( )	( )	( )
Hoarseness	( )	( )	( )
Gum trouble	( )	( )	( )
Dental decay	( )	( )	( )

PAIN OR NUMBNESS	C	F	O
Shoulders	( )	( )	( )
Arms	( )	( )	( )
Hands	( )	( )	( )
Hips	( )	( )	( )
Legs	( )	( )	( )
Knees	( )	( )	( )
Ankles	( )	( )	( )
Feet	( )	( )	( )
Sciatica	( )	( )	( )
Swollen Joints	( )	( )	( )

GASTROINTESTINAL	C	F	O
Excessive hunger	( )	( )	( )
Burping or gas	( )	( )	( )
Liver trouble	( )	( )	( )
Colitis	( )	( )	( )
Colon trouble	( )	( )	( )
Constipation	( )	( )	( )
Diarrhea	( )	( )	( )
Stomach pain	( )	( )	( )
Gall bladder trouble	( )	( )	( )
Hemorrhoids	( )	( )	( )
Intestinal Worms	( )	( )	( )
Jaundice	( )	( )	( )
Nausea	( )	( )	( )
Vomiting	( )	( )	( )
Blood in vomit	( )	( )	( )

GENITO- URINARY	C	F	O
Bed wetting	( )	( )	( )
Blood in urine	( )	( )	( )
Frequent urination	( )	( )	( )
Uncontrolled Urine	( )	( )	( )
Kidney infection	( )	( )	( )
Painful urination	( )	( )	( )
Prostate trouble	( )	( )	( )
Pus in urine	( )	( )	( )

FOR WOMEN ONLY	C	F	O
Cramps	( )	( )	( )
Heavy flow	( )	( )	( )
Light flow	( )	( )	( )
Irregular cycle	( )	( )	( )
Painful cycle	( )	( )	( )
Discharge	( )	( )	( )
Sore breasts	( )	( )	( )

Menopausal:	Y	N
Pregnant	Y	N
If pregnant, Due Date		

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FEES, INSURANCE COVERAGE AGREEMENT and CONSENT TO TREAT

Fees

All visit charges are expected to be paid at the time service is rendered. For your convenience we accept cash, cheque, debit card, Visa and MasterCard.

B.C. Medical

Generally, MSP will not cover any Naturopathic visits.

Premium Assistance

Each person on Premium Assistance is eligible for a combined total of **10 visits** per calendar year. You will still pay our normal fee amount, less the $23 that MSP covers.

Extended Medical

Your medical insurance policy is a contract between you and your insurance company. This office does not collect payment from any insurance company nor guarantee reimbursement.

Worker's Compensation Board and ICBC

Naturopathic visits are not accepted by WCB. Full fee for naturopathic visits must still be paid at time of service regardless of WCB or ICBC claim.

Declaration

This is to acknowledge that I have been informed that:

1. Any treatment or advice provided to me by Dr. Brent Barlow, N.D. at the Kelowna Wellness Clinic (KWC) is not mutually exclusive from any other treatment or advice that I may now be receiving or may in the future receive from another licenced health care provider.
2. I am at liberty to seek or continue medical care from a medical doctor or other care providers licenced to practice in British Columbia.
3. I declare that I have received a full and complete explanation of the treatment, possible side effects and/or services that I will receive and hereby authorize and consent to treatment by Dr. Brent Barlow.
4. I agree to pay my full account at the time of each visit or treatment, including fee for service, cost of supplements and remedies, cost of laboratory tests and other fees.
5. I understand that treatment advice will not be given over the phone unless directly related to specifics discussed during intake of case.

Patients are responsible for their appointments. Please ensure that you either receive an appointment card or verify your appointment time with our staff. We require **24 hours notice** to cancel your appointment. Any missed appointments or cancellations with insufficient notice will result in a fee charge.

Please sign and date:

I, _____, am fully aware of the billing procedures of this clinic. I agree to pay the full office fee for services rendered by practitioners at Kelowna Wellness Clinic.

_____ _____

Date Patient Signature (Parent or Guardian)