Dr. Michael D Bastien BSc, ND
7865 Edmonds Street, Burnaby
Office: 604-524-4959

Dr. Bastien new patient intake

All Information entered will remain confidential in accordance with Personal Information Protection Act. If you have any questions please ask.

Contact Information

First Last

Name:_____ Date: (D/M/Y)___/___/___

Age:_____ Gender: M: F: Birth date: (D/M/Y)___/___/___

Mother's Name:_____ Father's Name:_____

Home Address:_____

City: _____ Province:_____ Postal Code:_____

Parental Contact: Phone:_____ Email:_____

Permission to communicate with you with this email: Y / N

Emails are not 100% confidential and run the risk of having content viewed by other parties if accounts are compromised. All efforts are made to ensure confidentiality, but the use of email does pose some inherent risk

Care Card Number:_____

Medical Doctor:_____ Phone:_____

Other health care providers:_____

_____

Extended Medical Coverage: Y / N MSP Premium Assistance: Y / N

Provider:_____

Do you have an active ICBC or WCB claim: Y / N Claim number:_____

How did you hear about Dr. Bastien:_____

Chief Health Concerns

Please rank concerns in order of importance to you When did it start?

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

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Family Medical History

List any medical conditions of the members of your immediate family.

Father:_____

Mother:_____

Brother(s):_____

Sister(s):_____

Father's Mother:_____ Mother's Mother:_____

Father's Father:_____ Mother's Father:_____

Asthma, Allergies, Eczema, Autoimmune, Thyriod Disease, Diabetes, Heart Disease, Stroke, Hypertension, Arthritis, Liver Disease, Kidney Disease, Mental Illness, Addiction, Cancer

Medical History

Significant illnesses: Please check any that apply and give the **year they started**

____□ Measles ____□ Scarlet Fever ____□ Rheumatic Fever ____□ German Measles ____□ Frequent colds

____□ Mumps ____□ Chicken Pox ____□ Ear infections ____□Throat infections ____□ Cancer

____□ Diabetes ____□ Rashes ____□ Hepatitis ____□ HIV ____□ Birth defects

□ Surgery:_____

□ Major accidents/trauma:_____

□ Other:_____

Vaccinations

□ Polio □ Tetanus □ Hepatitis □ HPV □ Rabies

□ MMR □ Diptheria □ Pertussis □ Chicken Pox □ Other:_____

Female

Age of 1st menses_____Cycle Length (days)_____Days of menses_____Date of last menses___/____/___

General Health

Height_____Weight_____Weight 1 yr ago_____Highest Weight_____

Bed time?_____Stays asleep for?_____Hours of sleep per night?_____

Second hand smoke exposure? Y N Pets at home?_____

Exercise: Type:_____Hours/week:_____

Allergies: Drug:_____Food:_____

Foods you avoid:_____

Medications and Supplements

_____Dose:_____Indication:_____

_____Dose:_____Indication:_____

_____Dose:_____Indication:_____

_____Dose:_____Indication:_____

_____Dose:_____Indication:_____

_____Dose:_____Indication:_____

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Review of Systems

For the following please write:
C for **Current** health concern, **P** for **Past** resolved concern, **O** for **Occasionally** a concern

General
__low appetite __strong thirst __chills __tremors __sudden energy drop __localized weakness
__poor balance __fever __fatigue __weight loss __weight gain __sweat easily
__cravings __night sweats __poor sleep __bleed/bruise easily

Skin and Hair
__rashes __ulcers __hives __itching __eczema __pimples __dandruff
__hair loss __new moles __pigment changes __dry skin

__other skin/hair concerns:_____

Head, Eyes, Ears, Nose and Throat
__sinuses __swollen glands __excess saliva __dizziness __concussions __headaches __migraines
__sore throat __poor vision __contacts __cataracts __eye strain __eye pain __night blindness
__poor hearing __earaches __ringing ears __grinding jaw __cavities __jaw clicks __nose bleeds
__loss of smell __facial pain __sore lips __sore tongue

__other head/neck concerns_____

Cardiovascular
__chest pain __palpitations __irregular beat __swollen feet/ankles __blood pressure
__murmurs __cold hands/feet __rheumatic fever __fainting

__other heart or blood vessel concerns:_____

Respiratory
__cough __phlegm __shortness of breath __pleurisy __coughing blood __asthma
__wheezing __bronchitis __pneumonia

__other breathing concerns:_____

Gastrointestinal
__nausea __indigestion __chronic laxative use __diarrhea __constipation __vomiting
__belching __bad breath __abdominal pain __black stools __gas __rectal pain
__other digestive concerns:_____

Genitourinary
__hurts to urinate __blood in urine __frequent urination __bladder urgency __unable to hold urine
__other urinary concerns:_____

Musculoskeletal
__Joint pain: Hand / Wrist / Elbow / Shoulder / Foot / Ankle / Knee / Hip / Back / Rib / Neck / Jaw
__muscle weakness __broken bones __tendonitis
__other bone or muscular concerns?_____

Neurological
__seizures __depression __tingling __loss of balance __concussions __anxiety
__poor memory __prone to stress __irritable __numbness __nervousness __lack of coordination

__have you ever been treated for emotional concerns?_____

__have you ever considered or attempted suicide?_____

__other neurological or psychological concerns?_____

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Canopy Integrated Health

INFORMED CONSENT

I would like to take this opportunity to welcome you to Canopy Integrated Health. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. If you are working with a Naturopathic Doctor a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

Printed name _____

As a patient of this clinic I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As Canopy Integrated Health is an integrated health clinic, I recognize that all the practitioners that are working with me may have access to my file. I also recognize that even the gentlest therapies may have risks or complications. In certain physiological conditions or in very young children or those on multiple medications the chance of these risks may be higher and hence the information provided is complete and inclusive of all health concerns and all medications. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries and vascular events from spinal manipulations.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

_____	_____/_____/_____	_____
SIGNATURE	DATE	WITNESS SIGNATURE

Parental Consent

_____	_____/_____/_____
SIGNATURE OF PARENT/GUARDIAN	DATE