Patient Intake Form

Date: _______________

Name: ____ Date of Birth: __________________

Address: ____Postal Code:____________________

City:____Phone Number:_____________________

Email Address: ____

Referred to clinic by: ____

Current Supplements:

Current Medications:

Please list any events, physical and emotional during these age spans (loss of job, moving, death, accidents, injuries, surgeries, hospitalizations)

Age	Event
0-5	
6-10	
11-18	
18-25	
26-40	
41-50	
Over 50	

How much sleep do you get each night?______Is your sleep restful Yes [ ] No [ ]
What is your occupation?________________________
If you are retired what was your previous occupation___________________
What is your stress level? High [ ] Low [ ] Manageable [ ]
How much water do you drink a day?_____________
Do you drink tea or coffee? __________ How much?___________
Are you pregnant? Yes [ ] No [ ]Number of previous pregnancies_________________

Medical History **Self [X] Mother [M] Father [F] Sibling [S] Grandparent [G]**

Diabetes [ ]
High Blood Pressure [ ]
High Cholesterol [ ]
Parkinson's[ ]
Heart Disease/ Stroke [ ]
Thyroid [ ]
Mono [ ]
Asthma [ ]
Addictions [ ]
Arthritis [ ]
Alzheimer Disease [ ]
Tick Bites [ ]
Auto Immune [ ] Type__________________
Cancer [ ] Type_______________________

Medical Doctor_________________ Date of last visit:________________________
Naturopathic Doctor:_____________ Date of last visit:__________________________
Chiropractor:______________________ Date of last visit:__________________________
Other Health Care Provider:__________Date of last visit:__________________________

Do you have any known allergies? Yes [ ] No [ ]
Food____
Environmental____

Do you smoke? Yes [ ] No [ ]If yes, how many cigarettes per day___________
Do you drink alcohol? Yes [ ] No [ ] If yes, how many drinks per day_________
Do you use recreational drugs? Yes [ ] No [ ] If yes, how often______________

Present Concerns:____
____
____
____

The MSA Pro is a device whose function is to assess stress within the energy pathways of the body. It is not a diagnostic tool for disease identification. The MSA Pro can help restore functional health by recommending remedies that restore balance to affected energy pathways.

I understand that the exchange of information is for educational purposes and to be used at my discretion.
I recognize that my health and well being depend on how well I care for myself, and I accept responsibility for myself and the choices I make.
I certify that the above information is correct to the best of my knowledge.
Payment in full is expected at time of service.
Circle of Health does not prescribe, diagnose or treat specific conditions, and does not intend to replace medical treatments.

Client Signature:________________________________
Legal Guardian (if under 18):______________________Relationship to Client: _____________________

Congratulations on taking this important and proactive step for your health! Together we will create a healing strategy specific to your individual needs. Please keep in mind that our services/assessments differ from the medical diagnostic testing you may be familiar with. The energetic imbalances detected during a Meridian Stress Assessment are not intended to replace or contradict treatment you may be receiving from your physician.

1. **Appointments:**
Please- avoid using lotions on hands and feet, perfume or any scented products *** we have a SCENT-FREE policy***
For MSA testing -bring all supplements in original bottle as well as a list of medications
-any bloodwork or medical reports from the last year
-a pen and note book for taking notes
Follow up appointment times are scheduled for either 30, 45 or 60 minutes, appointments that run over the scheduled time will be charged in 15 min increments.
While we do our best to contact you prior to your appointment for a reminder, it is ultimately your responsibility to remember your appointments.

2. **Confidentiality:** Respecting your privacy is very important to us at Circle of Health, all personal information that is collected in the course of professional treatments is considered highly sensitive and private and shall not be shared. To prevent wrongful disclosure of information to anyone other than yourself, please provide your preferred telephone number and email address so that we may contact you directly.
Telephone number:___________________________Email address:________________________________
(please ensure your email address is printed legibly)

3. **Cancellations:** Please note that a late cancellation or a 'no-show' prevents other patients from enjoying the benefits of our services; at the same time making it difficult for our employees to replace and re-structure appointments.
If you must cancel or re-schedule your appointment, we **request at least 48 hours notice (earlier notice would be appreciated)** by calling **905-371-3331** or emailing **reception@circleofhealth.ca**.
In the event of a cancellation with less than 48 hours notice or of a 'no show' appointment, Circle of Health reserves the right to charge 100% of the intended appointment fee to the credit card on file.

Print Name:___________________________

Signature:______________________________Date:_____________________________________

4. **Financial Transactions:** For after-hours supplement pick-up, postal delivery of supplements and/or for express service or missed appointments we are pleased to hold your credit card information securely on file.
Credit Card #:____________________________CVC# (last 3 digits on back of card)______Type: VISA [ ] MC [ ]
Expiry date:____________________

Print Name:_____________________________

Signature:______________________________Date:____________________________________
Should you have questions or comments about the practices outlined above, please don't hesitate to contact us Thank you for choosing Circle of Health as your Alternative Health Care provider.

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