Circle of Health

Patient Intake Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____ Postal Code: _____

City: _____ Phone Number: _____

Email Address: _____

Referred to clinic by: _____

Occupation (Previous occupation if retired): _____

Please list all Medications and Supplements:

Please list any medical conditions you have:

[ ] Diabetes [ ] High Blood Pressure [ ] High Cholesterol [ ] Parkinson's [ ] Heart Disease / Stroke

[ ] Thyroid [ ] Mono [ ] Asthma [ ] Alzheimer Disease [ ] Arthritis [ ] Tick Bites [ ] Addictions

[ ] Auto Immune [ ] Cancer [ ] Other: _____

Do you have a pacemaker? Yes [ ] No [ ]

Please list any surgeries or significant life events (e.g., loss of job, moving, death, accidents, injuries, hospitalizations):

Additional information related to Medical History (optional):

6009-107a Valley Way, Niagara Falls, ON L2E1X9

circleofhealth.ca reception@circleofhealth.ca 905-371-3331

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Health Care Providers (Please list any that apply)	**Date of Last Visit**
Medical Doctor:	
Naturopathic Doctor:	
Chiropractor:	
Other Health Care Provider:	

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? _____

How much water per day? _____ Tea: _____ Coffee: _____

What is your stress level? High [ ] Low [ ] Manageable [ ]

Are you currently pregnant? Yes [ ] No [ ]	# of Previous Pregnancies: _____
How much sleep do you get each night? _____	Is your sleep restful? _____

Client Signature: _____

Legal Guardian: _____ (If under 18)	Relationship to Client: _____

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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.

Appointments:

Please avoid using lotions on hands and feet, perfume or any scented products, **we have a SCENT-FREE policy**

For MSA testing, please bring:

- All supplements in original bottle
- A list of any medications,
- Any blood work 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.

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: _____	Email Address: _____

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: _____

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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. We accept **Visa** and **MasterCard**

Credit Card #: _____	Type: VISA [ ] MC [ ]
CVC# (Last 3 digits on back of card): _____	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.

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 wellbeing 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.

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