

Hello and welcome to the Daziran Integrative Health. We are privileged to be a part of your healing team. For most people, the naturopathic experience will be quite different than the conventional medical system to which they are accustomed. Your initial visit will include a consultation, detailed history, relevant physical exam, screening diagnostics and naturopathic assessments. Other lab work may be requested depending upon your specific presentation and concerns.

Your second visit, usually two weeks later, will include a detailed report of findings and your individualized treatment plan will be discussed. Also, any remaining portion of the relevant physical exam will be completed on this visit. Treatment plans may include dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy, or hydrotherapy

Subsequent visits are typically every 4 to 6 weeks, though may be more frequent if your case requires active treatments or close follow-up. As you start to experience greater health and wellness, an office visit every three months is recommended for general health maintenance and disease prevention. If ever an acute, non-emergency condition occurs, please call the office as naturopathic treatments may be indicated.

At Daziran, we attempt to treat the whole person with an emphasis on the cause of their concerns, not just the symptoms. Our treatment plans are gentle and non-invasive, working with the body's inherent ability to heal itself. Client education is strongly emphasized as it encourages our patients to become invested in their health and therefore increases the likelihood of a successful outcome.

Contrary to what you might think, naturopathic care does not need to be practiced in isolation. Many of our clients with pre-existing medical concerns and subsequent treatment seek out our services to best ensure that all their health needs are met. We look forward to continued professional relations with the medical community so that our patients get the best of what both approaches have to offer. An integrative approach to health is an essential part of building happy and healthy communities.

With all this in mind, please take a few minutes to answer the following health questionnaire openly and honestly. Our ability to treat you with the best that naturopathic care has to offer depends on it. Additionally, please include a copy of your most recent lab work or imaging studies as these will help direct the course of your individualized treatment.

Looking forward to meeting you,

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Dr. Marika Geis, BSc, ND  
Daziran Integrative Health

**Patient Information:**

Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Age: \_\_\_\_\_ M/F  
(First) (Middle) (Last) (dd/mm/yy)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_  
(Box Number) (Number) (Street) (suite/apt #)

\_\_\_\_\_  
(City) (Province) (Postal Code)

Home Phone Number: \_\_\_\_\_ Cell Phone number: \_\_\_\_\_

Work Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

I would like to receive Dr Geis' newsletter

Where is the most convenient place to reach you? \_\_\_\_\_

Marital Status: \_\_\_\_\_ # of children? \_\_\_\_\_

Occupation: \_\_\_\_\_

How did you hear of our clinic? \_\_\_\_\_

**In Case of Emergency, Contact:**

Name: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Home Phone number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

**Office use only:** Credit Card Number: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

**Context of Care**

What about Naturopathic Medicine interests you?

What 3 expectations do you have from this visit?

What are your LONG TERM health goals?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Please rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe SUPPORT your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are NOT supporting your optimal health?

What potential obstacles do you foresee in being able to undertake and maintain the lifestyle recommendations and therapeutic interventions that I will share with you?

Who do you know that will sincerely support you, consistently, with the potential lifestyle changes you will be making?

How would you describe your general state of health?

**Current Health Concerns:**

What are your health concerns in order of importance to you?

- a) \_\_\_\_\_
- b) \_\_\_\_\_
- c) \_\_\_\_\_
- d) \_\_\_\_\_

**Medical History:**

Are you currently seeing a family physician? Y/N

Name of family doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Have you recently had any lab work or imaging studies done? Y/N

If so what were the results?

\_\_\_\_\_

Current/Past Illnesses, Conditions  
Hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List medications or supplements used currently:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies/sensitivities (food, drug,  
seasonal, pets, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medications/supplements used in the  
past:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Date of last antibiotic use: \_\_\_\_\_

***Diet and Lifestyle***

Please list a typical day's diet

Breakfast \_\_\_\_\_ How many glasses of water per day?

Lunch \_\_\_\_\_ How many caffeinated drinks per day?

Dinner \_\_\_\_\_ How many alcoholic beverages per week?

Snacks \_\_\_\_\_ How many cigarettes per day?

How many hours do you sleep per night?

Do you wake feeling rested?

How many times per week do you exercise?

How would you rate your stress levels? Low? Moderate? High?

What are the sources of stress in your life?

To your knowledge, have you ever been exposed to any hazardous chemicals?

***Family Health History***

Please indicate whether a close family relative (mother (M), father (F), siblings (S), grandparents (G) or child (C)) has had any of the following:

Allergies \_\_\_\_\_ Cancer \_\_\_\_\_

Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_

Heart disease \_\_\_\_\_ Depression \_\_\_\_\_

High blood pressure \_\_\_\_\_ Substance abuse \_\_\_\_\_

Kidney disease \_\_\_\_\_ Other mental illness \_\_\_\_\_

Epilepsy \_\_\_\_\_ Genetic defect \_\_\_\_\_

Other: \_\_\_\_\_

## Review of Systems

Please check all that apply- if you've had the condition now or in the past.

Symptom	Currently	Never	Past	Symptom	Currently	Never	Past
Acne				Excessive thirst			
AIDS/HIV				Exposure to toxins/chemicals			
Allergies				Eye floaters			
Anemia				Eyeredness/itching/discharge			
Anxiety/depression				Eye pain			
Arm/shoulder pain				Fainting			
Asthma				Fibrocystic breasts			
Black stools				Frequent colds/flu			
Bladder problems				Glaucoma			
Bleeding gums				Headaches			
Bloating/gas				Heartburn			
Blood/mucus in stool				Heart disease			
Blood in urine				Heart murmurs			
Breast lumps				Heavy menses			
Breast tenderness				Hemorrhoids			
Broken bones				High blood pressure			
Brittle nails				Hoarse voice			
Cancer				Hernias			
Cataracts				Herniated disks			
Chest pain				Inability to hold urine			
Chronic cough				Indigestion			
Chronic fatigue				Infertility			
Cold hands/feet				Insomnia			
Constipation				Irregular menstrual cycle			
Deafness/impaired hearing				Joint pain/stiffness			
Dental caries				Kidney problems			
Diabetes				Leg pain/cramps			
Diarrhea				Lines on nails			
Digestion problems				Loss of balance			
Genital discharge				Loss of taste			
Dizziness/vertigo				Low back pain			
Dry skin				Memory loss			
Ear aches/infection				Migraines			
Epilepsy				Muscle weakness			
Excessive hunger				Nail fungus			
Ear ringing				Nausea/vomitting			
Easy bruising				Neck pain			
Eczema				Night sweats			
Excessive sweating				Nose bleeds			

Symptom	Currently	Never	Past	Symptom	Currently	Never	Past
Numbness/tingling				Shortness of breath			
Osteoarthritis				Sinus problems			
Osteopenia				Sore throats			
Osteoporosis				Speech problems			
Pacemaker				Spitting up blood			
Pain on urination				Stomach pain			
Painful intercourse				Stroke			
Painful menses				Swollen neck glands			
Palpitations				Testicular mass/pain			
Paralysis				Thyroid problems			
PMS				TMJ			
Poor circulation				Urinary tract infections			
Prostate problems				Urinary urgency			
Psoriasis				Urination at night			
Rashes				Vaginal itching			
Rheumatoid arthritis				Venereal disease			
Sciatica				Weight gain (unexplained)			
Seizures				Weight loss (unexplained)			
Shingles				Wheezing			

Please use this space to add any other information about yourself that you think would be of help to us

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***Fee Schedule***

**Naturopathic Consultations**

Initial Appointment	75 minutes	\$150
Second Appointment	45 minutes	\$115
Follow-up Appointment	30 minutes	\$75
Pediatric Initial Appointment (Under 12 years of age)	75 minutes	\$125
Pediatric Follow up	30 minutes	\$50

**In-House Treatments**

Acupuncture	30 minutes	\$65
6 treatments		\$400
Intravenous Therapy Injections	60 minutes (approx.)	\$85 \$4 per cc. of medicine
House calls		Add \$20

*Prices do not include GST*

- Phone consultations are available only after the first two visits at the cost of a regular follow-up visit.
- Laboratory tests are priced on an individual basis.
- Full fees apply to missed/cancelled appointments with less than 24 hours notice.

**INFORMED CONSENT  
FOR NATUROPATHIC DIAGNOSTIC & TREATMENT PROCEDURES**

**Your signature is required before any treatment is rendered. Your signature acknowledges the following:**

1. You are ultimately responsible for your own health.
2. It is your responsibility to inform your Naturopathic Doctor of: any medical conditions or allergies that you are suffering from; any medications/supplements that you are currently taking; and if you are pregnant, may be pregnant, or if you are breast-feeding.
3. While changes in habits are not a prerequisite for treatment, failure to follow the recommended nutritional and lifestyle programs could undermine the expected results.
4. You understand that that it takes time to feel better when using naturopathic medicine. You accept that positive changes will occur more rapidly with increased compliance.
5. You are accepting or rejecting this naturopathic medical care of your own free will and choice. You are free to withdraw your consent and to discontinue treatment at any time.
6. You accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered. You acknowledge that canceling or rescheduling appointments must be done 24 hours in advance.
7. If you have any questions regarding your treatment program, it is your responsibility to clarify these issues with your Naturopathic Doctor.
8. Naturopathic Doctors (ND) are not Medical Doctors (MD). Therefore, if standard medical treatment (drugs, surgery, etc.) is necessary, it must be obtained from a Medical Doctor.
9. You are not an agent of any private, local, county, provincial or federal agency attempting to gather information without stating your intention to do so.
10. There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to: pain, bruising, or injury from acupuncture or injections; allergic reactions to certain supplements and herbs; and aggravation of pre-existing symptoms.

I, \_\_\_\_\_ (please print),

**have read, understood, and acknowledge the above statements.**

**Patient or Lawful Representative Signature** \_\_\_\_\_

**Date Signed** \_\_\_\_\_ **Witness** \_\_\_\_\_

## Release of Medical Records

Instructions:

1. Please read and sign the following document.
2. When completed, we will fax your general practitioner. (Note: Any reports done by specialists will have been sent to your GP).
3. Please give your GP a courtesy call to confirm document was received and will be sent to our office. (Note: There may be a fee for the release of records, the records will not be sent until this fee is paid).

Please send or fax copies of:

\_\_\_\_\_ D.O.B. \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

**LAB REPORTS ONLY** to our office:

\_\_\_\_\_ All Previous Lab Reports.

\_\_\_\_\_ Lab Reports only in the past \_\_\_\_\_ years/months.

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Requested By:

Dr. Marika Geis, ND (#438)  Faxed: By: \_\_\_\_\_

Received: By: \_\_\_\_\_