



**PYATT HEALTH CENTRE**  
NATUROPATHIC FAMILY MEDICINE & ONCOLOGY CARE

**PATIENT INFORMATION:**

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

Address \_\_\_\_\_  
Street Name & Number

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

Phone # \_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Alt Phone # \_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Home Work Cell Home Work Cell

Email address: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
Phone #

Alberta Health Care # \_\_\_\_\_

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

**MEDICAL INFORMATION**

Family Doctor \_\_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Name Phone #

Year of last physical exam \_\_\_\_\_ Year of last blood work \_\_\_\_\_

Are you pregnant or may you become pregnant? Y / N Are you breastfeeding? Y / N

Hospitalizations & surgeries: \_\_\_\_\_

\_\_\_\_\_

Prescribed medications: \_\_\_\_\_

\_\_\_\_\_

Over the counter medication and supplements: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies : \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

\_\_\_\_\_

**HEALTH INFORMATION**

Patient name: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Diagnosed conditions: \_\_\_\_\_

Current treatments (other than medications & supplements) \_\_\_\_\_

Significant family health history: \_\_\_\_\_

Please rate the following where 1 = very poor and 10 = your ideal state:

Overall health \_\_\_\_ / 10 Energy \_\_\_\_ / 10 Sleep \_\_\_\_ / 10 Stress tolerance \_\_\_\_ /10

**REVIEW OF SYSTEMS**

Please state any health issues in the following categories that are not already mentioned above, including any significant past issues as well, indicated by a (P) after the condition:

Skin, Hair, Nails: \_\_\_\_\_

Digestive: \_\_\_\_\_

Respiratory: \_\_\_\_\_

Eyes, Ears, Nose, Throat: \_\_\_\_\_

Immune System: \_\_\_\_\_

Cardiovascular: \_\_\_\_\_

Nervous System: \_\_\_\_\_

Hormones: \_\_\_\_\_

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

Urinary: \_\_\_\_\_

Musculoskeletal: \_\_\_\_\_

Mental Emotional: \_\_\_\_\_

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



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To serve your needs better we ask for your credit card information.

**Credit Card Information:**

Card Type: \_\_\_\_ Master Card \_\_\_\_ Visa

Card Holder Name \_\_\_\_\_

Card Number: \_\_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_ C.C.V.: \_\_\_\_ Postal Code \_\_\_\_  
MM YY On Back of Card Associated with Card

I, \_\_\_\_\_ authorize  
Printed Name

Pyatt Health Centre to charge my credit card listed above for agreed upon purchases. I understand that my information will be saved to an encrypted file for future transactions on my account.

X \_\_\_\_\_ Date : \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Signature Day Month Year



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**CONSENT TO TREAT & PATIENT RESPONSIBILITY**

The Undersigned patient and/or responsible relative or person hereby consents to the following:

I authorize Pyatt Health Centre naturopathic doctors and medical personnel to administer and perform medical examinations, investigations, and medical treatments during the course of my care that are deemed advisable or necessary.

I consent to Pyatt Health Centre contacting me by telephone if needed regarding appointments and follow-up needs.

I am responsible for making my own appointments and notifying Pyatt Health Centre with sufficient notice (one business day prior to my appointment) should I be unable to attend a scheduled appointment. Appointments missed or rescheduled without sufficient notice may carry a financial penalty.

I understand that should I be later than half the length of my appointment I will likely need to reschedule. Though every attempt will be made to accommodate late clients, Pyatt Health Centre is unable to make guarantees in this regard.

I realize that I am responsible for all costs associated with my care at Pyatt Health Centre. This includes, but is not limited to, consultations, treatments, evaluations & labs, supplementation, professional letters/ correspondences and courier & shipping costs. I also know that I will be duly informed by a member of Pyatt Health Centre of any cost prior to my incurring them.

I understand that it is my responsibility to follow-up with my primary care provider at Pyatt Health Centre via a phone or clinic consult every 4 weeks. Inquiries regarding clarification, changes or continuation of my treatment plan will require a follow-up appointment with my primary doctor at Pyatt Health Centre. Email to front desk may be used for general questions or to notify practitioners of adverse reactions or quick up-dates. I understand that my doctor can not diagnose or treat over e-mail.

I will familiarize myself with all instructions or guidance for testing or visits provided by Pyatt Health Centre prior to the scheduled appointment.

Out of respect for the healing environment at Pyatt Health Centre I will refrain from wearing any toiletries and cosmetics that are heavily scented.

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Patient Signature

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Date