ESSENCE
WELLNESS CLINIC

DIETITIAN INTAKE FORM

Patient Information:

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: (H) _____(Cell) _____

Date of Birth: _____(YYYY/MM/DD) Age: ____ Sex: M / F / □ _____

Occupation: _____ Email: _____

By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.

In case of emergency, who should we contact: _____

How did you find out about our services? _____

Patient Health History:

Please list your **health concerns** (from major to minor):

1. _____
2. _____
3. _____

Please list all **accidents**, **surgeries** or **hospitalizations** and the **year** they occurred:

_____ _____

_____ _____

_____ _____

Please list any **medications** and **supplements** you are currently taking and **dosage**:

_____

_____

_____

Are you currently seeing any other **alternative health care** professionals? (Chiro, Massage, etc)

_____

_____

_____

Please list all **allergies/sensitivities**:

_____

When was your **last physical exam**? _____

When was your **last blood test**? _____

Female patients: When was your last **breast exam/PAP smear**? _____

Family Doctor's name: _____

Clinic Name/Area: _____ Phone Number: _____

Please list all immediate **family members** who have any major health conditions:

_____

_____

Please list all conditions for which you have been treated in the past **10 years**:

_____

_____

Please list **all other conditions** that you currently have but are not the primary concern:

_____

_____

Consent for Treatment with Essence Wellness Clinic

I am hereby requesting Dietitian treatments that may include but are not limited to nutritional consultation, diet and lifestyle changes or any other adjunct treatments. New complications and concerns, if they do arise, will be discussed with my practitioner/therapist, and appropriate action will be taken. I understand that although these are natural and alternative treatments I am seeking, there may be risks of reactions to new dietary changes and worsening of symptoms during the healing process. I also understand that there are no guarantees for cure for any of my ailments or improvements of my symptoms. I hereby release Essence Wellness Clinic and all practitioners/therapists treating me from all liabilities.

I am also aware of the clinic's late cancellation policy of a charge of **50% of the visit cost if I fail to give less than 24 hours notice for cancellations. I will be responsible to pay that charge before I can re-book.**

Signature _____ Date_____