Aster Wellness Centre

Suite #203 – 2550 Shaughnessy Street, Port Coquitlam, V3C 3G2
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www.AsterWellness.ca

Please take a moment to fill out our intake form. Any information you provide is confidential and will only be accessible to Aster Wellness Centre.

Full Name: ________________________________

Mailing Address: ____

Birthdate: Day____ Month_____ Year_____ Age today _____

Preferred Phone #: ____________________ ☐ Please do not leave voicemails on this line

Email: _______________________________ ☐ Others have access to this email account

Family Doctor:____________________________ Tel:____________________________

Other Health-Care Professionals we should know about (Medical doctor, oncologist, etc)

1) ______________________ 2)______________________ 3) ______________________

Your Emergency Contact: __________________________ Tel: _________________________

How did you hear about Aster? ❑ Other: _________________________

❑ Google ❑ Dr. Lee's website ❑ Aster Wellness' website ❑ Yelp

❑ Facebook ❑ Friend/colleague ❑ Medical referral ❑ Family

With my signature below, I acknowledge that I have read and understand the Client-Care Rights & Responsibilities Treatment Agreement, and that I agree with the terms described.

Client Signature: 1)_________________________ Date: _______________________

Aster Wellness practitioner: ______________________ Date: _______________________

Credit Card Information:

Aster Wellness Centre requires credit card info to be stored on file in the event of a missed appointment, or if you wish to direct-bill. This information is confidential and will be stored securely along with any client files. If the credit card info changes or expires, you are required to update Aster Wellness Centre with new credit card details.

Credit card Type:

(please circle)

VISA MasterCard American Express

Name as shown on card: ____

Credit card #: _________ _________ _________ _________

Expiry Date: ________________

3-digit security @ back of card: __ __ __

Postal code of billing address: __ __ __ __ __ __

24 hours notice is required to cancel or change an appointment time. If sufficient notice is not provided, the entire amount of the session price will be charged to this credit card.

I agree to these terms:

Card-Holder Signature: _______________________

Client-Care Rights & Responsibilities Treatment Agreement

Confidentiality & Consultation

Personal information that you discuss with your Aster Wellness Centre practitioner is confidential. No identifying information will be released to any third party without your prior authorization. To ensure you receive the best care possible, supervision/consultation on your case with identifying details removed may occasionally be sought with other registered practitioners affiliated with Aster Wellness Centre.

While the details of your consultation are held in strict confidence, there are instances where we as health & wellness practitioners are legally required to release your personal information. Specifically, if you reveal information that indicates a clear and immediate danger of harm to yourself or others, or that a child or a vulnerable adult is in need of protection, the practitioner will need to contact the appropriate authorities. Additionally, practitioners that you work with here at Aster Wellness Centre are required to release records if mandated by a court order.

Client Rights

You may inquire about the qualifications and background of the practitioner as related to the practice of the service you are receiving. At any time, you may discuss these points with your consultant, and if requested, a referral can be made to another consultant or clinic if necessary.

Responsibility

Your participation in the consultation process can be enhanced with additional efforts on your part made between sessions. These efforts may include thinking about the material covered in the sessions, monitoring the behaviours you are trying to change, or working on specific skills learned in session. While exercises and activities may be suggested in session, they are not mandatory. We encourage you to discuss any suggestions made by your consultant and to work at your own pace.

Missed Appointments

Payment after your consultation session is required via credit card/cash/cheque before departing the Aster Wellness Centre. Your session is a reserved appointment time that belongs just to you, and so it is important that you attend all sessions that you schedule to **avoid paying in full for a missed session**. If you are unable to attend your session for any reason, please cancel via email or voicemail at least 24 hours before your session.

If cancellation is received after this deadline, or you miss the appointment entirely, **the entire amount of the session will be charged.**

Risks and Benefits

Naturopathic medicine is the treatment and prevention of diseases by natural means, which are used to stimulate the body's inherent healing capacity. Naturopaths assess the whole person, including physical, mental, emotional and spiritual aspects of the individual. Your visit may consist of a thorough case history and a screening physical examination, including a breast exam for females. It is important that we are informed of any diseases that you are suffering from and if you are on any

medication or over the counter drugs. If you are pregnant, suspect you are pregnant or are breast-feeding, please let us know immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising or injury from acupuncture or cupping; fainting or puncturing of an organ with acupuncture needles. Results are not guaranteed and not all risks and complications can be anticipated and explained.

There are both risks and benefits to participating in wellness practices, consultation, therapies or psychological consultation of any sort. Some of the therapies provided may trigger old memories; you may remember unpleasant events and experience strong and/or unanticipated feelings. Benefits of the consultation may include an increased ability to live more effectively in life areas such as interpersonal relationships, career, goals and personal development. You may also experience greater self-awareness, self-esteem and lessened distresses like anxiety and anger.

Naturopathic Session Fees and Format:

Individual sessions are priced as follows, and require immediate payment.

- Initial consultation - $185 (60 minutes)
- Oncology Initial Consultation - $235 (75 minutes)
- Second visit - $140 (45 minutes)
- Follow-up consultations - $185/60min, $140/45min, $100/30min, $60/15min.
- Acupuncture-only or Reiki-only follow-up visits: $80 (30 min)
- Acupuncture-only or Reiki-only package: $450 for 6 prepaid 30-minute sessions
- Facial Rejuvenation Acupuncture package: $140 (45 min) per session, $800 for 6 prepaid sessions
- Phone consults: billed as above

The time required for each session goes well beyond the face-to-face contact that you and your practitioner will share. Case notes, treatment development, research and consultation requires a great deal of time to develop appropriate understanding of your specific concerns or issues.

A copy of this document should be provided to you for your records. At any time, feel free to discuss these points over the course of your sessions.

We look forward to working with you. If you have any other questions or concerns, please don’t hesitate to let us know!

Please keep this copy for your records, and acknowledge the content described by signing our consent form.

Sincerely,

Dr. Vanessa Lee, BSc, N.D.

____________________________ Patient Signature

__________________________ Today’s date

Name: ________________________________ **Birthdate:** ____/____/____ (d/m/y)

Goals

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

1. ____
2. ____
3. ____

Occupation ____

Do you exercise regularly? Y / N Type of exercise ________________ how often ________

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you regularly exposed to toxins/hazards at work, home, hobbies, etc.? Please describe.

____

Medical history

How is your health in general? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Please indicate any serious conditions, illnesses, injuries, and hospitalizations, along with dates.

____

____

Do you have allergies (drugs, food or environmental)?

____

____

List food allergies/intolerances/restrictions (religious, vegetarian/vegan, health-related, etc.)?

____

Current medications/supplements (prescription, over-the-counter, vitamins, herbs, chemo…)

____

____

Conditions in your close family (e.g. cancer, diabetes, heart disease, mental illness, etc):

____

____

☐ I don't know my family medical history

Do you frequently use any of the following? (circle)

Alcohol: _______ per day or _______ per week Tobacco: _________ per day

Recreational drugs: what and how often ____

Have you ever had bad reactions to immunization shots? Y / N or to antibiotics? Y / N

Do you get regular screening tests from another doctor? (Pap, blood tests, etc.)? Y / N

Females: Are you currently pregnant? Y / N Are you planning to get pregnant? Y / N

Review of Systems (Please circle any of the following issues that apply to you)

Skin	Rashes	Eczema	Acne	Itching	Color / mole change	Skin cancer
Head	Headaches	Head injury	Dizziness			
Eyes	Glasses / contacts	Pain	Tearing / Dryness	Double vision	Glaucoma Cataracts	Allergies
Ears	Impaired hearing	Earache	Discharge	Freq. infections		
Nose & sinuses	Frequent colds	Nose bleeds	Sinus problems	Allergies		
Mouth & Throat	Frequent sore throats	Sores	Hoarseness	Loss of taste	Gum problems	
Neck	Lumps	Goiter	Swollen glands	Pain	Stiffness	
Lungs	Emphysema	Cough	Spit up blood	Wheezing	Pneumonia	Asthma
	Shortness of breath	Shortness of breath lying down	Pain on breathing	Bronchitis	Tuberculosis	
Heart	Heart disease	Angina	High blood pressure	Murmur	Chest pain	Cyanosis
	Swelling in ankles	Palpitations				
Extremities	Deep leg pain	Cold hands/feet	Varicose Veins	Numbness	Coldness	Swelling
	Leg cramps	Ulcers				
Blood & Lymphatics	Anemia Transfusions?	Low platelets	Low WBC	Easy bleeding	Swollen nodes	Low Mag
Digestion	Trouble swallowing	Food allergies	Change in Thirst	Change in Appetite	Vomiting	Vomiting Blood
	Nausea	Heartburn	Gas	Hernia	Ulcers	Pain

	Constipation	Diarrhea	Blood in stools	Rectal Bleed	Hemorrhoids	
Urinary	Pain	Increased frequency	Frequency at night	Frequent infections	Kidney stones	Blood in urine
	Urgency	Hesitancy	Inability to hold urine			
Male reproductive	Hernia	Testicular mass/pain	Veneral diseases	Discharges or sores	Sexual difficulties	

Female reproductive	Age menses began			Number of pregnancies	
	Average number of days of bleeding			Number of live births	
	Length of cycle			Number of miscarriages	
	Last menstrual period			Number of abortions	
	Bleeding between periods			Painful menses	
	Are cycles regular	Y	N	Excessive flow	
	Pain during intercourse	Y	N	PMS	
	Difficulty conceiving			Vaginal discharge	
	Sexual difficulties			Vaginal itching	
	Venereal Disease			Date of last PAP	
	Are you sexually active?	Y	N	Type of birth control?	
	Do you do self- breast exams regularly?	Y	N	Breast pain/ tenderness	
	Breast lumps			Nipple discharge	

Muscles & Joints	Joint pain or stiffness	Arthritis	Spasms / cramps	Weakness	Joint swelling	Backache
Neurologic	Fainting	Seizures / Convulsions	Paralysis	Muscle weakness	Numbness or tingling	Loss of memory
	Involuntary movement	Loss of balance	Speech problems			
Endocrine	Heat or cold intolerance	Thyroid trouble	Excessive thirst	Excessive hunger	Excessive urination	Excessive sweating
	Diabetes	Hypo-glycemia	Hormone therapy			
Emotional	Alcohol / Drug abuse	Mood swings	Anxiety or nervousness	Tension	Depression	Insomnia

Hobbies & Habits	Do you eat three meals daily?	Y	N	Do you take vacations?	Y	N
	Do you awake rested?	Y	N	Do you enjoy your work?	Y	N
	Do you sleep well?	Y	N	Do you read?	Y	N
	Do you average 6-8 hours sleep?	Y	N	How much TV do you watch?		

Thank you for taking the time to complete this form.

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