Ottawa Integrative Health Centre Inc.
1129 Carling Ave., Ottawa, ON K1Y 4G6
P: (613) 798-1000 F: (613) 798-9995 www.oihc.ca

Pharmacist Intake Form

Patient Information

Name_____ Date_____

Address_____

City_____ Province_____ Postal Code_____

Home Phone_____ E-Mail _____

☐ Yes, sign me up for the monthly e-newsletter

Emergency Contact Information (Name and Ph. Number): _____

Name of Family Medical Doctor/ Naturopathic Doctor /Specialists

_____

_____

Occupation _____

Age _____ Height _____ Sex _____

Medication Allergies

_____

List current health conditions for which you are being treated

_____

_____

_____

_____

_____

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What types of therapies have you tried for these problem(s) or to improve your health overall:

☐ Diet modification ☐ Vitamins/minerals ☐ Herbs

Other

_____

_____

Allergies to natural health products/herbs?

_____

Do you experience any of these general symptoms on a regular basis? Please check.

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Vision Problems
☐ Bleeding	☐ Chest Pains	☐ Headaches	☐ Vomiting
☐ Anxiety	☐ Discharge	☐ Disinterest in eating	☐ Dizziness
☐ Diarrhea	☐ Low-grade fever	☐ Itching/rash	☐ Chronic pain/ inflammation

Current medications (prescription or over-the-counter) and dosages:

_____

_____

_____

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_Previous Laboratory Work.

_____

_____

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

YEAR	SURGERY, ILLNESS OR INJURY	OUTCOME

How much alcohol do you drink per week? _____

How much *tobacco* do you consume per day? _____

How much *caffeine* do you consume per day?

Coffee - # 6 oz cups per day: _____ Tea- # 6 oz cups per day: _____ Soda - #cans per day: _____

How many glasses of *water* do you consume per day? _____

How much do you exercise?

☐ *5-7 days/wk* ☐ *3-4 days/wk* ☐ *1-2 days/wk*

How long do you exercise per workout?

☐ *45 minutes or more* ☐ *30-45 minutes* ☐ *Less than 30 minutes*

Please circle your diet description:

Mixed food diet (animal/vegetable sources) Vegetarian Vegan Salt restriction

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Fat restriction	Carbohydrate restriction	Gluten Free	Total calorie restriction

Please circle any food restrictions/ Food Allergies.

Dairy	Wheat	Eggs
Soy	Corn	gluten

Please list the number of servings you eat per day of:

Fruit _____Vegetables _____

Please circle what best describes your eating habits.

Skip meals (which meals) _____	One meal a day	Three meals a day	small frequent meals
Generally eat on the run	Eat constantly when hungry		

Please list which natural supplements you are currently taking.

_____

_____

_____

_____

_____

_____

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Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

What do you feel is the main cause of your stress? Is it ongoing?

_____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Healthy weight Your weight: _____lbs

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months?

_____

Are you exposed to chemicals on a regular basis?

Recent blood pressure readings:

_____

_____

List your current health goals?

_____

_____

_____

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Energy and vitality

I would like to:

☐ Feel more vital ☐ Have more energy ☐ Have more endurance ☐ Be less tired after lunch
☐ Sleep better ☐ Be free of pain ☐ Get less colds and flus ☐ Get rid of allergies

☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.

☐ Stop using laxatives and stool softeners

Medical History- Parents and Siblings

☐ *Arthritis* ☐ *Cancer* ☐ *Eating disorder* ☐ *Infertility* ☐ *Migraine headaches* ☐ *Stroke*

☐ *Asthma* ☐ *Depression* ☐ *Genetic disorder* ☐ *Learning disabilities* ☐ *Neuro-logical (Parkinson's)* ☐ *Addisons*

☐ *Alcoholism* ☐ *Diabetes* ☐ *Glaucoma* ☐ *Mental illness* ☐ *Obesity* ☐ *Other* _____

☐ *Alzheimer's disease* ☐ *Drug addiction* ☐ *Heart disease* ☐ *Mental retardation* ☐ *Osteo-porosis*

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Medical History- General

☐ *Arthritis*	☐ *Chronic fatigue syndrome*	☐ *Drug addiction*	☐ *Glaucoma*	☐ *Mental illness*	☐ *Seasonal affective disorder*
☐ *Allergies or hay fever*	☐ *Addisons*	☐ *Eating disorder*	☐ *Gout*	☐ *Migraine problems*	☐ *Skin problems*
☐ *Asthma*	☐ *Cholesterol, elevated*	☐ *Emphysema*	☐ *Heart disease*	☐ *Neuro-logical – Parkinson's*	☐ *Tuberculosis*
☐ *Alcoholism*	☐ *Circulatory problems*	☐ *Eyes, ears, nose, throat problems*	☐ *Infection, chronic*	☐ *Sinus problems*	☐ *Ulcer*
☐ *Alzheimer's disease*	☐ *Colitis*	☐ *Environmental sensitivities*	☐ *Inflammatory bowel disease*	☐ *Stroke*	☐ *Urinary tract infection*
☐ *Autoimmune disease*	☐ *Dental problems*	☐ *Fibromyalgia*	☐ *Irritable bowel syndrome*	☐ *Thyroid trouble*	☐ *Varicose veins*
☐ *Blood pressure problems*	☐ *Depression*	☐ *Food intolerance*	☐ *Kidney or bladder disease*	☐ *Obesity*	☐ *Other* _____
☐ *Bronchitis*	☐ *Diabetes*	☐ *Gastro-esophageal reflux*	☐ *Learning disabilities*	☐ *Pneu-Monia*	
☐ *Cancer*	☐ *Diverticular disease*	☐ *Genetic disorder*	☐ *Liver or gallbladder disease (stones)*		

Medical History (Men Only)

☐ Benign prostatic hyperplasia	☐ Prostate cancer

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Medical History (Women Only)

☐ Menstrual irregularities ☐ Endometriosis ☐ Infertility ☐ Fibrocystic/ ovarian cysts ☐ Fibrocystic breasts ☐ PMS- ☐ Pelvic inflammatory disease ☐ Vaginal infections

Medical History – Women Only

Are you pregnant/ breastfeeding? _____

Date of last GYN exam_____

Mammogram ☐ + ☐ —

PAP ☐ + ☐ _

Form of birth control _____ _____

# of pregnancies _____

C-section _____ _____

Age of first period _____

Date of last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)

_____

☐ Surgical menopause

☐ Menopause

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Patient/Client Agreement Form

Each patient/client is required to read the following before consultation.
Your signature below acknowledges the following:

1. I understand that Pharmacist Consultations and other services provided at OIHC are not covered by the provincial government. A professional services invoice will be provided.

2. The fees and services have been clarified in advance. Payment is due at the end of each visit as the clinic does not bill insurance companies directly. Cash, cheque, Interac, Visa, and MasterCard (no other credit card) are acceptable methods of payment

3. Forty-eight hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment.

4. Items purchased are non-refundable, whether or not they have been opened.

5. I understand that natural health care is a joint responsibility between me (the patient/client) and my practitioner. Improving my lifestyle can be as important as the remedies and treatments.

6. I understand that I may contact my health care provider by phone or e-mail and that all emails will be screened by reception and forwarded to the appropriate Naturopathic doctor/practitioner.

7. I realize that integrative health care/medicine is not an isolated system and that all our health care providers welcome teamwork with NDs, MDs, DCs, RMTs, and other health practitioners.

8. I understand that this is a new patient visit, and follow up visits will be advised if needed and that I may also make an appointment for a follow-up visit.

Client Signature_____ Date_____

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Informed Consent

During the process of pharmacist consultation, history taking and review of medication/ supplements/questionnaires/diet & lifestyle and lab work ordering & review will occur. Recommendations will be provided for diet & lifestyle modifications, natural supplements, lab work and medications.
Family doctor or specialists may be contacted to facilitate treatment plans.

Some therapies must be used with caution when dealing with particular conditions (such as pregnancy and lactation, kidney disease, and heart disease), it is very important that you inform your pharmacist immediately of any disease that you are suffering from, as well as any forms of medication, drugs, or supplements you are taking. It is also important that you contact us for a follow-up if any changes in medical condition or medication occurs while you are still on our treatment plan.

There exist slight health risks when receiving treatment recommendations. These risks include, but are not limited to, aggravation of pre-existing symptoms and allergic reactions.

I understand that a record will be kept of the health services provided to me, and that it will be kept confidential and will not be released to others unless so directed by me, unless the law requires it.
I understand that I may look at my medical records at any time, and can request a copy of this record by paying the appropriate fee.
I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.
I understand that the practitioner will answer any questions that I may have to the best of her ability.
I understand that results cannot be guaranteed.
I do not expect the Practitioner to be able to anticipate and explain all risks and complications.

I understand that consultation with the pharmacist **is not for the purposes of medical diagnosis** and for this purpose I will see a physician.

With this knowledge, I voluntarily consent to the procedures mentioned above.
I intend this consent form to cover new and follow-up consultations.
I understand that I am free to withdraw my consent and to discontinue my participation in these procedures at any time.
I understand if I am seeing more than one practitioner at the Ottawa Integrative Health Centre I imply consent for them to share and discuss my file as deemed necessary by the practitioners.

Client Name_____

Client/Parent Signature_____
Date_____

*Ottawa Integrative Health Centre care provider:*_____