Via Natural Medicine
554-A Des Meurons St. Winnipeg, MB Canada R2H 0P8
Phone: 204.615.5225 | Fax 204.615.5201
email: welcome@vianatural.ca | www.vianatural.ca

NEW PATIENT INTAKE FORM - ADULT
Dr. Heather Cardona, HD

Personal Information

We respectfully ask that you complete this form prior to arriving for your scheduled appointment time.

Patient Name: _____ Date of Birth: ____/____/_____
First Name Last Name DD MM YYYY

Gender: _____ Marital Status: _____ # of Children: ____ Age(s): _____

Home Address: _____ City: _____ _____

Province: _____ Postal Code: _____ Phone #: (____) _____

Email: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact's Phone #: (____) _____

Family Doctor: _____ Specialists: _____

_____

Other Health Care Provider(s): _____

Medical Information

Allergies, if known (medical, environmental, foods):_____

_____

Dietary Restrictions, if any (religious/vegetarian/vegan):_____

_____

Current Medication(s) & dosage: _____

Prescription, over-the-counter, vitamins: _____

_____

Past prescription medications: _____

_____

Past serious conditions, illnesses, injuries and/or hospitalizations & dates: _____

_____

_____

Current Level of Pain & Dysfunction (please circle one): Least 1 2 3 4 5 6 7 8 9 10 Worst

Other medical conditions? _____

_____

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General Health Information

Do you use any of the following? List the type and frequency if applicable:

- ☐ Alcohol: _____
- ☐ Antacids: _____
- ☐ Caffeine: _____
- ☐ Cigarettes: _____
- ☐ Recreational Drugs: _____
- ☐ Tylenol/Aspirin/Advil: _____

Any antibiotic treatments in the last 5 years: Y / N If yes, how many? ____

Any history of adverse reactions to immunizations: Y / N

Are you currently pregnant: Y / N

Do you get regular screenings by another doctor? (Pap, Blood Tests, etc...): Y / N

Have you ever had an abnormal pap (if applicable): Y / N

Typical diet, very generally:

Breakfast: _____ Snacks: _____

Lunch: _____ Dinner: _____

Beverages (type and amount): _____

_____

Do you exercise regularly? Y / N If yes, type and frequency: _____

Are you regularly exposed to toxins or other hazards that you know of? Y / N

If yes, where? (Home, Work, Other) : _____ please describe _____

_____

If you have further information regarding your health, please take a moment to describe below:

_____

_____

_____

_____

_____

_____

Thank you for taking the time to complete this intake form. We look forward to working with you to optimize your health and well being.

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1. I understand that Dr. Cardona is a Homeopathic Physician, and will use only natural, non-invasive methods of assessment and treatment.
2. I understand that any advice given to me as a patient at Via Natural Medicine is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.
3. I understand that I am at liberty to seek, or to continue medical care from another qualified health care provider.
4. I understand that Dr. Heather Cardona reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.
5. I understand that I am accepting or rejecting this care by my own free will.
6. I understand that no employee or physician at Via Natural Medicine is suggesting to me to refrain from seeking the advice of another health care provider.
7. I understand that the services offered here are not covered by Manitoba Health, and that fees are payable at the time of appointment, including fees for services, prescriptions, and laboratory tests.
8. I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the payment of a cancellation fee.
9. I understand that any therapies recommended will be explained to me in full by Dr. Heather Cardona, and that I will give consent to treatment based on informed consent.

I, _____ have read, understood and agree to the above statements
First Name Last Name

Signature: _____ Today's Date: ____/____/_____
DD MM YYYY

Informed Consent for Communication

We value our relationship with you and would like to send you information electronically relating to Via Natural Medicine. In order to do this, we are collecting your consent to receive electronic messages from us in the form of **appointment reminders**, newsletters, upcoming events and other clinic information. Please take a moment to select either "OPT IN" or "OPT OUT". Opting in will provide Via Natural Medicine consent to communicate with you electronically. Opting out will indicate that you do not wish to receive any electronic communication from us.

Opt IN: ☐ Opt OUT: ☐

Signature: _____ Today's Date: ____/____/_____
DD MM YYYY