AWEN
health centre

Dr. Keith Condliffe, B.A., N.D.
1819 Beaufort Ave., Unit 102
Comox, BC V9M 1R9
1 (888) 675-8344

Welcome to the Awen Health Centre. We look forward to working with you.

Please either:
1) print and complete this document (6 pages) and bring it with you to your first visit, or
2) electronically fill, digitally sign, and email this document to *clinic@awenhealth.ca*.

Please initial or check (if filling it out digitally) your agreement in each box below:

☐ I have read, understand and accept the Working Together at Awen document, including the 48 hour cancellation policy and the fee schedule. I agree to pay my account in full after every visit, unless other arrangements have been made prior to my visit.

☐ I consent to my clinic health file and medical records being stored in a secure, password-encrypted electronic format, backed up to a secure, password-encrypted server service in Canada.

☐ I consent to being added to the client email list (optional and recommended). Clinic-related announcements may be sent out to this list (average once or twice per year). I can unsubscribe from this list at any time.

☐ I consent to clinic and health-related email correspondence between my email address and a clinic email address (optional and recommended). This may include digital copies of my program suggestions, receipts, and / or answers to health-related questions that I initiate.

☐ I have read and signed the consent form, and completed the questionnaire as fully and honestly as possible.

☐ I accept responsibility for my health. This includes informing Dr. Keith if my program does not suit my needs or expectations.

☐ The day of my first appointment, I will take any prescription medications as usual and bring them with me to my visit. I will also bring with me any supplements and / or homeopathic remedies. If possible, I will refrain from taking non-prescription supplements the day of my visit. (This makes it easier to accurately assess the needs of your body and establish safety between any supplements, homeopathic remedies and prescription drugs you may be taking.)

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Consent to the Treatment of an Adult

I, _____
(please print name)

of the following address _____

acknowledge and declare that I have the option of seeking/continuing allopathic (conventional) medical care from a medical doctor and that the naturopathic medical treatments at this clinic and allopathic medical treatments are different but not mutually exclusive. I confirm that there has been no suggestion made to me by Keith Condliffe, The Awen Health Centre, or anyone under its direction or control, that I refrain from seeking or following conventional medical treatment.

I also understand that the Naturopathic Physician at The Awen Health Centre is trained to read and interpret x-rays, ultrasounds, and other conventional medical tests but is (currently) restricted from ordering several of these tests in the Province of British Columbia. Therefore, it is my responsibility to maintain contact with a Medical Doctor so that all necessary testing may be performed as required to monitor my condition. Furthermore, I realize that the Naturopathic Physician at this clinic may use testing procedures that are not conventional to assess the progress of therapy, and are by no means tools to accurately diagnose a disease.

I understand that the Naturopathic Physician at the Awen Health Centre does not treat the symptoms of disease; rather he will help me assess and correct the imbalances in my body, nutrition and lifestyle so that my body can begin and / or continue to heal itself.

I understand that all information given to the Awen Health Centre is guarded in strict confidence at all times, subject to doctor-patient confidentiality laws. I also acknowledge that for the purposes of teaching other healthcare practitioners, broad information about my case may be reviewed in a classroom context, with absolutely no identifying information disclosed at any time.

On reading and understanding the above, including page one of this document, I hereby give my consent to assessment and treatment by the Naturopathic Physician at The Awen Health Centre.

Signed in _____, British Columbia, Canada, this ____ day of _____ 20 ___.

Signature: _____

Thank you for taking time to fill out this form. It is important in the assessment of your case.

Name: _____ Phone: _____ Cell

Address: _____ Phone: _____ H / W

City & Province: _____ Postal Code: _____

Referred by: _____ Email: _____

Date of Birth: _____ Birthplace: _____ Sex: _____

1. Why did you choose to come to the Awen Health Centre?

_____

2. What do you know about our approach?

_____

3. What expectations do you have in coming to the Awen Health Centre?

_____

4. What expectations do you have of me personally as your Naturopathic Physician?

_____

5. What is your present level of commitment to address any underlying causes of your signs and symptoms? (Rate from 0 to 10, 10 being 100% committed) _____

6. What behaviours or habits do you currently engage in regularly that you believe support your health?

_____

7. What potential obstacles do you foresee in addressing your health goals and in following a treatment plan?

_____

8. Who do you know that will sincerely support you in this process?

_____

9. What do you LOVE to do?

_____

10. What are your main health concerns and/or goals? (list in order of importance, from most to least)

Concern(s) and / or goal(s)	**Date started**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

MD's Name: _____ MD's Phone: _____

MD's Address: _____ City: _____

Date of last physical exam : _____ Weight: _____ Height: _____ Blood Type: ____

Name and type of other care providers: _____

Most recent medical procedures & blood tests *(please check all that apply)*

Procedure	Abnormal?	Date	Procedure	Abnormal?	Date
☐ Colonoscopy	☐	_____	☐ Complete Blood Count	☐	_____
☐ MRI / CT scan	☐	_____	☐ Cholesterol Panel	☐	_____
☐ Blood/plasma transfusion	☐	_____	☐ Liver Enzymes	☐	_____
☐ Pap Smear	☐	_____	☐ Thyroid Panel	☐	_____
☐ Mammogram	☐	_____	☐ Fasting blood glucose	☐	_____
☐ Digital Rectal Exam / PSA	☐	_____	☐ Hormone Panel	☐	_____
☐ EKG / EEG	☐	_____	☐ Other: _____	☐	_____
☐ X-ray(s)		_____	Location of x-ray(s) _____		

Please list current medications and supplements that you are taking.

Medication / Supplement	Dose	How Often	For How Long	Reason

How many courses of antibiotics have you had in the past 10 years? _____

Have you had any bad reactions to medications / supplements? _____

Please list all allergies (food, environmental, medications): _____

_____

Vaccinations

☐ DTP ☐ hepatitis A ☐ chicken pox ☐ flu shot If yes, how often? _____

☐ MMR ☐ hepatitis B ☐ HPV ☐ haemophilus influenza B

Others? _____ Past adverse reactions? ☐ Yes ☐ No

If yes to adverse reactions, please describe _____

Childhood illnesses

☐ eczema ☐ ear infections ☐ chickenpox ☐ mononucleosis ☐ measles ☐ mumps

☐ scarlet fever ☐ whooping cough ☐ diphtheria ☐ meningitis ☐ other: _____

Medical procedures: ☐ internal pins ☐ artificial joints ☐ pacemaker ☐ transplant ☐ implant ☐ wires

If yes, where and when placed? _____

Dental history: silver fillings white fillings root canals caps dentures

Please check those which apply to you.

☐ drink water	glasses/day	_____	What source(s) of water? _____
☐ drink coffee	glasses/day	_____	
☐ drink tea	glasses/day	_____	What kind(s) of tea? _____
☐ drink pop/soda	glasses/day	_____	Which brand(s)? _____
☐ drink wine / alcohol	glasses/week	_____	Which alcohol(s)? _____
☐ smoke tobacco	packs/week	_____	What brand(s)? _____
☐ smoked in past	packs/week	_____	For how many years? _____
☐ recreational drugs	times/week	_____	What kind(s)? _____
☐ drug use in past			For how many years? _____
☐ exposed to allergens / toxins	hours/week	_____	What type(s)? _____
☐ use artificial sweeteners	packets/day	_____	Which sweetener? _____
☐ chew gum	pieces/day	_____	Which brand? _____
☐ eat large fish (tuna / sword)	servings/month	_____	Which fish? _____
☐ cell phone use	minutes/day	_____	Do you use a headset? ____
☐ use antiperspirant			Which brand? _____

Living situation

No. in living space: _____ No. of children: _____ Marital Status: _____

Occupation/ Role: _____ Past occupations: _____

Retired? _____ If yes, when? _____ Religion / personal philosophy: _____

Family History: Please make note under any applicable blood relative(s).

Please check all that apply	Mother	Father	Sibling	Child	Grandparent	Others
☐ Cancer (what type?)						
☐ Hereditary Disease (what type?)						
☐ Skin Disease (what type?)						
☐ Arthritis / Gout						
☐ Kidney Disease						
☐ Lung Disease / Asthma / TB						
☐ Liver Disease / Cirrhosis						
☐ Hypoglycemia / Diabetes						
☐ Thyroid Problems / Obesity						
☐ Heart Disease / Stroke						
☐ Syphilis / Gonorrhea / HIV						
☐ Mental Illness / Epilepsy						
☐ Miscarriages						
☐ Other _____						

Please list in order of appearance from your birth, all hospitalizations, surgeries, diseases, accidents, traumas & scars (emotional & physical).

Age: _____

Age: _____

Age: _____

Age: _____

Age: _____

Age: _____

Age: _____

Age: _____

Age: _____

Age: _____

Is there anything else that you feel I should know about you? _____

_____

_____