Retail Store & Pharmacy:
1111 West Broadway
Vancouver, B.C., V6H 1G1
(604) 733 - 5323

Health Centre:
G104 - 2480 Spruce
Vancouver, B.C. V6H 2P6
(604) 734 - 7760

Homeopathy Acute Consultation Intake Form

Date: ____________

Full Name: ______________________________
Address: ______________________________
City Province: ______________________________
Postal Code: ______________________________
Phone #: ______________________________
Other #: ______________________________
Email: ______________________________
Birthday (M/D/Y): ______________________________
Sex: ______________________________
Height: ______________________________
Weight: ______________________________

Hair colour: ______________________________
Eye colour: ______________________________
Marital Status: ______________________________
Occupation: ______________________________
Family Doctor (FD): ______________________________
FD Phone Number: ______________________________
FD Fax: ______________________________
FD Email: ______________________________
FD Adress: ______________________________
FD City / Province: ______________________________
Postalcode: ______________________________

Please list your acute symptoms in order of greatest severity and discomfort to you:

1.

2.

3.

4.

5.

6.

Please list any medications you are currently taking (prescription pharmaceuticals and over the counter meds):

Please list any herbs or nutritional supplements you are currently taking (including homeopathics):

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Do you use the following (please circle all that apply):

Alcohol:	Y / N	Fast foods:	Y / N	Sweets:	Y / N
Antacids:	Y / N	Fried Foods:	Y / N	Tea:	Y / N
Carbonated drinks:	Y / N	Laxatives:	Y / N	Tobacco:	Y / N
Coffee:	Y / N	Margarine:	Y / N	Wheat products:	Y / N
Dairy products:	Y / N	Non-sugar sweeteners:	Y / N		
Distilled water:	Y / N	Salt:	Y / N		

I, ___________________ , the undersigned understand that Kathryn Final is not a medical doctor, but instead a Registered Homeopath. As such, I acknowledge that it is my right and responsibility, at any time throughout my treatment with Kathryn Final, to seek medical counsel and diagnosis, if so desired, from a medical doctor, for any present and/or future conditions. I also reserve the right to terminate homeopathic treatment at any time if so inclined. I acknowledge that the state of my health is my own responsibility and that I am exercising my right to choose an alternative method of treatment, in homeopathy, that addresses my health in its totality.

As homeopathy is not covered by existing government medical insurance plans, I agree to pay all fees incurred (rates are subject to change).

Some extended health care plans now cover Homeopathy

Please Note:
- All fees are payable at the end of each consultation
- Fees do not include tax or remedies

Patient's Signature: ________________________ Date: ______________________________________
(If under 18 years of age, a parent or guardian must sign on your behalf)

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Informed Consent

Statement of Acknowledgement

As a patient of this Health Centre I have read the information and understand that the form of medical care is based on alternative and other supportative principles and practices. As Finlandia is an integrated health centre, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

______________________________ ______________________________

Signature Date