MEDIWORKS
REJUVENATION CENTRE

Please complete this form and bring it to your initial visit with Dr. Badesha

NEW PATIENT INTAKE FORM

NAME________________________ **AGE**________ **BIRTHDAY**________________ **SEX**__________

If the patient is a child:

Mother's name: ______________**Father' name** ____________________

ADDRESS________________________ **CITY**________________**POSTAL CODE** ____________

PHONE # (HOME)________________(WORK)________________(CELL)________________

EMAIL________________________

OCCUPATION________________________ **REFERRED BY**________________________

CONTACT IN CASE OF EMERGENCY________________________ PHONE#________________

PRESENT HEALTH CONCERNS *list in order of significance*

1. ________________________
2. ________________________
3. ________________________
4. ________________________
5. ________________________
6. ________________________
7. ________________________
8. ________________________

LABORATORY PROCEDURES PERFORMED FOR THIS PROBLEM(S)(BLOOD TESTS ETC.)

____

____

WHAT TYPE OF THERAPY HAVE YOU TRIED FOR THIS PROBLEM(S)?

____

____

LIST CURRENT HEALTH PROBLEMS FOR WHICH YOU ARE BEING TREATED:

____

____

PAST MEDICAL HISTORY

HEALTH AS A CHILD? Good________________ Fair ___________ Poor____________

HOSPITALIZATIONS *(year & reasons)*____

SURGERIES *(year & type)*____

ACCIDENTS OR MAJOR TRAUMA (SCARS-GIVE LOCATION)____

SERIOUS ILLNESS OR INJURY *(year & cause)*____

VACCINATIONS- all childhood? Yes_____________ No________ **Other** (year, type, adverse reactions)______________________________

HOW MANY ANTIBIOTIC TREATMENTS HAVE YOU RECEIVED? **0 – 5 TIMES____ 6 – 13 TIMES______ MORE THAN 13 TIMES________**

HAVE YOU TRAVELLED OUTSIDE OF CANADA IN THE PAST FIVE YEARS? YES_____ NO________

WHERE?____

MEDICATIONS c*ircle any you are taking*

Antacids Anti diabetic/Insulin Antibiotic/Antifungal Anti-Inflammatory Cortisone High blood pressure Laxatives

Antidepressants Relaxants/Sleeping pills Radiation Aspirin/Tylenol Lithium Thyroid Chemotherapy Heart Medications

Oral Contraceptives Hormones Ulcer Medications Other____

ALLERGIES *list any allergies and what happens when you have an allergy attack*

DRUGS____

FOODS____

OTHER____

DIET AND LIFESTYLE FACTORS

Please circle the following

Do you crave: Starches Y N Sweets Y N Salt Y N Fat Y N **Are you a vegetarian** Y N Vegan Y N

Do you have any dietary restrictions? (if yes, please explain) Yes___ No______

____

Do you enjoy your work Y N **Type of exercise you do/get**____

Do you: Sleep well Y N Wake rested Y N **Average hours of sleep per night is** _____________________________________

What is the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest)__________

Do you meditate or use any relaxation exercise? Yes______ No______

Do you use: Alcohol Y N Tobacco or live(d) with a smoker Y N Caffeine Y N Past

Recreational drugs Y N Stimulants or fat burners Y N

Occupational exposure to chemicals Y N Type____

REVIEW OF SYSTEMS

Please circle: Yes - a condition you have now
No - never had
Past - a condition you have had in the past

General
Weight ___________
Height ___________
Night sweats Y N P
Fatigue Y N P

Skin
Rashes or Infections Y N P
Growths Y N P
Changes in hair/nails Y N P

Head
Headache Y N P
Head Injury Y N P

Eyes
Impaired vision Y N P
Eye pain Y N P
Tearing Y N P
Dryness Y N P

Ears
Impaired hearing Y N P
Ringing Y N P
Earache/Itch Y N P
Dizziness Y N P

Nose & Sinuses
Frequent colds Y N P
Nose bleeds Y N P
Stuffiness Y N P
Sinus Problems Y N P
Post nasal drip Y N P

Mouth & throat
Frequent sore throat Y N P
Sore tongue Y N P
Sore mouth and lips Y N P
Gum problems Y N P
Hoarseness Y N P
Dental problems Y N P
Root canals Y N #______

Neck
Swollen glands Y N P
Pain or stiffness Y N P

Blood
Anemia Y N P
Easy bleeding or bruising Y N P

Respiratory
Cough Y N P
Spitting up blood Y N P
Wheezing Y N P
Pain on breathing Y N P
Shortness of breath Y N P
Positive TB test ever Y N P

Heart
Heart disease Y N P
High blood pressure Y N P
Rheumatic fever Y N P
Chest pain Y N P
Swelling in ankles Y N P
Palpitations/fluttering Y N P

Digestion
Trouble swallowing Y N P
Heartburn Y N P
Stomach pain Y N P
Change in thirst Y N P
Change in appetite Y N P
Nausea or vomiting Y N P
Bowels move daily Y N P
Loose stools Y N P
Blood in stools Y N P
Bowel gas Y N P
Bloating Y N P
Belching Y N P
Liver/gall bladder disease Y N P
Hemorrhoids Y N P

Emotional
Depression Y N P
Mood swings Y N P
Anxiety or nervousness Y N P

Neurologic
Fainting Y N P
Seizures Y N P
Paralysis Y N P
Numbness or tingling Y N P
Loss of memory Y N P

Musculoskeletal
Joint pain or stiffness Y N P
Broken bones Y N P
Muscle spasms/cramps Y N P
Weakness Y N P

Urinary
Pain on urination Y N P
Increased frequency Y N P
Frequency at night Y N P
Urgency Y N P
Inability to hold urine Y N P
Bladder infections Y N P
Difficulty urinating Y N P

Circulation
Deep leg pain Y N P
Cold hands/feet Y N P
Varicose veins Y N P

Endocrine
Ever any thyroid problem Y N P
Heat or cold intolerance Y N P
Hypoglycemia Y N P
Excessive thirst Y N P
Easy weight gain Y N P

Male Reproduction *(men only)*
Hernias Y N P
Testicular masses Y N P
Testicular pain Y N P
Are you sexually active Y N P
Sexual difficulties Y N P
Prostate problems Y N P
Venereal disease Y N P
Discharge of sores Y N P
Difficulty with urination Y N P
Birth control Y N P
What type ______________

Female Reproduction *(women only)*
Age menses started ___________
# of days menstrual flow ___________
Length of complete cycle ___________
Bleeding between periods Y N P
Are cycles regular Y N P
Pain during intercourse Y N P
Cramps Y N P
Abnormal vaginal discharge Y N P
Excessive flow Y N P
PMS Y N P
Date of last PAP smear ___________
Abnormal PAP Y N P
Date of last menstrual period___________
# of pregnancies ___________
Number of miscarriages ___________
Birth control Y N P
What type ___________
Difficulty conceiving Y N P
Menopausal symptoms Y N P
Are you sexually active Y N P
Sexual difficulties Y N P
Venereal disease Y N P

Breasts
Do self-exam regularly Y N P
Lumps Y N P

Mark any illnesses which you now have with (Y) or have had in the past (P);

Abscesses __________
Acne __________
AIDS __________
Alcohol addiction __________
Allergies __________
Alopecia __________
Anemia __________
Arthritis __________
Asthma __________
Attempted suicide __________
Back problems __________
Benign breast tumor __________
Bleeding gums __________
Bronchitis __________
Cancer __________
Candida albicans __________
Cataracts __________
Chest pains __________
Chicken pox __________
Cirrhosis __________
Crohn’s disease __________
Depression __________
Diabetes __________
Diphtheria __________
Diverticulosis __________
Drug addiction __________
Ear infections __________
Eating disorder __________
Eczema __________
Emphysema __________
Endometriosis __________

Epilepsy __________
Excessive fatigue __________
Eye disease __________
Fainting or dizzy __________
Gallstones __________
Gastritis __________
Gingivitis __________
Glaucoma __________
Goiter __________
Gonorrhea __________
Gout __________
Hay fever __________
Hearing problems __________
Heart disease/stroke __________
Hemorrhoids __________
Hepatitis __________
Hernia __________
Herniated disc __________
Herpes __________
High blood pressure __________
Hypothyroidism __________
HIV __________
Insomnia __________
Jaundice __________
Kidney disease __________
Kidney stones __________
Liver disease __________
Low blood pressure __________
Lupus __________
Major surgery __________
Malaria __________

Measles __________
Meningitis __________
Mononucleosis __________
Multiple sclerosis __________
Mumps __________
Myopia __________
Nervous breakdown __________
Neurological disease __________
Obesity __________
Osteoporosis __________
Pancreatitis __________
Persistent cough __________
Pneumonia __________
Polio __________
Psoriasis __________
Rheumatic fever __________
Rheumatoid arthritis __________
Scarlet fever __________
Sciatica __________
Senility __________
Shingles __________
Skin ulcers __________
Skipped heartbeats __________
Stroke __________
Stomach ulcer __________
Syphilis __________
Tuberculosis __________
Thyroid disease __________
Ulcerative colitis __________
Vision problems __________

Other____

PLEASE INDICATE ANY SIGNIFICANT HEALTH CONDITIONS OF OTHER FAMILY MEMBERS

____
____
____
____
____
____
____
____

INFORMED CONSENT FOR TREATMENT

I, ____________________________ herby authorize Mediworks Health and Weight Loss Centre to perform the follow specific treatments, but not excluding other treatment protocols, as deemed necessary to facilitate my diagnosis and treatment:

Common diagnosis procedures: e.g. venipuncture, Pap smear, radiology, laboratory, x-ray.
Minor Office procedures: e.g. dressing a wound, ear cleansing.
Medical use of nutrition: therapeutic nutrition, nutritional supplements containing vitamins, minerals, amino acids, hormones and glandulars, and intramuscular and intravenous vitamin, mineral and homeopathic injections.
Homeopathic medicine: the use of highly diluted quantities of naturally occurring plant, animals and minerals to encourage the body's natural healing mechanisms.
Botanical Medicines: the use of standardized plant extracts to encourage the healing process.
Therapeutic Injections: Neural therapy, prolotherapy and trigger point injections.
Lifestyle counseling and hygiene: diet therapy, health promotion including recommendations on exercise, sleep, stress reduction, and the balance of work and social routines.
Naturopathic manipulations: diverse techniques for correction of musculo-skeletal and neurological conditions.

I recognize the potential risks and benefits of these procedures as described below:
Potential risks: allergic reaction or side effects from prescribed herbs, supplements, or natural medication; inconvenience as the result of lifestyle change, injury and infection from injections, venipuncture or procedures.
Potential benefits: restoration of health and the body's maximum function capacity; relief from pain and other disease symptomatology; assistance is recovery from disease or injury; disease prevention; inhibition of disease progression.
Notice to pregnant women: all female patients must alert the doctor if they know or suspect that they are pregnant, as some treatments could present a risk to the pregnancy.

With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Mediworks Health and Weight Loss Centre or any of its personnel regarding a cure or improvement of my current condition(s). I understand that I am free to withdraw my consent and discontinue participation in these procedures at any time.

I understand that a record of health services provided to me will be kept by the Centre. This record will be kept completely confidential and will not be released to others without my personal consent or that of my representative or unless it is required by law. I understand that I may look at my medical records anytime and can request a copy of this record by paying an appropriate fee. I understand that my medical record will be kept for a minimum of three, but not more than ten years after the date of my last visit. I understand that information from my medical record may be analyzed for research purposes and that in such instance my identity will be protected and kept confidential. I understand that any questions I have will be answered to the best of practitioner's ability.

___________________________________ ______________________________

Date Signature of Patient

___________________________________ _________________________________

Date Signature of Representative or Guardian