Green Apple HEALTH CARE Ltd.

Welcome

Green Apple Health Care Ltd. treats the core cause of health problems, rather than the symptoms, by using a natural, customized, integrated and preventative approach. We offer treatment options for all health conditions from colds and flus to advanced cancers.

1. What to Expect

First Appointment

- Your doctor will take a detailed medical history and evaluate your health
- Your doctor may recommend testing and will provide treatment options
- The appointment may take up to 1 hour to complete
- Treatment often starts at this time, but we may have to wait for lab results

Book your next appointment at the end of each appointment, as appointments are first-come first-serve.

Follow-up Appointments

Follow up appointments occur four to six weeks after your first appointment to evaluate your progress and move to the next stage of your treatment program. Treatment schedules vary from once a month, once every three months or once every six months.

Consultations

Consultation options:

- In-office appointment (first appointment must be in person)
- Phone consultation (for emergencies or special circumstances)

Questions

If you have any questions about your treatment, call our office and leave a message. Our staff will do their best to get a response from a doctor that day. Your patience is appreciated.

We may recommend that you schedule a consultation so we can properly evaluate your condition.

2. Clinic Policies

These guidelines will help you understand how our clinic works and ensure you are satisfied with your experience.

Fees

- Please refer to our website for the current doctor fees
- Supplements, lab test charges and treatments are charged separately
- Payment is due after each appointment and is subject to GST
- We accept all major credit cards, cash, debit cards and cheques
- Interest and service fees will be charged to all outstanding bills

Note that rates are subject to change without notice.

Cancellation Policy

We require 24 hours notice to cancel an appointment.
We reserve the right to not book appointments if a patient does not keep their appointments or pay outstanding fees.

Cancellations with less than 24 hours notice will be charged the **full appointment cost.**

Late Arrivals

If you are late, you will be charged from when your appointment was supposed to start. If you are ***too*** late, the doctor may not have enough time to see you and you will need to rebook. If this occurs, you will be charged for the missed appointment.

Missed Appointments

Your credit card information is kept securely on file.
If you miss an appointment, your credit card will be charged.

Scent - Free

Due to the impact scented personal care products have on the health of others, please refrain from using scented products when you are in the office.

3. Patient Acknowledgment and Declaration

Preferred method of appointment reminder (please check one):

❑ phone ❑ email ❑ SMS text

Your credit card information is collected when you book your first appointment and is kept securely on file. We do enforce our clinic policies and your credit card will be charged accordingly.

I have read, understand and agree to the policies on this document.

Signature: _____ Date: _____

(Parent or Legal Guardian must sign for patients under 18)

Suite 221, 9148 - 23 Ave, Edmonton, AB T6N 1H9 **Phone:** 780.485.9468 **Fax:** 780.485.3587 **Web:** greenapplehealthcare.ca

Green Apple HEALTH CARE Ltd.

First Name: _____

Last Name: _____

Middle Initial:_____ Birth Date: (m)_____ (d)_____ (y)_____

Age:_____ Gender: ❑ male ❑ female

Marital Status: _____

Occupation:_____

Current Employment Status: _____

Emergency contact name: _____

Phone: _____

Primary care physician name: _____

_____

Phone: _____

Any other doctors/therapists patient is currently seeing:

_____

_____

_____

Handedness: ❑ right ❑ left ❑ ambidextrous

If patient is under 18: Name of legal custodian, parent or

_____

Home Address: _____

Apt. _____ City:_____

Province: _____ Postal Code: _____

Phone: (home) _____

(work) _____

(cell)_____

Email:_____

Would you like to receive our newsletters and announcements?

❑ yes ❑ no

If you are staying in Edmonton from out of town,
please provide Edmonton address and phone number:

_____

_____

Chief complaint(s) in order of importance:

1 _____

2. _____

3. _____

4. _____

5. _____

6. _____

List all vitamins, minerals, herbs and/or medications that you are currently taking. Also indicate the dose and time you take them:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10 _____

Allergies (food, drug, other):

1 _____

2. _____

3. _____

4. _____

Please indicate which doctor you would like an appointment with (refer to our website to learn more about our doctors).

❑ Dr. Michael Nowazek, BSc, ND

❑ Dr. Briana Botsford, BSc, BPHE, ND

❑ Dr. Kirk Westby, DTCM

❑ Dr. Briana Lutz, BSc, ND

How did you hear about Green Apple Health Care?
(please be specific):

_____

_____

Green Apple HEALTH CARE Ltd.

Health Questionnaire

POINT SCALE

0 Never or almost never have the symptom
1 Occasionally have it, effect is not severe
2 Occasionally have it, effect is severe
3 Frequently have it, effect is not severe
4 Frequently have it, effect is severe

EXAMPLE

3 Headaches
0 Faintness
1 Dizziness
4 Insomnia
8 Total

Please **rate** the following symptoms you may have according to the **Point Scale**

HEAD
- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia
- ☐ Total

EYES
- ☐ Watery or itchy eyes
- ☐ Swollen, reddened or sticky eyelids
- ☐ Bags or dark circles under eyes
- ☐ Blurred or tunnel vision (does not include near-or far-sightedness)
- ☐ Total

EARS
- ☐ Itchy ears
- ☐ Earaches, ear infections
- ☐ Drainage from ear
- ☐ Ringing in ears, hearing loss
- ☐ Total

NOSE
- ☐ Stuffy nose
- ☐ Sinus problems
- ☐ Hay fever
- ☐ Sneezing attacks
- ☐ Excessive mucus formation
- ☐ Total

MOUTH/THROAT
- ☐ Chronic coughing
- ☐ Gagging, frequent need to clear throat
- ☐ Sore throat, hoarseness, loss of voice
- ☐ Swollen or discolored tongue, gums or lips
- ☐ Canker sores
- ☐ Total

SKIN
- ☐ Acne
- ☐ Hives, rashes, dry skin
- ☐ Hair loss
- ☐ Flushing, hot flashes
- ☐ Excessive sweating
- ☐ Total

HEART
- ☐ Irregular or skipped heartbeat
- ☐ Rapid or pounding heartbeat
- ☐ Chest pain
- ☐ Total

LUNGS
- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Total

DIGESTIVE TRACT
- ☐ Nausea, vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloated feeling
- ☐ Belching, passing gas
- ☐ Heartburn
- ☐ Intestinal/stomach pain
- ☐ Total

JOINTS/MUSCLES
- ☐ Pain or aches in joints
- ☐ Arthritis
- ☐ Stiffness or limitation of movement
- ☐ Pain or aches in muscles
- ☐ Feeling of weakness or tiredness
- ☐ Total

WEIGHT
- ☐ Binge eating/drinking
- ☐ Craving certain foods
- ☐ Excessive weight
- ☐ Compulsive eating
- ☐ Water retention
- ☐ Underweight
- ☐ Total

ENERGY/ACTIVITY
- ☐ Fatigue, sluggishness
- ☐ Apathy, lethargy
- ☐ Hyperactivity
- ☐ Restlessness
- ☐ Total

MIND
- ☐ Poor memory
- ☐ Confusion, poor comprehension
- ☐ Poor concentration
- ☐ Poor physical coordination
- ☐ Difficulty in making decisions
- ☐ Stuttering or stammering
- ☐ Slurred speech
- ☐ Learning disabilities
- ☐ Total

EMOTIONS
- ☐ Mood swings
- ☐ Anxiety, fear, nervousness
- ☐ Anger, irritability, aggressiveness
- ☐ Depression
- ☐ Total

OTHER
- ☐ Frequent illness
- ☐ Frequent or urgent urination
- ☐ Genital itch or discharge
- ☐ Total

☐ GRAND TOTAL

Informed Consent

This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's ability to heal and to improve a patient's quality of life and health through natural means.

Your practitioner will conduct a thorough case history. If you are working with a naturopathic doctor, a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment. All of your personal and medical information will be kept strictly confidential.

Statement of Acknowledgment

I have read the information and understand that the medical care I will receive is based on Naturopathic and other supportive principles and practices.

I recognize that all the practitioners working with me will have access to my file, as Green Apple Health Care is an integrated health clinic.

I recognize that even the gentlest therapies can have complications in certain physiological conditions and therefore the information I provided is complete and identifies all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements.

I understand 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.

Signature: _____ Date: _____

(Parent or Legal Guardian must sign for patients under 18)

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