



**Dr. Alexis Blanks, ND**  
**Naturopathic Doctor**

Welcome to naturopathic medicine at the Cook St. Village Health Centre! I am honoured that you have chosen me to help guide you towards optimal health.

It is my belief that health and wellbeing are multidimensional and must be treated accordingly. Many different factors have contributed to the way you are in the world today; your inherited genetic individuality, how you nourish and care for your physical body, the belief system that you filter your thoughts through as well as the emotions that are experienced with them, and finally, your sense of purpose and connectedness to life. My goal is to keep all of these factors in mind while using my experience and knowledge to help you understand and take control of your health.

Before your first visit please complete the New Patient Intake Form. This form will provide me with important information that will help me create the best possible treatment plan for you. If possible, please mail or fax it to me before your visit so that I may review your information before we meet. If you have any medical records or copies of recent pertinent lab work please bring these with you to our first appointment.

Your first visit with me will be one to one and a half hours. At this time I will ask you a series of questions regarding your health and lifestyle. This first visit will also include a brief physical examination using standard diagnostic instruments. Your second visit will be from 45 minutes to an hour and will include a treatment plan tailored to your individual needs. Subsequent visits will be 30-45 minutes in length depending on your needs and the complexity of your case.

I look forward to meeting you!

Cook St. Village Health Centre  
#200 – 1075 Pendergast Street  
300 block Cook St. (above Starbucks)  
Victoria BC V8V 0A1  
Phone: (250) 477-5433

Fax: (250) 477-5431

## ***Naturopathic Office Fees***

Introductory meeting (15 minutes): free

Initial consultation (1 to 1.5 hours): \$120

Second Consultation (45 minutes-1 hour, depending on the complexity of your case): \$90

Follow up visit 45 minutes: \$90

Follow up visits 30 minutes: \$60

Brief visit 15 minutes: \$30

First three visits package: \$240

Acupuncture: As above or 6 visits for \$300. For maximum benefit acupuncture treatments are given in groups of 6; appointments are booked either weekly or twice weekly. The package must be used within a 6 month period.

### **Children:**

Initial consultation (45 minutes): \$90

Follow up visits (15-45 minutes): \$30-\$90

### **Phone calls:**

It is important that you feel you can call the office (477-5433) if you have any questions, concerns or need clarification regarding your treatment plan. There will be no charge for calls of this nature. Extended calls will have a charge of \$25 and upwards, depending on time spent. Calls over 20 minutes will be billed as a regular visit.

Fees do not include G.S.T. All fees must be paid at the time of the visit including services, remedies and supplements, and cost of laboratory tests.



## Confidential New Patient Intake Form

### PERSONAL INFORMATION

Date of First Visit (M/D/Y) \_\_\_/\_\_\_/\_\_\_ Name \_\_\_\_\_

Age \_\_\_\_\_ Date of birth (M/D/Y) \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Province/State \_\_\_\_\_ Postal Code \_\_\_\_\_ Phone (home) \_\_\_\_\_

Phone (work) \_\_\_\_\_ Best time to call \_\_\_\_\_

Email address \_\_\_\_\_

Would you like to receive emails with information regarding clinic activities, news letters, etc? Yes No (circle one)

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about the clinic?

\_\_\_\_\_

Name of current general practitioner (MD) and contact information:

\_\_\_\_\_

Please list below all other health professionals you are currently seeing (complimentary and conventional) and their contact numbers. Include their area of practice (eg. Chiropractor, other specialists).

\_\_\_\_\_

\_\_\_\_\_

### HEALTH OVERVIEW

What are your goals for coming here? \_\_\_\_\_

\_\_\_\_\_

What are your most important health concerns? List as many as you'd like in order of importance.

1. \_\_\_\_\_ Since when? \_\_\_\_\_

2. \_\_\_\_\_ Since when? \_\_\_\_\_
3. \_\_\_\_\_ Since when? \_\_\_\_\_
4. \_\_\_\_\_ Since when? \_\_\_\_\_
5. \_\_\_\_\_ Since when? \_\_\_\_\_

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

---

---

---

Please list any major illnesses, hospitalizations, surgeries, X-rays, CAT scans, EEG, EKG's that you have had (include the year).

---

---

---

Please circle the best answer. Your general state of health is:

Excellent      Good      Average      Fair      Poor

Current weight \_\_\_\_\_ Height \_\_\_\_\_ Weight one year ago \_\_\_\_\_

Maximum adult weight \_\_\_\_\_ Minimum adult weight \_\_\_\_\_

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (If so place a star next to the event).

- 1) \_\_\_\_\_ Date \_\_\_\_\_
- 2) \_\_\_\_\_ Date \_\_\_\_\_
- 3) \_\_\_\_\_ Date \_\_\_\_\_
- 4) \_\_\_\_\_ Date \_\_\_\_\_
- 5) \_\_\_\_\_ Date \_\_\_\_\_

## **FAMILY HISTORY:**

Please circle if blood relations have or have had any of the following:

Alcoholism/Drug Addiction	Allergies	Arthritis/Gout	Cancer
Crohn's/Colitis/Celiac disease	Depression	Diabetes	Eczema
Epilepsy	Headaches	Heart Disease	Hepatitis
High Blood Pressure	Kidney Disease	Mental Illness	Stroke

Other \_\_\_\_\_

What is your ethnic heritage? \_\_\_\_\_

## **REVIEW OF SYSTEMS:**

Please mark symptoms you currently have with a **C**, or have had in the past with a **P**.

### 1. GENERAL

Fatigue/Weakness  
Fever/Chills

### 2. SKIN

Rashes  
Eczema, hives  
Acne, boils  
Itching  
Colour change  
Lumps  
Night sweats  
Dryness/Moistness  
Temperature  
Nail changes  
Change in Mole  
Skin Cancer

### 3. HEAD

Headache  
Head injury  
Dizziness

### 4. EYES

Impaired vision  
Glasses/Contacts  
Eye pain  
Tearing or dryness

Double vision

Glaucoma

Cataracts

Blurring

Bothered by sun

Itching

Redness

Discharge

Blind spot

### 5. EARS

Impaired hearing

Earache

Dizziness

Discharge

Infections

### 6. NOSE and SINUSES

Frequent colds

Nose bleeds

Stuffiness

Hay fever

Sinus problems

### 7. MOUTH and THROAT

Frequent sore throat

Sore tongue/mouth

Gum problems

Hoarseness

Dental cavities

Loss of taste

### 8. NECK

Lumps

Swollen glands

Goiter

Pain or stiffness

### 9. RESPIRATORY

Cough

Sputum

Spitting up blood

Wheezing

Asthma

Bronchitis

Pneumonia

Pleurisy

Emphysema

Difficulty breathing

Pain on breathing

Shortness of breath

Shortness of breath at night

Shortness of breath  
lying down  
Tuberculosis  
Tuberculin Test

10. **CARDIOVASCULAR**  
Heart disease  
Angina  
High blood pressure  
Murmurs  
Rheumatic fever  
Chest pain  
Swelling in ankles  
Palpitations, fluttering  
Cyanosis  
Past ECG  
Other heart tests

11. **BREASTS**  
Do you do self exams?  
Lumps  
Pain (or tenderness)  
Nipple discharge

12. **GASTROINTESTINAL**  
Trouble swallowing  
Heartburn  
Change in thirst  
Change in appetite  
Nausea  
Vomiting  
Vomiting blood  
Blood in stool  
Belching or passing gas  
Jaundice (yellow skin)  
Liver disease  
Gall Bladder disease  
Ulcer  
Indigestion  
Diarrhea  
Rectal bleeding  
Hemorrhoids  
Black, tarry stool  
Abdominal pain

Food allergy  
Hernias

13. **URINARY**  
Pain on urination  
Increased frequency  
Frequency at night  
Inability to hold urine  
Frequent infections  
Kidney stones  
Blood in urine  
Urgency  
Hesitancy

14. **MALE  
REPRODUCTIVE**  
Hernias  
Testicular masses  
Testicular pain  
Are you sexually  
active?(Y/N)  
Sexual difficulties  
Venereal disease  
Discharge or sores

15. **FEMALE  
REPRODUCTIVE**  
Bleeding between  
periods  
Regular cycles  
Pain during intercourse  
Painful menses  
Excessive flow  
PMS  
Birth control?  
Pregnancy  
Miscarriage  
Abortion  
Difficulty conceiving  
Sexually active?  
Sexual difficulties  
Venereal Disease  
Vaginal discharge  
Vaginal itching

16. **MUSCULOSKELETAL**  
Joint pain or stiffness  
Arthritis  
Broken bones  
Muscle spasms or  
cramps  
Weakness  
Joint swelling  
Backache

17. **PERIPHERAL  
VASCULAR**  
Deep leg pain  
Cold hands/feet  
Varicose veins  
Thrombophlebitis  
Leg cramps  
Extremity numbness  
Extremity coldness  
Extremity swelling  
Extremity ulcers

18. **NEUROLOGIC**  
Fainting  
Seizures/Convulsions  
Paralysis  
Muscle weakness  
Numbness or tingling  
Loss of memory  
Involuntary movement  
Loss of balance  
Speech problems

19. **ENDOCRINE**  
Heat or cold intolerance  
Thyroid trouble  
Excessive thirst  
Excessive hunger  
Excessive urination  
Excessive sweating  
Diabetes  
Hypoglycemia  
Hormone therapy

20.  
BLOOD/LYMPHATIC  
Anemia  
Easy bleeding or  
bruising  
Past transfusions  
Lymph node swelling

21. ALLERGIC  
HISTORY  
Drug sensitivity  
Reaction to vaccine  
Allergies

21. EMOTIONAL  
Depression

Mood swings  
Anxiety or nervousness  
Tension  
Phobias  
Alcohol/Drug abuse  
Insomnia

**ALLERGIES / SENSITIVITIES**

Are you hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental or chemical sensitivities? \_\_\_\_\_

**SOCIAL HISTORY/LIFE STYLE**

Describe your current living arrangements. \_\_\_\_\_

Describe the emotional environment at home. \_\_\_\_\_

Are you (Circle): Married    Separated    Divorced    Widowed    Single

In a supportive relationship    other \_\_\_\_\_

Sexual Orientation: \_\_\_\_\_

Do you have any children? Yes    No    Please list their age(s) \_\_\_\_\_

What do you enjoy most in your life? \_\_\_\_\_

What are your main interests and hobbies? \_\_\_\_\_

What do you worry about most in your life? \_\_\_\_\_

What are your strategies for dealing with stress? \_\_\_\_\_

How often do you exercise per week? \_\_\_\_\_ What kind and for how long? \_\_\_\_\_

Do you have a religious or spiritual practice and what is it? \_\_\_\_\_

Do you have dietary restrictions, religious or ethical? \_\_\_\_\_

Please check which substances you use and describe how much.

Substance	√	How much do you consume and how often?
Caffeine		
Tobacco		
Alcohol		
Recreational drugs		
Other		

Do you enjoy your work? (Y/N)      Do you take vacations? (Y/N)

How often do you get colds and flus? \_\_\_\_\_

### **WORK AND HOME ENVIRONEMENT**

Is your home damp or moldy? (Y/N)

Does your work expose you to toxic chemicals and fumes? (Y/N)

Do any of your hobbies expose you to toxic chemicals? Y/N)

Are you exposed to second hand smoke? (Y/N)

Thank you for your time in providing this information.

Please feel free to comment on any other concerns on the bottom of this page.

**Ask not what disease the person has, but rather  
what person the disease has.**

**- Sir William Osler**

**Cook St. Village Health Centre  
#200 – 1075 Pendergast Street  
300 block Cook St. (above Starbucks)  
Victoria BC, V8V 0A1  
Phone: (250) 477-5433  
Fax: (250) 477-5431**

## Consent for Treatment

Your naturopathic doctor will take a thorough case history, perform a physical examination, including a breast exam and may take blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important that you inform your naturopathic doctor immediately of any disease process that you are suffering from and any supplements/medications/over the counter drugs that you are currently taking. Please advise immediately if you suspect you are pregnant, or if breast-feeding.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your naturopathic doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture.
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, disc injuries from spinal manipulation.
- The very small potential for stroke is a concern in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.
- Your naturopathic doctor is trained to handle emergencies should the need arise.

### **Cancellation policy:**

- In the event that you must reschedule your appointment or that you will be late, we ask that you give 24 hours notice of this change. A charge of \$25 dollars will be applied if appropriate notice is not received. Also, the full treatment payment will be charged for those who do not show for their appointed date/time and do not give prior notice of cancellation.
- Please initial here if you have read and understand our cancellation policy: \_\_\_\_\_

### **Important points to note:**

- The clinic does not guarantee treatment results.
- A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others without your consent, unless required by law.
- Your naturopathic doctor will explain to you the exact nature of any treatment provided and will answer any questions you may have to the best of her ability.
- You are free to withdraw your consent and to discontinue treatment at any time.

---

I certify that I have read and understood the above **Consent for Treatment**.

Patient Name: (Please print name): \_\_\_\_\_

Signature of patient or guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of naturopathic doctor: \_\_\_\_\_

**For Patients of Dr. Steven Gordon, MD and Dr. Talita Strumpfer, MD only:**

Date: \_\_\_\_\_

Print name here: \_\_\_\_\_

For the best, safest and most efficient treatment possible it would be beneficial for Dr. Gordon/Strumpfer and Dr. Blanks to have your permission to discuss your case when needed.

Do you give your permission for Dr.'s Gordon/Strumpfer and Blanks to discuss your case where necessary?

Yes No (circle one) Signature: \_\_\_\_\_

Do you give your permission for Dr. Blanks to have your laboratory reports ordered by Dr. Gordon/Strumpfer, printed from Dr. Gordon's/Strumpfer's file and placed in your file with Dr. Blanks?

Yes No (circle one) Signature: \_\_\_\_\_

Please note that your consent may be withdrawn at any time.