



Opti-Balance Naturopathic Medicine

Dr. Tara Macart - Naturopathic Physician

4-161 Fern Road West
Qualicum Beach, BC. V9K 1T2
Phone 250.752.2711 Fax 250-594-2711

www.opti-balance.com

office@opti-balance.com

Opti-Balance Naturopathic Medicine Intake Form

Personal Information:

Name: _____			
	(First,	Middle,	Last)
Birth Date: _____	Age: _____	Blood Type: _____	Gender: M / F
Social Insurance Number: _____		Height: _____	Weight: _____
Address: _____			
City: _____		Postal Code: _____	
Phone: (Home) _____	(Work) _____	(Other) _____	
Fax: _____	Email: _____		
Occupation: _____			
Employer: _____			
Employer Phone: _____			
Emergency Contact: _____			
Phone: _____	Relationship: _____		

Medical Coverage:

BC Care Card Number: _____	Phone: _____
Insurance Company: _____	
Policy or Group Number: _____	

Medical Doctor:

Name: _____	Phone: _____
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How did you find out about Dr. Macart ND?

Brochure	Yellow Pages	Family Doctor	BCNA
Television	Friend	Chiropractor	Directory
Radio	Relative	Specialist	Newspaper
Internet	Coworker	Health Professional	Health Food Store
Other: _____			

List your main health concerns in order of importance / severity?

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.



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Medical History:

Describe your general state of health:	Excellent	Good	Fair	Poor
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Indicate any serious conditions, illnesses, injuries, surgeries, or hospitalizations including approximate dates:

Please list all **current** medications:

(Include all prescriptions, over the counter products, vitamins, herbs, homeopathics, etc.)

Please list **past** medications:

(Include all prescriptions, over the counter products, vitamins, herbs, homeopathics, etc.)

How often do you use any of the following?

	Aspirin
	Alcohol
	Caffeine
	Diet pills
	Hormone therapy
	Laxatives
	Pain killers
	Recreational drugs
	Tobacco

How many times have you been treated with antibiotics? _____

What immunizations have you had and any adverse reactions?

	DPT (diphtheria/pertussis/tetanus)	HiB / Meningococcal
	Tetanus (booster)	Gardasil
	MMR (measles / mumps / rubella)	Other



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	Hemophilus influenza B	
	"Flu"	
	Polio	
	Hepatitis A	
	Hepatitis B	
	Smallpox	
	Shingles	

Do you have any allergies, sensitivities, or intolerances? Please explain.

	Medications	
	Animals	
	Feathers	
	Molds	
	Perfumes	
	Latex	
	Nuts	
	Milk products	
	Eggs	
	Wheat	
	Any Other	

Please rate your stress level: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

Family History:

Please indicate which of your close relatives has had any of the following:

	Alcoholism / Drug Abuse	
	Allergies	
	Asthma	
	Cancer	
	Depression	
	Other mental illness	
	Diabetes	
	Heart problems	
	Kidney problems	

Dietary Intake:

Do you have any dietary restrictions? (allergic, religious, vegetarian, vegan, etc.)

Have you ever been on a special diet? If so, please explain. _____



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Review of Systems: Please check boxes for any of the following that you have or have had previously.

O = occasional, F = frequent, C = constant

O	F	C	General	O	F	C	Gastro-Intestinal	O	F	C	Cardio-Vascular
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching or gas	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hardening of arteries
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colon trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain over heart
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult digestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rapid heart beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal distension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow heart beat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal worms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficult breathing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up phlegm
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting of blood				
			Muscle and Joint								Skin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis				Eyes, ears, nose, throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Boils
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or allergy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lower back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumbago	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dental decay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin eruptions (rash)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or numbness in:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear noises				Genito-Urinary
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Elbows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor kidney control
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Far sightedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gum trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful tail bone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal obstruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pus in urine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Near sightedness				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Women
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Congested breasts
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps / backache
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excess menstrual flow
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breasts
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menopause
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menstruation
								<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge

Please check the following conditions you have had:

<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	Typhoid fever
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Venereal disease
<input type="checkbox"/>	Arteriosclerosis	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Measles	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	Whooping cough
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	Scarlet fever		
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Fever blisters	<input type="checkbox"/>	Mono	<input type="checkbox"/>	Shingles		
<input type="checkbox"/>	Chorea	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	Stroke		
<input type="checkbox"/>	Cold sores	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Tuberculosis		



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Informed Consent to Naturopathic Procedures

Communication with Dr. Macart may occur as office visits, telephone consultations, tele/video conferencing, or email communication.

Initial Consultation – 55 minutes / \$200.00.

Neurologically Focused Initial Consultation - \$225.00

Initial Consultation – Child under 12 \$125.00

Return Office Visits - Time based 41-55 minutes / \$200

26-40 minutes / \$150

11-25 minutes / \$100

1-10 minutes / \$50

Phone Consultation – Time based as above.

There will be additional charges for services, products and testing as required.

GST will be applied where applicable by law.

Fees may be subject to change without notice.

All services, products and testing fees require payment at time of service.

Because everyone's time is precious, we require 24 hours notice of cancellation. For situations where this does not happen, the full visit will be charged.

I clearly understand that Dr. Macart is a naturopathic physician. I also understand that her practice and philosophy of medicine may not be in complete accordance with my other health care practitioners and I acknowledge and accept this. I consent to Dr. Macart being my naturopathic physician and that the usual Doctor/Patient privileges and confidentiality apply between Dr. Macart and/or her office or clinical assistants and myself.

Please print name: _____

Signature of patient: _____
(or lawful representative)

Date: _____