

**WHOLESOME WELLNESS  
FACIAL REJUVEATION ACUPUNCTURE INTAKE**

Dr. Julia Gill, Bsc. (Hon), ND  
Naturopathic Doctor

**PATIENT INFORMATION**

Name: \_\_\_\_\_ Today's Date: \_\_\_/\_\_\_/\_\_\_ (M/D/Y)  
 Age: \_\_\_\_\_ Gender:  Male  Female Date of Birth: \_\_\_/\_\_\_/\_\_\_ (M/D/Y)  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Other/Fax: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Email: \_\_\_\_\_  
 How did you hear about our clinic? \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Do you have extended health care insurance for Naturopathic Medicine? Y / N  
 Are you:  Married  Separated  Divorced  Widowed  Single  Partnership  
 Live with:  Spouse  Partner  Alone  Friends  Children  Parents

**PLEASE COMPLETE THE FOLLOWING QUESTIONS**

What are your main Facial Complaints:  
 \_\_\_\_\_

Do you have or have had any of the following:

<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Recent Botox or Juvederm/Restylane fillers, when?
<input type="checkbox"/> Clotting Disorders	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Former Cosmetic Surgery	<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Warts	<input type="checkbox"/> Herpes	
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Allergic Skin Reactions, to what?	
<input type="checkbox"/> Migraines	_____	

Do you currently have any of the following on your face:

<input type="checkbox"/> Wrinkles and fine lines	<input type="checkbox"/> Droopy eyelids	<input type="checkbox"/> Oily skin	<input type="checkbox"/> Scars
<input type="checkbox"/> Crow's feet	<input type="checkbox"/> Large pores	<input type="checkbox"/> Pigmented skin	<input type="checkbox"/> Double chin
	<input type="checkbox"/> Dry skin	<input type="checkbox"/> Discoloration	<input type="checkbox"/> Acne

Please list all medications and supplements that you are currently taking:

	Medication/Supplement	Dosage	Reason for use
1.			
2.			
3.			

Please list all allergies: \_\_\_\_\_

**WHOLESOME WELLNESS  
CONSENT TO TREATMENT**

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**PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1<sup>ST</sup> APPOINTMENT**

Naturopathic medicine is the treatment and prevention of diseases by natural means. Your ND will take a thorough case history, perform a physical examination that may include a breast exam and take blood and urine samples. Therefore, it is very important that you inform your ND immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your ND immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

(Initials)\_\_\_\_\_ I understand that although all therapies are natural and non-invasive, there may be potential health risks and complications including but not limited to: aggravation of current symptoms; Allergic reactions to the supplements or herbs; Bruising from Biopuncture, Vitamin Injections or Acupuncture; Fainting from needling or at a sight of blood; Accidental burning of the skin from the use of Moxa; and Muscle strains and sprains, disc injuries from spinal manipulation.

(Initials)\_\_\_\_\_ I understand that charges are to be paid in full at the time of the visit. Payment for all dispensary items is due at the time of the visit.

(Initials)\_\_\_\_\_ I understand that a \$50 fee will be charged for any missed appointments or late cancellation (less than 24 hours).

As the patient, I am responsible for the total charges incurred for each visit including costs of supplements. If I have coverage for naturopathic medicine, it is my responsibility to bill my insurance company. I understand that most insurance companies do not cover the cost of supplements. I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (Please Print): \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

“The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease”

-Thomas Edison -