Axiom Health

104-3040 TUTT STREET, Kelowna, BC V1Y 2H5

Welcome to the office of Dr. Alana Berg, ND and Dr. Audrey Wolter, ND, of Axiom Health Clinic! We are honoured that you have chosen us in your search for optimal health. Please fill out and sign the attached forms to the best of your ability, and bring them to the initial appointment. It will aid in your assessment of your present health, and facilitate in your process of healing.

If you wish to cancel or reschedule your appointment; please do so **48 hours** or more before your appointment. We do reserve the right to **charge full cost** of the visit for missed appointments, or if less than 24 hrs is given for cancellations. We will confirm your appointment 2 days prior to your visit by email reminder, please ensure you email is correct. If you are undergoing any treatments, please do not come on an empty stomach, as this may raise some of the risks associated with therapies. If you have any questions, please call our office or speak to the reception staff. We look forward to growing with you!

Note: many of our patient are sensitive to environmental substances; therefore, we ask that all patients refrain from wearing scented hairsprays, colognes, perfumes aftershaves, etc., on the day of your appointment.

Payment Requirements: Appointments must be paid for at the time of service. We accept VISA, MC, Debit, and cash.

Records: We keep a record of your health care services. We will not disclose your records to others unless you direct us to do so, or unless the law authorizes us to. You can obtain copies of the files for a small fee upon signing an authorization form. Please allow up to 10 working days to process the request.

Insurance: Axiom Health does not directly bill insurance companies. You may submit your paid invoice to your insurance company for reimbursement. We are also not a Government Funded healthcare provider, and no reimbursement will be honoured by this organization.

I understand that I am asking Dr. Berg and/or Dr. Wolter of Axiom Health Clinic for health assistance, and she will help to the best of her ability.

I have read and understand the above statements.

_____ _____ _____

Print Name Signature (signed by guardian if under-age) Date

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Adult Intake Form

Date:_____ How did you hear about us?_____

Name:_____ Birth date:(M)___/(D)___/(Y)____
Last First Middle Initial

Personal Health Care Number: _____ Gender: _____

Address:_____

City:_____ Province:_____ Postal Code:_____

Phone: Work:_____ Home:_____ Email: _____

Relationship Status: _____ Occupation:_____

Children: Y N Ages and Sex:_____

Emergency Contact: _____ Number: _____

Height: _____ Weight: _____

Max weight: _____ When: _____

Please list any Practitioners that you are currently seeing (conventional and/or alternative)

Name:	Number:	How long:

Please list your chief concerns in order of importance:	**Onset:**	**Frequency:**	**Severity:**
Example: Headaches	*June '91*	*3 X week*	*Mild/mod/severe*
1.			
2.			
3.			
4.			
5.			

What are your goals for this visit?

_____
_____
_____

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Have you been given a diagnosis from other practitioners for any of these problems – if so what?

_____

Please fill in this form with any prescription medication, vitamin, mineral, amino acid, or other supplements that you may be taking:

MEDICATION/ SUPPLEMENTATION	BRAND	FORM	DOSAGE	FREQUENCY
Example: Beta Blocker	*Metoprolol*	*Pill*	*200mg*	*1x day*

Comments:

_____

Please fill in this form with any non-prescription medication that you may be taking:

MEDICATION/ SUPPLEMENTATION	BRAND	FORM	DOSAGE	FREQUENCY
Example: Vitamin C	*Natural Factors*	*Tablet*	*500mg*	*3 X day*

Comments:

_____

PAST MEDICAL HISTORY:

Hospitalizations:_____
_____

Surgeries (year and type):_____
_____

Serious Illnesses/ Accidents/ Injuries (year, cause, and injury): _____
_____

Have you ever used general anaesthetic? Y N When? _____

Antibiotic use? Y N When? _____

Allergies (type and onset)?_____
_____

Pets (what kind and how many)? _____

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Female Health:

Last Pap: _____ First day of last menstrual period: _____
Days to cycle*(start to start):*_____Days of Bleeding:_____Age of first menses_____
Menstrual difficulties: Cramping Heaviness Spotting Irregularity No period
No. of pregnancies: _____ deliveries: _____ Complications: _____

Dental:

Please note to the best of your knowledge all dental work/treatments you have undergone including fillings (type), pulled teeth, root canals, dentures, braces, retainers, accidents, other: _____
_____

Childhood Illnesses:

Health as a child: (1) Poor to (10) Excellent_____ Explanation: _____

___ Rheumatic fever	___ German Measles	___ Polio
___Allergies	___ Chicken pox	___ Mumps
___ Asthma	___ Ear infections	___ Skin conditions

Vaccinations: (please check all that apply)

( ) DPTP (Diphtheria, Pertussis, Tetanus, Polio)	( ) Meningococcal
( ) Tetanus Booster	( ) Pneumococcal
( ) Chicken pox	( ) H. Influenza B
( ) MMR (Measles, Mumps, Rubella)	( ) HPV
( ) HBV (Hepatitis B Vaccine)	( ) Shingles
( ) Covid 19	( ) Flu shots

( ) Other (travel, etc) _____

Family History:

Has anyone in your immediate family had any of the following:

___Cancer	___High blood pressure	___Diabetes
___Heart Disease	___Allergies	___Arthritis
___Epilepsy	___Glaucoma	___Mental Illness
___Alcoholism	___Stroke	___Obesity

Other _____

CURRENT HEALTH SYSTEMS (circle all that apply):

Sleep: Number of hours:_Trouble falling asleep: Y / N Trouble staying asleep: Y / N
Mind restlessness: Y / N Body Restlessness: Y / N Refreshed upon waking: Y / N

Energy: High Moderate Low Times that are worse than others:_____

Digestion: Problems with (circle all that apply): Indigestion / Upset stomach / Gas Belching / GERD / Nausea / Bloating / Cramping / Heartburn
Bowel movements: _____ x day color: _____
(circle all that apply): Blood Mucus Undigested foods Pain
Anal itching Hemorrhoids Constipation Diarrhea

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Genitourinary: History of: Bladder Infections Kidney stones Other Kidney disease
Sexually transmitted infection Vaginal/genital infections Pain

Lung: History of: Frequent Cough Shortness of breath Smoking
Frequent infections Asthma Allergies Other

Cardiovascular: History of: Heart attack Stroke Palpitations Murmur
High Blood Pressure Arrhythmias Varicose veins Poor circulation

Nervous System: Numbness Tingling Atrophy Pinched Nerves Pain

Musculoskeletal: Injury Joint Pain Muscle Pain Muscle Fatigue Spasms
Muscle cramps Osteoporosis Arthritis Other

Ears: Pain Ringing Deafness Frequent Infections Other

Nose: Allergies Sinus congestion Post Nasal Drip Surgery Other

Eyes: Blurred vision Visual impairment Injury Floaters Pain Other

Throat: Frequent infections Thyroid Issues Loss of voice Pain Tonsillectomy

LIFESTYLE:

Please indicate your consumption level of the following?

	NONE	LIGHT	MODERATE	HEAVY
Salt	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Water	☐	☐	☐	☐

Toxin Exposures: (circle all)

1) Cigarette smoke: First-hand: *past / present* Second-hand *past / present*

2) Dental: Silver fillings: *past / present / removed* Root Canals: *present*

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3) **Home:** older than 1975 (*present or past*), old piping, water damage, mold, asbestos, new carpets, new cabinetry, chemical cleaners, use air fresheners, pets, attached garage, natural gas appliances

4) **Food**: organic ___% of food, tap water, avoid GMOs, aspartame: gum, diet pop

5) **Personal:** wear perfumes, petroleum products, use dry-cleaning, use antibacterial soap, deodorants, fluoride

6) **Occupation:** (*past or present*) painter, work with plastics, work with chemicals, construction industry, gasoline, insulation, cleaning, dentistry, farming, hair stylist, esthetician, with automobiles, driver, landscaping/planting, other:_____

7) **Live near:** golf course, orchard/farm, mine, factory

8) **Other:** frequent flying, golfing, sprays with gardening

24 Hour Diet Recall:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____ Beverages: _____
Daily Water intake: _____ Foods Avoided: _____
Food Cravings: _____ Food Allergies: _____

Mental Health:

Level of Stress (circle one): High / Mod / Low What are the major stressors in your life?

_____
_____
_____

How would you rate your mental health? Excellent / Fair / OK / Difficult / Struggling
Are you working with anyone on your mental health? Present / Past / No
Have you received a diagnosis regarding your mental health? _____
Have you ever taken medications for mental health? _____
Do you have a good support network (family, friends, groups)? _____
What is your current living situation? _____
Do you currently follow a (religious/spiritual) belief system? _____
Do you: Meditate Pray Use visualizations Other relaxation techniques _____
Hobbies? _____
Any Further Comments or Concerns? _____
_____
_____
_____