Information you need to know when visiting the Awen Health Centre.

When you arrive, please come in, take off your coat, and make yourself comfortable in the waiting area until Dr. Keith appears. We do our best to run on time, but we occasionally fall behind. May we suggest you allow for this when making arrangements for the remainder of your day. If you are driving please put more time on the meter than you expect to need. There are 2-hour street parking meters all along 6th Avenue.

Following treatment, you may wish to sit for a few moments before rushing back into your day. We encourage people to give themselves time to do this. There are several good restaurants in the area, where you can go to eat, and relax, before making your way home.

If you are going to miss your appointment, please notify us as soon as possible. If notice is not given within 48 hours, you will be charged for your office visit, as that time has been reserved for you.

The day of your appointment:

- If you are currently taking any prescription medications, please take them as usual.
- Any supplements and/or homeopathic remedies should NOT be taken the day of your appointment. This ensures we can accurately assess the needs of your body.
- We ask that any current prescription medications be brought with your visit. It is important we have these medications on hand to ensure harmony (and establish safety) between any supplements, homeopathic remedies and prescription drugs you may be taking.

We look forward to working with you at the Awen Health Centre.

Dr. Keith Condliffe, B.A., ND
220 - 1529 West 6th Ave.
Vancouver, BC V6J 1R1
604.616.4446

AWEN
health centre

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Consent to the Treatment of an Adult

I, _____
(please print name)

of the following address _____

acknowledge and declare that I have the option of seeking/continuing allopathic (conventional) medical care from a medical doctor and that the medical treatments at this clinic and allopathic medical treatments are different but not mutually exclusive. I confirm that there has been no suggestion made to me by the Awen Health Centre, or by anyone under its direction or control, that I refrain from seeking or following allopathic medical treatment.

I also understand that the Naturopathic Physician at this clinic is trained to read and interpret x-rays, ultrasounds, and other conventional medical tests but is (currently) restricted from ordering several of these tests in the Province of British Columbia. Therefore, it is my responsibility to maintain contact with a Medical Doctor so that all necessary testing may be performed as required to monitor my condition. Furthermore, I realize that the Physician at this clinic may use testing procedures that are not conventional and are used only to make an assessment of the progress of their therapy and are by no means tools to accurately diagnose a disease.

I understand that the Naturopathic Physician at the Awen Health Centre does not treat cancer, autoimmune diseases, genetic diseases, HIV/AIDS, sexually transmitted diseases, etc., rather he will help me assess and correct the imbalances in my body, nutrition and lifestyle so that my body can then heal itself.

I agree to pay my account in full after every visit unless other arrangements have been made with the Naturopathic Doctor at this clinic prior to my visit. As well, I have read and understand the fee schedule and understand the 48 hour cancellation policy.

I also understand that all information given to the Awen Health Centre is guarded in strict confidence at all times, subject to doctor-patient confidentiality laws. To deliver the best care, the Awen Health Centre uses a password-encrypted Electronic Medical Recording system that is backed up securely to a remote location. This ensures that information is available to your doctor on a closed network, a huge advantage for you and your doctor over traditional paper-filing systems.

I also acknowledge that for the purposes of teaching other healthcare practitioners, broad information about my case may be reviewed, with absolutely no identifying information disclosed at any time.

On reading and understanding the above, I hereby give my consent to assessment and treatment by the Naturopathic Physician at the Awen Health Centre.

Signed in Vancouver, in the province of British Columbia, Canada, this _____ day of _____, 20_____.

Signature: _____

Witness: _____

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Vancouver, BC V6J 1R1

Thank you for taking the time to fill out this form. The information is very important in the assessment of your case.

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Email: _____ Phone: _____ H/ W/ C Phone: _____ H/ W/ C

Sex: _____ Age: _____ Date of Birth: _____ Birthplace: _____

Referred by: _____

1. Why did you choose to come to the Awen Health Centre?

_____

2. What do you know about our approach?

_____

3. What expectations do you have from your first visit?

_____

4. What long term expectations do you have?

_____

5. What expectations do you have of me personally as your physician?

_____

6. What is your present level of commitment to address any underlying causes of your signs and symptoms?
(Rate from 0 to 10, 10 being 100% committed) 1 2 3 4 5 6 7 8 9 10

7. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

_____

8. What behaviors or lifestyle habits do you currently engage in regularly that you believe detract from your health?

_____

9. What potential obstacles do you foresee in addressing your health goals and in following a treatment plan?

_____

10. Who do you know that will sincerely support you in this process?

_____

11. What do you LOVE to do?

_____

What are your main health concerns and/or goals? (list in order of importance, from most important to least)

❑ Routine check up: no symptoms Date started:

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

MD's Name: _____ MD's Phone: _____

MD's Address: _____ City: _____

Date of last physical exam: _____ Weight: _____ Height: _____ Blood Type: _____

Are you currently seeking treatment from another health care provider? Y N If yes, what type? _____

Please fill in the following information about current medications and supplements that you are currently taking.

Medication	Dose	How Often	For How Long	Reason

Supplement	Dose	How Often	For How Long	Reason

Have you had any bad reactions to medications / supplements? _____

How many courses of antibiotics have you had in the past 10 years? _____

Please list all allergies (food, environmental, medications): _____

_____

Do you have any of the following? ❑ internal pins ❑ artificial joints ❑ pacemaker ❑ transplant ❑ implant ❑ wires

If yes, where and when placed? _____

Which of the following relates to your dental history? ❑ silver fillings ❑ white fillings ❑ root canals ❑ caps ❑ dentures

Childhood Illnesses *(please circle)*

Eczema	Ear infections	Chickenpox	Mononucleosis	Measles	Mumps
Scarlet fever	Whooping Cough	Diphtheria	Meningitis	Other: _____	

Vaccinations *(please circle)*

DTP	Hepatitis A	Chicken Pox	Flu shot If yes, how often?_____
MMR	Hepatitis B	HPV	Haemophilus Influenza B
Other? _____		Past adverse reactions? ❑ Yes ❑ No	

If yes, please describe reaction:_____

Most recent medical procedures & blood tests:

Procedure *(please circle)*	Abnormal?	Date	Blood Tests *(please circle)*	Abnormal?	Date
Sigmoidoscopy / Colonoscopy	❑	_____	Complete Blood Count	❑	_____
MRI / CT Scan	❑	_____	Cholesterol Panel	❑	_____
Blood / Plasma Transfusion	❑	_____	Liver Enzymes	❑	_____
Pap Smear	❑	_____	Thyroid Panel	❑	_____
Mammogram	❑	_____	Fasting blood glucose	❑	_____
Digital Rectal Exam / PSA	❑	_____	Hormone Panel	❑	_____
EKG / EEG	❑	_____	Other: _____	❑	_____

X-ray of the: ❑ Teeth ❑ Stomach / gallbladder ❑ Chest ❑ Colon ❑ Extremities Other:_____

Please answer the following as it best describes you.

Drink water	Y N	glasses/day _____	What source(s) of water? _____	
Drink coffee	Y N	glasses/day _____		
Drink tea	Y N	glasses/day _____	What kind(s) of tea? _____	
Drink pop/soda	Y N	glasses/day _____	What brand of pop/soda? _____	
Drink wine / alcohol	Y N	glasses/week _____	What kind of alcohol? _____	
Smoke tobacco	Y N	cigarettes/week_____	What kind of cigarettes? _____	
Smoked in past	Y N	cigarettes/week_____	For how many years? _____	
Recreational drugs	Y N	times/week _____	What kind of drug(s)? _____	
Drug use in past	Y N		For how many years? _____	
Exposed to allergens	Y N	hours/week _____	What type(s) of toxins? _____	
Use artificial sweeteners	Y N	packages/day _____	Which sweetener? _____	
Chew gum	Y N	pieces/day _____		
Eat large fish (tuna/sword)	Y N	servings/month_____	What kind of fish? _____	
Cell phone use	Y N	minutes/day _____	Do you use a headset? ❑ Yes ❑ No	
Use antiperspirant	Y N		What brand of antiperspirant? _____	

Marital status: _____ No. in living space: _____ No. of children: _____

Occupation/ Role: _____ Past occupations: _____

Retired? ❑ Yes ❑ No If yes, when? _____ Religion / personal philosophy: _____

Family History: Please check which diseases apply to any blood relative.

Please circle if choice	Mother	Father	Sibling	Child	Grandparent	Others
Cancer (what type?)						
Hereditary Disease (what type?)						
Skin Disease (what type?)						
Arthritis / Gout						
Kidney Disease						
Lung Disease / Asthma / TB						
Liver Disease / Cirrhosis						
Hypoglycemia / Diabetes						
Thyroid Problems / Obesity						
Heart Disease / Stroke						
Syphilis / Gonorrhea / HIV						
Mental Illness / Epilepsy						
Miscarriages						
Other _____						

Please list in order of appearance from your birth, all hospitalizations, surgeries, diseases, accidents, traumas and scars. (emotional and physical).

Age:_____

Age:_____

Age:_____

Age:_____

Age:_____

Age:_____

Age:_____

Age:_____

Age:_____

Is there anything else that you feel I should know about you?_____

_____

_____