Retail Store & Pharmacy:
1111 West Broadway
Vancouver, B.C., V6H 1G1
(604) 733 - 5323

Health Centre:
G104 - 2480 Spruce
Vancouver, B.C. V6H 2P6
(604) 734 - 7760

Finlandia Health Centre Policies

YOUR FIRST VISIT

- Please bring along copies of lab work that you have available, as well as any supplements, herbs, or medications that you are currently taking.
- We will provide you with an intake form to fill out and bring to the first visit. Please fill out this form as completely and accurately as possible. If we have not provided you with an intake form prior to your initial visit, please arrive 15 minutes early to complete the forms here at Finlandia.

GENERAL APPOINTMENT GUIDELINES

- Please refrain from wearing heavily scented products or perfumes in the clinic.
- Full payment is mandatory at the time of each visit (Visa, Master Card, Amex, Debit, Cash)
- Most extended health plans will cover Naturopathic consultations. We will provide you an official receipt to submit to your provider.
- If you are on premium assistance, you are eligible to receive $23 off of each visit, up to a maximum of 10 visits per year.
- Any lab work or tests are an additional fee, separate from the consultations. Some extended health plans cover lab testing; check with your insurance provider for details.

CANCELLATIONS AND RESCHEDULING

- Please note that if you are more than 15 minutes late for an appointment, you may have to wait until the next available opening.
- We require a minimum of **48 hour** notice for cancellations or scheduling. A **$50** cancellation fee will apply if less than 48 hour notice is provided.
- We of course understand emergencies or other unforeseen circumstances can arise at the last minute, and this will certainly be taken into consideration. Our answering machine is always operating and is checked regularly.
- Please call **604-734-7760** to cancel or change an appointment.

PURCHASING REFILLS OF RECOMMENDED SUPPLEMENTS

- Please inform our cashiers which doctor you have seen at the time of your purchase.

FEE GUIDE			
Initial Consultation (1 hour)	$165	ETA Initial Scan	$250
Follow-Up Consultation (30 minutes)	$85	ETA Re-Scan	$150
Follow-Up Consultation (15 minutes)	$50	REBA Scan	$150
Acupuncture (1 hour)	$80	Injection	$15-$45
Bowen Therapy (45 minutes)	$80	IV	$60
Cold Laser Treatment	$45-$80	Breast Thermography	$350

Finlandia
PHARMACY & NATURAL HEALTH CENTRE

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Naturopathic Intake Form

Our professional association requires us to maintain contact information for our patient records. The information provided in this document is entirely confidential, used for internal office purposes only. We will not distribute your personal and private details.

Date: _____

Full Name	Date of Birth (MM/DD/YY)	Age
Address	City, Prov., Postal	
Home #	Work #	
Cell #	Email	
Family Doctor	Family Doctor #	
Emergency Contact	Emergency Contact #	

❒ YES, please email me about important clinic information and updates.

❒ NO, I would not like to be contacted by email.

How did you hear about our Naturopathic services?

Health concerns in order of importance:

1. 2.

3. 4.

Past Medical History (including childhood diseases, surgeries, accidents, infectious diseases, degenerative conditions, allergies, hospitalization, and abuse of drugs/alcohol/cigarettes): Please use back if necessary

Please list all current medications (prescription, OTC, vitamins, herbs, and homeopathics):

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Please list any past prescription medications:

Please list any allergies you may have:

Family medical history (including close relatives, siblings, children):

Personal Health Habits

Height	Weight	Weight 1 Year Ago
Are you a smoker? Y N	How many years?	Packs/Day
Do you drink alcohol? Y N	Type:	Frequency:
Do you use recreational drugs? Y N	Type:	Frequency:
Do you drink coffee? Y N Cups/day:	Do you drink tea? Y N	Cups/day:
Do you exercise regularly? Y N	Type:	Frequency:
Hours of sleep/night:	Do you stay asleep through the night? Y N	Do you wake up feeling rested? Y N

Typical day's diet

Breakfast: _____

Lunch: _____

Dinner: _____

Beverages: _____

Snacks: _____

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Environment:

Occupation: _____

Hobbies: _____

Exposure to animals: _____

Exposure to toxins: _____

Women's Health

Are you currently pregnant? Y N
Number of months:
Number of pregnancies:
Number of miscarriages:
Number of abortions:
Difficulty conceiving? Y N
Number of viable births:
Date and result of last Pap smear:

Men's Health

Date and result of last prostate exam:

External Influences

How would you describe the emotional climate of your home?

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

Is there anything that you feel is important that has not been covered?

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Review of Systems – please check if you have experienced any of these in the last 12 months:

Skin and Hair

- ❒ Rashes
- ❒ Itching
- ❒ Dandruff
- ❒ Change in texture
- ❒ Poor healing sores
- ❒ Eczema
- ❒ Loss of hair
- ❒ Hives
- ❒ Pimples
- ❒ Recent Moles

Head

- ❒ Light headedness
- ❒ Fainting
- ❒ Loss of memory
- ❒ Difficulty concentrating
- ❒ Headaches/Migraines
- ❒ Sinus congestion

Eyes

- ❒ Eye pain
- ❒ Sensitive to light
- ❒ Loss of vision
- ❒ Blurred vision
- ❒ Difficulty seeing at night
- ❒ Itchy, inflamed or infected

Mouth

- ❒ Sores on lip/mouth
- ❒ Loss of taste
- ❒ Painful in gums or tongue

Throat

- ❒ Sore throat/hoarseness
- ❒ Difficulty swallowing

Nose

- ❒ Loss of smell
- ❒ Nose pain
- ❒ Nosebleeds

Lungs

- ❒ Shortness of breath
- ❒ Difficulty breathing
- ❒ Chronic cough
- ❒ Chronic phlegm/mucus
- ❒ Chronic infections

Immunity

- ❒ Frequent colds
- ❒ Use antibiotics

Cardiovascular

- ❒ High blood pressure
- ❒ Low blood pressure
- ❒ Irregular heart beat

Ears

- ❒ Loss of hearing
- ❒ Loss of balance
- ❒ Dizziness
- ❒ Ear pain
- ❒ Ringing in ears
- ❒ Ear infections

Respiratory

- ❒ Cough
- ❒ Coughing blood
- ❒ Difficulty breathing when lying down
- ❒ Production of phlegm
- ❒ Bronchitis
- ❒ Pneumonia
- ❒ Asthma
- ❒ Pain on breathing

Gastro-Intestinal

- ❒ Nausea
- ❒ Constipation
- ❒ Abdominal pain
- ❒ Blood in stools
- ❒ Hemorrhoids
- ❒ Food cravings
- ❒ Vomiting
- ❒ Black stools

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Informed Consent

Statement of Acknowledgement

Printed Name: _____

As a patient of Finlandia Health Centre, I acknowledge that I have read this document and understand that naturopathic medical care is based on alternative and other supportive principles and practices. I recognize that even the gentlest therapies have the potential to have serious complications and I verify that all the information I have provided is complete and inclusive of all health concerns (including risk of pregnancy) and all medications, including over the counter drugs and supplements. I recognize that when used improperly medicinal herbs and intravenous treatments can cause serious side-effects, including; pain, fainting, bruising, or injury from venipuncture or acupuncture; muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial, or federal agency. I accept full responsibility for any fees incurred during care and treatment.

SIGNATURE	DATE	WITNESS