Retail Store & Pharmacy:
1111 West Broadway
Vancouver BC V6H 1G1
604 733 5323

Health Centre:
G104 - 2480 Spruce
Vancouver, BC 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, 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 **24 hours notice** for cancellations or scheduling. A **$35** cancellation fee will apply if less than 24 hours 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 let the cashier know which doctor you have seen at the time of you 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

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Pediatric 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) | Care card #

Gender: M F | Age:

Mother's Name: | Father's Name:

Address: | City/Prov/Postal:

Pediatrician: | Pediatrician #:

Home Phone#: | Parent's Cell#: | Parent's Work#:

❒ 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:

- ❒ Chicken pox
- ❒ Scarlet fever
- ❒ Roseola
- ❒ Mononucleosis
- ❒ Measles
- ❒ Pneumonia
- ❒ Strep throat
- ❒ Impetigo
- ❒ Mumps
- ❒ Whooping cough
- ❒ Ear infections
- ❒ Rubella
- ❒ Rheumatic fever
- ❒ Other (please list)

Surgeries, accidents, hospitalizations:

What screening tests has your child had? (blood, hearing, vision, etc)

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

Please list your child's known allergies (food and/or environmental):

Family Medical History (including close relatives, siblings, children):

- ❒ Heart disease
- ❒ Diabetes
- ❒ Birth abnormality
- ❒ Hypertension
- ❒ Arthritis
- ❒ Tuberculosis
- ❒ Eczema
- ❒ Mental illness
- ❒ Asthma
- ❒ Cancer
- ❒ Allergies
- ❒ Celiac disease
- ❒ Other (please list)

Immunizations

- ❒ MMR
- ❒ DPT
- ❒ Hepatitis A
- ❒ Meningococcal
- ❒ Polio
- ❒ Influenza
- ❒ Hepatitis B
- ❒ Other:
- ❒ HIB
- ❒ HPV
- ❒ Pneumococcal

Birth Mother's Prenatal History

Mother's age at child birth: Mother's health during pregnancy?

Which (if any) of the following experienced during pregnancy:

- ❒ Bleeding
- ❒ High blood pressure
- ❒ Physical/emotional trauma consumption
- ❒ Nausea/Vomiting
- ❒ Thyroid problems
- ❒ Illnesses
- ❒ Medications
- ❒ Gestational Diabetes
- ❒ Cigarettes, alcohol, drugs

Child's Birth History

Term: ❒ Full ❒ Premature _____ weeks ❒ Late _____ weeks Weight at birth: _____

Length of labour: Any complications?

Birth: ❒ Vaginal ❒ C-Section ❒ Induced ❒ Forceps ❒ Anesthesia used

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Did your child have any of the following problems shortly after birth?

- ❒ Birth abnormality
- ❒ Cerebral palsy
- ❒ Colic
- ❒ Other (please explain):
- ❒ Birth injuries
- ❒ Seizures
- ❒ Fever
- ❒ Blue baby
- ❒ Jaundice
- ❒ Rashes

Feeding: Breastfed? ❒ Yes ❒ No How long?

Formula? ❒ Yes ❒ No If yes: ❒ Cow's Milk ❒ Soy ❒ Other

Child's sleep patterns:

How would you describe your child's temperament?

Any dietary restrictions (religious, vegetarian, vegan, etc)?

Age began solids: Which foods?

Age began: _____ Sitting _____ Crawling _____ Walking _____ Talking

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Review of Systems – please check if your child has experienced any of these in the last 6 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
- ❒ Glaucoma/Cataracts

Urinary

- ❒ Pain on urination
- ❒ Urgency of urination
- ❒ Impotency
- ❒ Frequent urination
- ❒ Kidney stones
- ❒ Inability to hold urine
- ❒ Blood in urine
- ❒ Irregular flow

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
- ❒ Phlebitis
- ❒ Palpitations
- ❒ Swelling of hands/feet
- ❒ Varicose veins
- ❒ Chest pain
- ❒ Cold hands/feet
- ❒ Blood clots
- ❒ Difficulty breathing

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
- ❒ Indigestion
- ❒ Mucus in stools
- ❒ Gas
- ❒ Poor appetite
- ❒ Diarrhea
- ❒ Bad breath
- ❒ Heartburn
- ❒ Rectal pain
- ❒ Bloating
- ❒ Difficult swallowing

____ Number of bowel movements/day

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Informed Consent

Statement of Acknowledgement

Patient's Printed Name: _____

As the parent/guardian of a patient of Finlandia Health Centre, I have read the information and understand that the form of medical care is based on Naturopathic principles and practices. As Finlandia is an integrated health centre, I recognize that all the practitioners that are working with my child will have access to his/her file. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications, and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy and all medications, including over the counter drugs and supplements. The slight health risks of some treatments include, but are not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, 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 on behalf of my child, of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

SIGNATURE (parent/guardian)	DATE	WITNESS