Dr. Clayton Koganow, ND
902 9 Street South
Lethbridge, AB T1J 2M2

Patient Intake Form

Today's date: _____

Name:_____ Age:_____ Date of birth:_____ M □ F □
Address: _____ City: _____ Postal Code: _____
Home Phone #: (_____)_____Work #: (_____)_____
Email: _____ (only for appointment reminders, no junk mail will be sent)
Emergency Contact name, phone #, and relationship to you:_____
Your Current Occupation(s):_____Are you satisfied with your work situation? Y □ N □
How did you hear about us?_____
Name and phone # of other Healthcare providers you are seeing:
1._____ 2._____

Section 1: Current Health Concerns

What are your chief health concerns? (Please list them in order of importance to you)

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

Previous treatments and results:
_____
_____
_____

Section 2: Medical History

Please check the following that apply to you:

□ Cancer	□ Diabetes Mellitus	□ Surgeries	□ Venereal disease
□ High blood pressure	□ Seizures	□ Asthma	□ Allergies
□ Heart disease or stroke	□ Hepatitis	□ Depression	□ Other mental illness
□ Rheumatic fever	□ Thyroid disease	□ Arthritis	□ Alcoholism
□ Kidney disease	□ HIV	□ Drug abuse	□ Anemia
□ Shingles	□ Fibromyalgia	□ Ulcer	□ Digestive disorders
□ Neuromuscular disease	□ high triglycerides	□ Liver disease	□ Lung/pulmonary disease
□ Osteoporosis	□ Gall bladder disease	□ Miscarriage	□ Autoimmune disease

□ Eating disorders
□ Serious childhood illnesses _____
□ Significant trauma (auto accidents, falls, etc.)_____
□ Hospitalizations or surgeries _____
□ Other (please specify)_____

Section 3: Family Medical History (please write the family member beside checked category, ex. "mother")

□ Cancer_____ □ High Blood pressure_____
□ Asthma _____ □ Depression _____
□ Diabetes _____ □ Heart Disease _____
□ Allergies _____ □ Thyroid disease _____
□ Seizures _____ □ Stroke _____
□ Alcoholism _____ □ Kidney disease _____
□ Liver disease_____ □ Hepatitis/jaundice _____
□ Autoimmune disease _____ □ Arthritis_____
□ Colitis/Crohn's disease _____
□ Other (please specify): _____

Section 4: Medical and Lifestyle Information

Date of last physical exam:_____Height_____Weight_____Weight 1 year ago_____

Date of last dental checkup: _____

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How would you describe your general state of health?
 Excellent Very Good Good Fair Poor

Please list all your current prescription medications:

_____

_____

Please list all vitamin/mineral/herb supplements you are currently taking and indicate dosage:

_____

_____

Do you regularly use any of the following: aspirin /Tylenol antacids laxatives diet pills

Do you have any known allergies or sensitivities (environmental, medicine, seasonal, pets, etc) If yes, what are they?
_____

Do you get regular screening tests done by another doctor (Pap smear, breast, prostate, blood tests, etc?)
Y N

What goals do you have for your health care at this time? (Symptom relief, achieving optimal health, etc.) :
_____

FEE SCHEDULE, CANCELLATION POLICY, PAYMENT OPTIONS

The following fee schedule includes GST.

First Office Visit $115.50
Return Office Visit - 30 minute $63.00
Brief Visit-15 minute $31.50
Brief Visit Consult from Referral- 63.00

Late Cancellation Charge (less than 24h notice) $55.00

Any prescribed supplements or laboratory workups are not included in the above rates

Cancellation Policy

Your appointment has been reserved especially for you. Please provide at least 24 hour notice if you need to cancel or reschedule your appointment.

Payment Options

Current methods of payment are Cash, Debit, Visa and MC

Patient Confirmation

I, _____, have read, understood, and acknowledged the above information about fee schedule, cancellation policy, and payment options. I have been honest and provided all answers to be best of my ability.

Patient Signature: _____ Date: _____