

NEW PATIENT INTAKE FORM – ADULT

Please print this form, complete as much as possible, and bring with you on the day of your first appointment to our clinic. We look forward to meeting you.

Name		Date of Birth	Age	Gender
Today's Date	Primary Phone (circle: home / cell / work)		Alternate Phone (circle: home / cell / work)	
How would you prefer to receive appointment reminders? <input type="radio"/> Text <input type="radio"/> Voicemail <input type="radio"/> Email				
Mailing Address				
City		Province	Postal Code	
Email		Skype name		
Relationship status / Partner's name		Occupation (underline: part time / full time / other)		
Emergency Contact Name / Relationship		Emergency Contact Phone		
Are you currently receiving healthcare at another location/s? Please name other healthcare providers and their role in your medical care:				
How did you hear about us?				

1. Why did you choose to come to Restoration Health Clinic? What do you know about our approach?
2. What **three** expectations do you have for your first visit to our clinic?
3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0-10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviours or habits do you currently engage in regularly that you believe support your health?

b) What behaviours or lifestyle habits do you currently engage in regularly that you believe are damaging lifestyle habits?

5. What potential obstacles exist in your life that will prevent you from changing your lifestyle and adhering to suggestions we make for you?

6. What brings you joy?

Primary Concerns List in order of priority. Describe your concerns below if necessary.

Concern Example: Headaches	Onset Example: January 2013
1	
2	
3	
4	
5	

Medical History

Eyes Please check <input checked="" type="checkbox"/> all that apply. <input type="radio"/> Current = C and/or <input type="radio"/> Past = P		
C P <input type="radio"/> <input type="radio"/> Glasses or contacts <input type="radio"/> <input type="radio"/> Colour blind <input type="radio"/> <input type="radio"/> Double vision <input type="radio"/> <input type="radio"/> Spots in eyes	C P <input type="radio"/> <input type="radio"/> Recent change in vision <input type="radio"/> <input type="radio"/> Blurred vision <input type="radio"/> <input type="radio"/> Eye pain/strain <input type="radio"/> <input type="radio"/> Sensitivity to light	C P <input type="radio"/> <input type="radio"/> Eyes watery or dry <input type="radio"/> <input type="radio"/> Bloodshot eyes <input type="radio"/> <input type="radio"/> Puffy eyes
Head Please check <input checked="" type="checkbox"/> all that apply. <input type="radio"/> Current = C and/or <input type="radio"/> Past = P		
C P <input type="radio"/> <input type="radio"/> Headaches <input type="radio"/> <input type="radio"/> Migraines	C P <input type="radio"/> <input type="radio"/> Jaw or TMJ problems	C P <input type="radio"/> <input type="radio"/> Head injury

Ear/Nose/Mouth/Throat/Neck Please check ✓ all that apply. Current = **C** and/or Past = **P**

C P	C P	C P
<input type="radio"/> <input type="radio"/> Impaired hearing	<input type="radio"/> <input type="radio"/> Frequent colds or flus	<input type="radio"/> <input type="radio"/> Dental cavities or infections
<input type="radio"/> <input type="radio"/> Ringing in ears	<input type="radio"/> <input type="radio"/> Sleep Apnea	<input type="radio"/> <input type="radio"/> Jaw clicks
<input type="radio"/> <input type="radio"/> Sensitivity to noise	<input type="radio"/> <input type="radio"/> Teeth/gum problems	<input type="radio"/> <input type="radio"/> Cold sores
<input type="radio"/> <input type="radio"/> Earache	<input type="radio"/> <input type="radio"/> Mercury (silver) amalgam fillings	<input type="radio"/> <input type="radio"/> Root canals
<input type="radio"/> <input type="radio"/> Frequent ear infections	<input type="radio"/> <input type="radio"/> Copious saliva	<input type="radio"/> <input type="radio"/> Regular dental cleanings
<input type="radio"/> <input type="radio"/> Discharge from ears	<input type="radio"/> <input type="radio"/> Dry mouth	<input type="radio"/> <input type="radio"/> Lumps in neck
<input type="radio"/> <input type="radio"/> Nose bleeds	<input type="radio"/> <input type="radio"/> Mouth ulcers	<input type="radio"/> <input type="radio"/> Swollen nodes/glands
<input type="radio"/> <input type="radio"/> Sinus problems	<input type="radio"/> <input type="radio"/> Teeth grinding	<input type="radio"/> <input type="radio"/> Goiter
<input type="radio"/> <input type="radio"/> Stuffiness	<input type="radio"/> <input type="radio"/> Sore tongue or lips	<input type="radio"/> <input type="radio"/> Pain or stiffness in neck
<input type="radio"/> <input type="radio"/> Loss of smell	<input type="radio"/> <input type="radio"/> Hoarse voice	<input type="radio"/> <input type="radio"/> Other:
<input type="radio"/> <input type="radio"/> Hayfever	<input type="radio"/> <input type="radio"/> Loss of voice	
<input type="radio"/> <input type="radio"/> Frequent sore throat		

Respiratory Please check ✓ all that apply. Current = **C** and/or Past = **P**

C P	C P	C P
<input type="radio"/> <input type="radio"/> Cough	<input type="radio"/> <input type="radio"/> Difficulty breathing	<input type="radio"/> <input type="radio"/> Asthma
<input type="radio"/> <input type="radio"/> Mucous/phlegm	<input type="radio"/> <input type="radio"/> Shortness of breath with light exercise	<input type="radio"/> <input type="radio"/> Bronchitis
<input type="radio"/> <input type="radio"/> Spitting up blood	<input type="radio"/> <input type="radio"/> Shortness of breath lying down	<input type="radio"/> <input type="radio"/> Pneumonia
<input type="radio"/> <input type="radio"/> Wheezing		<input type="radio"/> <input type="radio"/> Emphysema
<input type="radio"/> <input type="radio"/> Painful breathing		<input type="radio"/> <input type="radio"/> Other:

Cardiovascular + Blood Please check ✓ all that apply. Current = **C** and/or Past = **P**

C P	C P	C P
<input type="radio"/> <input type="radio"/> Heart disease	<input type="radio"/> <input type="radio"/> Valve prolapse	<input type="radio"/> <input type="radio"/> Edema/swelling in ankles or feet
<input type="radio"/> <input type="radio"/> Elevated cholesterol	<input type="radio"/> <input type="radio"/> Blood clots	<input type="radio"/> <input type="radio"/> Deep leg pain
<input type="radio"/> <input type="radio"/> High blood pressure	<input type="radio"/> <input type="radio"/> Easy bleeding or bruising	<input type="radio"/> <input type="radio"/> Varicose veins
<input type="radio"/> <input type="radio"/> Low blood pressure	<input type="radio"/> <input type="radio"/> Chest pain	<input type="radio"/> <input type="radio"/> Cold hands/feet
<input type="radio"/> <input type="radio"/> Angina	<input type="radio"/> <input type="radio"/> Dizziness with standing or fainting	<input type="radio"/> <input type="radio"/> Anemia
<input type="radio"/> <input type="radio"/> Pacemaker	<input type="radio"/> <input type="radio"/> Murmurs	<input type="radio"/> <input type="radio"/> Other:
<input type="radio"/> <input type="radio"/> Rheumatic Fever	<input type="radio"/> <input type="radio"/> Palpitations or flutter	
<input type="radio"/> <input type="radio"/> Arrhythmia		

Gastrointestinal Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <input type="radio"/> <input type="radio"/> Constipation <input type="radio"/> <input type="radio"/> Diarrhea <input type="radio"/> <input type="radio"/> Difficulty swallowing <input type="radio"/> <input type="radio"/> Heartburn <input type="radio"/> <input type="radio"/> Change in thirst <input type="radio"/> <input type="radio"/> Change in appetite <input type="radio"/> <input type="radio"/> Abdominal cramping or pain <input type="radio"/> <input type="radio"/> Burping	<p>C P</p> <input type="radio"/> <input type="radio"/> Flatulence <input type="radio"/> <input type="radio"/> Nausea <input type="radio"/> <input type="radio"/> Vomiting <input type="radio"/> <input type="radio"/> Hemorrhoids <input type="radio"/> <input type="radio"/> Black or dark tarry stools <input type="radio"/> <input type="radio"/> Blood or mucous in stool <input type="radio"/> <input type="radio"/> Undigested food in stool <input type="radio"/> <input type="radio"/> Jaundice (yellow skin)	<p>C P</p> <input type="radio"/> <input type="radio"/> Gallbladder disease <input type="radio"/> <input type="radio"/> Irritable Bowel Syndrome <input type="radio"/> <input type="radio"/> Crohn's <input type="radio"/> <input type="radio"/> Ulcerative Colitis <input type="radio"/> <input type="radio"/> Gastritis or Peptic Ulcer <input type="radio"/> <input type="radio"/> GERD <input type="radio"/> <input type="radio"/> Celiac Disease <input type="radio"/> <input type="radio"/> Other:
---	---	---

Genital + Urinary Systems Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <input type="radio"/> <input type="radio"/> Increased frequency of urination <input type="radio"/> <input type="radio"/> Frequency of urination at night (more than once) <input type="radio"/> <input type="radio"/> Pain on urination	<p>C P</p> <input type="radio"/> <input type="radio"/> Difficulty starting to urinate <input type="radio"/> <input type="radio"/> Inability to hold urine <input type="radio"/> <input type="radio"/> Blood in urine	<p>C P</p> <input type="radio"/> <input type="radio"/> Kidney Stones <input type="radio"/> <input type="radio"/> Urinary Tract Infections <input type="radio"/> <input type="radio"/> Yeast Infections <input type="radio"/> <input type="radio"/> Other:
---	---	---

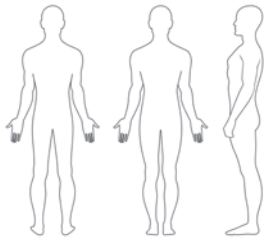
Inflammatory/Autoimmune Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <input type="radio"/> <input type="radio"/> Chronic Fatigue Syndrome <input type="radio"/> <input type="radio"/> Autoimmune Disease <input type="radio"/> <input type="radio"/> Rheumatoid Arthritis <input type="radio"/> <input type="radio"/> Immune Deficiency Disease <input type="radio"/> <input type="radio"/> Severe Infectious Disease	<p>C P</p> <input type="radio"/> <input type="radio"/> Poor Immune Function/ Frequent Infections <input type="radio"/> <input type="radio"/> Food Allergies <input type="radio"/> <input type="radio"/> Lupus SLE <input type="radio"/> <input type="radio"/> Environmental Allergies	<p>C P</p> <input type="radio"/> <input type="radio"/> Multiple Chemical Sensitivities <input type="radio"/> <input type="radio"/> Latex Allergy <input type="radio"/> <input type="radio"/> Other
--	--	---

Metabolic/Endocrine Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <input type="radio"/> <input type="radio"/> Heat or cold intolerance <input type="radio"/> <input type="radio"/> Excessive thirst <input type="radio"/> <input type="radio"/> Excessive fatigue <input type="radio"/> <input type="radio"/> Excessive hair growth <input type="radio"/> <input type="radio"/> Thyroid – low or overactive <input type="radio"/> <input type="radio"/> Weight gain <input type="radio"/> <input type="radio"/> Weight loss	<p>C P</p> <input type="radio"/> <input type="radio"/> Frequent weight fluctuations <input type="radio"/> <input type="radio"/> Excessive sweating <input type="radio"/> <input type="radio"/> Night sweats <input type="radio"/> <input type="radio"/> Type 1 Diabetes <input type="radio"/> <input type="radio"/> Type 2 Diabetes <input type="radio"/> <input type="radio"/> Metabolic Syndrome/Insulin Resistance	<p>C P</p> <input type="radio"/> <input type="radio"/> Hypoglycemia <input type="radio"/> <input type="radio"/> Polycystic Ovarian Syndrome (PCOS) <input type="radio"/> <input type="radio"/> Bulimia <input type="radio"/> <input type="radio"/> Anorexia <input type="radio"/> <input type="radio"/> Eating disorder <input type="radio"/> <input type="radio"/> Other:
---	---	--

Musculoskeletal Pain Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Joint pain or stiffness</p> <p><input type="radio"/> <input type="radio"/> Broken bones</p> <p><input type="radio"/> <input type="radio"/> Muscle weakness</p> <p><input type="radio"/> <input type="radio"/> Muscle cramping or spasms</p> <p><input type="radio"/> <input type="radio"/> Arthritis</p> <p><input type="radio"/> <input type="radio"/> Fibromyalgia</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Chronic Pain</p> <p><input type="radio"/> <input type="radio"/> Sprain</p> <p><input type="radio"/> <input type="radio"/> Swelling</p> <p><input type="radio"/> <input type="radio"/> Sciatica</p> <p><input type="radio"/> <input type="radio"/> Motor vehicle accident</p> <p><input type="radio"/> <input type="radio"/> Other:</p>	<p>Please mark areas of current pain:</p> 
---	---	---

Skin Diseases Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Rashes</p> <p><input type="radio"/> <input type="radio"/> Eczema</p> <p><input type="radio"/> <input type="radio"/> Hives</p> <p><input type="radio"/> <input type="radio"/> Psoriasis</p> <p><input type="radio"/> <input type="radio"/> Acne</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Boils</p> <p><input type="radio"/> <input type="radio"/> Colour change</p> <p><input type="radio"/> <input type="radio"/> Lumps</p> <p><input type="radio"/> <input type="radio"/> New or changing mole</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Dry or scaling</p> <p><input type="radio"/> <input type="radio"/> Itching</p> <p><input type="radio"/> <input type="radio"/> Hair loss</p> <p><input type="radio"/> <input type="radio"/> Other</p>
---	--	--

Mood + Emotional Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Depression</p> <p><input type="radio"/> <input type="radio"/> Anxiety or nervousness</p> <p><input type="radio"/> <input type="radio"/> Difficulty concentrating</p> <p><input type="radio"/> <input type="radio"/> Poor memory</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Tension</p> <p><input type="radio"/> <input type="radio"/> Easily stressed</p> <p><input type="radio"/> <input type="radio"/> Mood swings</p> <p><input type="radio"/> <input type="radio"/> Lack of pleasure or motivation</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Considered suicide</p> <p><input type="radio"/> <input type="radio"/> Bipolar Disorder</p> <p><input type="radio"/> <input type="radio"/> Schizophrenia</p>
--	--	--

Neurologic Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Vertigo</p> <p><input type="radio"/> <input type="radio"/> Loss of balance</p> <p><input type="radio"/> <input type="radio"/> ADD/ADHD</p> <p><input type="radio"/> <input type="radio"/> Sensory Integrative Disorder</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Autism</p> <p><input type="radio"/> <input type="radio"/> Mild Cognitive Impairment</p> <p><input type="radio"/> <input type="radio"/> Multiple Sclerosis</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> ALS</p> <p><input type="radio"/> <input type="radio"/> Seizures</p> <p><input type="radio"/> <input type="radio"/> Paralysis</p> <p><input type="radio"/> <input type="radio"/> Other:</p>
---	--	---

Cancer Please describe.

Male History Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <input type="radio"/> <input type="radio"/> Hernias <input type="radio"/> <input type="radio"/> Prostate problems <input type="radio"/> <input type="radio"/> Testicular masses <input type="radio"/> <input type="radio"/> Testicular pain <input type="radio"/> <input type="radio"/> Do you do testicular self-exam?	<p>C P</p> <input type="radio"/> <input type="radio"/> Venereal disease <input type="radio"/> <input type="radio"/> Discharge or sores <input type="radio"/> <input type="radio"/> Are you sexually active? <input type="radio"/> <input type="radio"/> Erectile dysfunction <input type="radio"/> <input type="radio"/> Low libido	<p>C P</p> <input type="radio"/> <input type="radio"/> Premature ejaculation <input type="radio"/> <input type="radio"/> Sexually transmitted infection <input type="radio"/> <input type="radio"/> Type of birth control used (please list):
---	--	--

Female History Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <input type="radio"/> <input type="radio"/> Irregular cycles <input type="radio"/> <input type="radio"/> Bleeding between cycles <input type="radio"/> <input type="radio"/> Heavy or excessive flow <input type="radio"/> <input type="radio"/> Clotting <input type="radio"/> <input type="radio"/> Pain in abdomen/pelvis/back <input type="radio"/> <input type="radio"/> PMS <input type="radio"/> <input type="radio"/> Do you use contraception	<p>C P</p> <input type="radio"/> <input type="radio"/> Are you sexually active <input type="radio"/> <input type="radio"/> Low libido <input type="radio"/> <input type="radio"/> Pain with intercourse <input type="radio"/> <input type="radio"/> Vaginal dryness <input type="radio"/> <input type="radio"/> Vaginal discharge <input type="radio"/> <input type="radio"/> History of sexually transmitted infection <input type="radio"/> <input type="radio"/> History of sexual trauma	<p>C P</p> <input type="radio"/> <input type="radio"/> Difficulty conceiving <input type="radio"/> <input type="radio"/> Perimenopausal <input type="radio"/> <input type="radio"/> Breast pain <input type="radio"/> <input type="radio"/> Lumps in breast <input type="radio"/> <input type="radio"/> Do you do regular self breast exams? <input type="radio"/> <input type="radio"/> Nipple discharge
--	---	---

Female History - Short Answer

Age at first period: Age at last period (if menopausal): Date of last menstrual period: Length of cycle (in days):	Duration of menses (in days): Number of pregnancies: Number of live births: Date of last pap:	Abnormal pap? When? Birth control type:
---	--	---

Family Medical History

List any diseases for each family member. Please include family member's age and cause of death if no longer alive.

Mother	Maternal Grandmother	Maternal Grandfather
Father	Paternal Grandmother	Paternal Grandfather
Siblings		

Surgeries & Hospitalizations Include injury, date, location.

Medical Testing Include xrays, CT scans, ultrasounds, MRI, ECG.

Medications & Supplements:

Medication (Over the counter / prescription)	Dosage & Frequency
Supplements (Including brand name)	Dosage & Frequency

Allergic reaction/intolerances to Medications Example: penicillin causes hives

Allergic reaction/intolerances (Foods, Environment) Example: cow's milk causes bloating

Diet & Lifestyle

1. What do you typically eat in a day?

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

2. What are the least healthful foods in your diet?

3. Do you drink: Coffee Black tea Green tea Juice Pop _____

Milk (note if dairy alternative) _____

Alcohol _____ (Estimated drinks per week _____ Preferred drink _____)

Water _____

4. How often do you eat out?

5. Do you have any questions or concerns about your diet?

6. Do you exercise? Yes No Hours per week: _____ Type of exercise (describe): _____

7. Tobacco: Yes No

Yes: Cigarettes Age ____ to ____ / ____ packs per day Yes: Cigars Yes: Chewing tobacco

8. Prescription drugs used for recreational purposes: Yes No Type:

Other drugs: Yes No Type(s) and frequency:

9. How many hours sleep do you get?

10. What are your main interests and hobbies?

11. Do you have a religious or spiritual practice?

12. What are the major stressors in your life?

13. Who are the people in your life that are most supportive of you and any changes you make in your lifestyle?

14. Have you had any prior experiences with natural medicine? If so, please describe.



AUTHORIZATION AND CONSENT

Dear Patient,

Thank you for your interest in retaining Restoration Health Clinic Inc. ("Restoration") to provide you or your child with naturopathic care and guidance to support and improve your or your child's health and well being.

Prior to Restoration agreeing to accept you or your child as a patient and provide you or your child with its naturopathic services, Restoration requires that you review and agree to the terms and conditions contained in this letter agreement.

Throughout this letter agreement the terms "you", "I", "me" and "my" shall refer to you the undersigned individual or your child (as applicable), specified at the end of this letter agreement.

I wish to retain Restoration to provide me or my child with naturopathic care, treatment and guidance to support and improve my or my child's health and well being (the "Treatment"). I understand and agree that prior to Restoration providing me the Treatment, Restoration requires, and is relying on, my consent and the following representations, warranties and covenants:

1. I understand and acknowledge that Restoration employs naturopathic doctors ("ND") to provide the Treatment and does **not** employ traditional medical doctors to provide the Treatment. For the purposes of providing the Treatment, I consent to one or more of Restoration's NDs or staff to carry out the following tasks:
 - (a) take a thorough case history and conduct a screening physical examination; which may include a breast exam, gynaecological, rectal, prostate, and blood and urine samples as required; and
 - (b) recording your personal medical information and sharing your personal medical information with Restoration Staff and other medical professionals solely in connection with your Treatment and subject to strict confidentiality guidelines implemented by Restoration.
2. I understand and acknowledge that Restoration employs the use of Botanical Medicine, Traditional Chinese Medicine, Acupuncture, Bony manipulations, Massage, Hydrotherapy, Nutrition, Lifestyle Counseling, Psychological counseling, Homeopathy, Intramuscular injections, intravenous injections, Pharmaceutical prescriptions, or Vaccinations in providing the Treatment.
3. I represent and warrant that all medical information provided by me to Restoration during my initial health assessment is true and correct. I will advise Restoration as soon as possible of any errors in the medical information I provided to Restoration or any changes to my current health status including any disease or ailments that I may be suffering from, any medication or over the counter drugs that I am consuming and whether I am pregnant, suspect I may be pregnant or am breast-feeding.
4. I hereby acknowledge and agree that Restoration has not made any warranties or representations of any kind to me regarding results that may be achieved from the Treatment. I understand that any results or outcomes arising from the Treatment are individual and may vary from person to person. I understand that the results of the Treatment are not guaranteed and do not expect the ND's will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the Treatment provided to me by Restoration.
5. I hereby acknowledge and agree that the Treatment may lead to certain unforeseen complications, including but not limited to: aggravation of pre-existing symptoms; allergic reactions to pharmaceuticals, supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations. I also acknowledge that I have the right to accept or reject this medical care of my own free will and choice.
6. I recognize that specific foods, botanicals and medications may create allergic and possible serious reactions, in particular, products containing nuts. I further acknowledge that these allergies may cause me serious bodily harm. I represent and warrant that I have provided to Restoration during my initial health and assessment a list of all items which, to the best of my knowledge, I am allergic or sensitive to.

7. I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. Notwithstanding, I understand that the Staff and ND's at Restoration are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats or harm to any individual and/or serious threat of suicide involved with my case. I understand that I may look at my medical records at anytime and can request a copy of it by paying the appropriate fees. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.
8. In consideration for Restoration agreeing to provide me with the Treatment, I hereby irrevocably and unconditionally release and forever discharge Restoration, its directors, officers, employees, agents and contractors and Restoration's successors, assigns, heirs and legal representatives (all such persons and entities being called the "Released Parties") of and from all manner of actions, causes of action, suits, demands, debts, accounts, covenants, contracts, damages and all other claims whatsoever, which the undersigned or its successors or assigns ever had, now has or may in the future have against any of the Released Parties for or by reason of any cause, matter or thing related to or arising from the Treatment provided to me including (but not limited to) any bodily harm or injury sustained by me or any other person. I further acknowledge and agree that the Released Parties will in no way be responsible for any bodily harm or injury suffered by me as a result of the Treatment.
9. I further agree and acknowledge that Restoration has the right to cease providing the Treatment to me at any time effective immediately, without any compensation to me whatsoever. This letter agreement will cover the entire course of my Treatment and I am free to withdraw my consent and to discontinue participation Treatment at any time.
10. Please note we require 48 hours notice for all cancelled appointments or the full visit fee will be charged.

We thank you for the opportunity of being able to work with you on improving your health, and wellbeing.

Yours truly,

RESTORATION HEALTH CLINIC INC.

I hereby certify that the representations and warranties contained in this letter agreement are true and correct and I hereby agree to the foregoing covenants and terms and conditions.

I hereby consent to _____ [enter name of ND] on behalf of Restoration and Restoration Health Clinic Inc. to provide me or my child with the Treatment described above.

Dated the ____ day of _____, 201____.

Print Name of Patient (if patient is a minor, print name guardian and relationship of guardian to patient):	
Signature of Patient (or signature of guardian if applicable):	
Address of Patient (and address of guardian if applicable):	
Telephone Number:	Email Address: