VHMEC
VISIONARY HEALTH MEDICAL EDUCATIONAL CLINIC
"HEALING WITH HEART"

Visionary Health Medical Educational Clinic (VHMEC)
5359 Dundas St West Unit 108, Toronto, ON M9B1B1 647-478-9029 FAX: 647-557-3323
vhmec108@gmail.com info@vhmec.com www.vhmec.com

Nutrition Initial Intake Form

First Name: ________________________________ Last Name: ____

Date of Birth (MM/DD/YYYY): _____________________ Address: ____

City:_____________ Postal Code:______________ Phone: _____________________ Cell: __________________

Emergency Contact. ____

Email: ____ Occupation: ____________________________________

How did you hear of Visionary Health? ____

Please list your top 3 health concerns: ____

Are you currently being treated by any other physician(s) or healthcare practitioners?

____

HEALTH HISTORY:

Height: ______________ Current Weight: ______________ Approx. weight 1 year ago: ______________________

Blood type: A □ B □ AB□ O□

Allergies: (please list any know allergies including medications, environmental & food related)

____

Medications: (please list all prescription and non-prescription medications including birth control, aspirin, etc.)

____

____

Supplements: (please list vitamins, minerals or other natural supplements your are taking, with doses if known)

____

Accidents/injuries/hospitalizations/surgeries (date and type): ____

____

Do you have any Gastro-intestinal (GI) concerns, such as Irritable bowel syndrome (IBS), inflammatory bowel disease (IBD), constipation, bloating etc….? Yes □ No □

Do you have any food triggers? Yes □ No □ If yes, please explain:

____

Do you have a problem with reflux or bloating? Yes □ No □

Do you fall asleep easily?

Do you wake up feeling rested?

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Family Medical History: (please check areas pertaining to blood relatives NOT including yourself)

☐ Alcoholism
☐ Asthma
☐ Anxiety
☐ Arthritis
☐ Cancer
☐ Diabetes
☐ Depression
☐ Eating disorder
☐ Epilepsy
☐ Hay fever/allergies
☐ Heart disease/stroke
☐ Herpes
☐ High Blood pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorder
☐ Neurological disorder
☐ Obesity
☐ Substance Abuse
☐ Thyroid problems
☐ Others (Please list):

____

____

____

Life Style:	Daily	Weekly
Tobacco	_________	__________
Alcohol	_________	__________
Drugs	_________	__________
Coffee/Caffeine	_________	__________
Dairy	_________	__________
Exercise	_________	__________
Meditation	_________	__________
Sweets	_________	__________
Other	_________	__________

Please give an example of your typical breakfast, lunch, dinner and snacks:

Breakfast:____

Lunch:____

Dinner:____

Are there any foods/food groups you avoid? ____

What is your daily water intake?

☐ 2 glasses (16 oz)
☐ 4 glasses (32 oz)
☐ 8 glasses (64 oz)
☐ 10 glasses (80 oz)
☐ Other:___________________

Personal and Social History:

How many times per week do you eat at restaurants/ take-out/ prepared meals?

____

Are there any cultural/ religious/ other considerations that may impact your diet?

Yes ☐ No ☐ If yes, please explain:

____

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INFORMED CONSENT- Nutrition

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and any recommended nutritional treatment or procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after being informed of any benefits and risks involved. This document is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment. You are requested to sign document; informed consent documentation; permission to obtain sample (s) of blooddroplets from you to view for the screening test and any other nutritional treatment protocol.

If you refuse any special procedure this will not affect your receiving other care or future treatments in the Clinic.

- I voluntarily give permission Diana Jursa to obtain information on my diet and other weight/nutritional data to help with my nutrition.
- I understand the information gained from this screening test, is of a nutritional nature and is not for a medical diagnosis,treatment or specific disease prevention.
- I understand that the procedure(s) that I am undergoing are not currently offered in medical laboratories.
- The professional conducting these nutritional procedures is a Nutritionist and not a medical doctor.
- I understand that any suggested nutrition is not intended as a primary therapy for any disease or symptom.
- The results, if applicable, after the evaluation, I may be referred to a practitioner for further care.
- I understand that my verbal consent to a specific treatment and my willing participation in receiving these procedures after explanation of benefits and risks is sufficient to indicate my consent to receive treatment.
- I waive the option of signing consent to treat for each and every special procedure at each treatment date.
- I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time.
- I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time.
- I understand that there is payment for today's treatment, and subsequent follow-ups, at the time of service accordingly to the fee schedule.
- A Missed Appointment Fee of $50 will be charged for any missed appointments or cancellations later than 9:30am of the business day prior to your appointment. (A business day is defined as Monday to Friday, excluding holidays)
- I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition.
- I understand that a record will be kept of the health services provided to me and will be kept confidential.
  I will give written/verbal consent and authorization for continued treatment/procedure(s) for any other practitioner.
  I understand that at the event there is a chance that media, audio or visual or published information could happen,all of which I am consenting to use all concerned forms of social media.
  I authorize the practitioner, clinic to make contact for educational events, promotions, incentives, newsletters, engaging and informing of any health benefits.
  I certify that I have read this form or have had it read to me, and that I understand its content and meaning. I havesufficient information to give this informed consent.

Patient Name (please print): ______________________________

Patient Signature:______________________ Date: ______________________