KIANI Naturopathic Clinic

Core Link Wellness Centre
2238 Caroline St. Burlington, ON, L7R 1M6

Intake Form for Cancer Care – Susan J. Morton CNP, CPCC

Name: _____ Address: _____

Blood Type: (A) (B) (AB) (O) _____

Date of Cancer Diagnosis: _____ Type of Cancer: _____

Stage of Cancer: _____

Have you been diagnosed with any other condition/disease? _____

_____Date:_____

What is your current medical treatment? _____

Other areas of Interest you would like to receive additional information:

□ Contributing risk factors
□ Treatment Options
□ Lifestyle links to recovery
□ Pain Management
□ Psychological/emotional support (support groups)
□ Exercise and breathing techniques
□ Environmental links to recovery
□ Nutritional tools: juicers, blenders, water systems
□ Kitchen clean up (replacing what you currently use with organic, wholesome ingredients)

Is there any other information you would like that is not included above?
_____

Are you currently on a medical diet? _____ what is it?: _____

Do you know take vitamins or supplements? _____Occasionally? _____ Daily? _____

Have you had any physical or exercise restrictions placed on you by your doctor? _____

What are they? _____

Are you taking any of the following treatments:

Chemotherapy: _____ Name of drug: _____

Radiation: _____ Type: _____

Hormone therapy: _____ Type: _____

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Susan J. Morton, CNP, CPCC - Certified Nutritional Practitioner -Nutrition & Lifestyle Counselling Services
Email: smorton@kianind.com

Nutritional Client Statement

I hereby attest the following:

1. I fully understand that **Susan J. Morton** is not a Medical Doctor, and I am not here for medical, diagnostic, or treatment procedures.

2. The services performed by **Susan J. Morton** are at all times restricted to consultation on the subject of nutritional/lifestyle matters intended for the maintenance of the best possible state of nutritional health, and do not involve the diagnosing, prognosticating, or prescribing of remedies for the treatment of disease. I shall advise my doctor(s) of any dietary or lifestyle changes I make so they may supervise my care as they find necessary.

Mr. Miss Mrs. or Ms.,_____

Address_____

City_____

Province _____

Postal Code _____

Home Phone ( ) _____ - _____ Cell Phone ( ) _____ - _____

Work Phone ( ) _____ - _____

Email address: _____

Age _____ Birth Date _____

Privacy Policy:

I understand the importance of protecting your personal information. To help you understand how I do that, I have outlined below how I am using and disclosing your information:
Collection of Consultation Fees, emailing, newsletters, seminars & workshops, when consulting with your doctor, to suppliers when shipping directly to you.
I will only share your information with your consent. Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols.

Present Date: _____ Signed on _____/_____ 20____

Signature _____