

Lemmo Integrated Cancer Care Inc.

330 – 2025 West 42nd Avenue

Vancouver, BC V6M 2B5

TEL (604) 788–8858

FAX (604) 263–6381

LEMMO
Integrated Cancer Care

www.lemmo.com

General Information

NAME

TODAY'S DATE (MM/DD/YY)

HEALTH CARE NUMBER

REFERRED BY

BIRTH DATE (MM/DD/YY)

AGE

Contact Details

STREET

CITY

POSTAL CODE

TELEPHONE (HOME/BUSINESS/MOBILE)

EMAIL ADDRESS

WOULD YOU LIKE TO RECEIVE DR. LEMMO'S ONLINE NEWSLETTER VIA EMAIL? (PLEASE CIRCLE)

YES NO

Emergency Contact

NAME

RELATIONSHIP TO YOU

TELEPHONE (HOME/BUSINESS/MOBILE)

Lifestyle

OCCUPATION(S)

YEAR(S)

HOURS PER WEEK

EDUCATION (LAST GRADE OR DEGREE COMPLETED)

STATUS (PLEASE CIRCLE)

SINGLE

MARRIED

COMMON LAW

OTHER

SEXUALLY ACTIVE (PLEASE CIRCLE)

YES

NO

NUMBER OF CHILDREN

NUMBER OF SIBLINGS

Enrollment

REASON FOR VISIT

WHAT DO YOU EXPECT FROM THIS VISIT?

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ARE YOU WILLING TO MAKE LIFESTYLE AND DIET CHANGES? (PLEASE ELABORATE)

Medical History

SURGERIES (PLEASE INCLUDE APPENDIX, WISDOM TOOTH EXTRACTIONS, ETC.)

ACCIDENTS (MOTOR VEHICLE, TRAUMA, ETC.)

MEDICATIONS (LAST 24 MONTHS, INCLUDING ANTIHISTAMINES, ASPIRIN, TYLENOL, BCPS, ANTIBIOTICS, ZANTAC/TAGAMET)

SUPPLEMENTS (VITAMINS & MINERALS, HERBAL, HOMEOPATHICS, ETC.)

Family History

PLEASE SPECIFY TYPE AND RELATION OF FAMILY MEMBER TO YOU

CANCER

OBESITY

HEART DISEASE

ALCOHOLISM

DIABETES

MENTAL ILLNESS

ALLERGIES

DEPRESSION

STOMACH OR INTESTINAL COMPLAINTS

SEIZURES

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Medical Checkup History

FAMILY DOCTOR (NAME)

(PHONE NUMBER)

YOUR LAST GENERAL CHECKUP (MM/DD/YY)

DENTAL CHECKUP (MM/DD/YY)

EYE CHECKUP (MM/DD/YY)

HAVE YOU SEEN A NATUROPATHIC DOCTOR BEFORE? (PLEASE CIRCLE)

YES NO

IF YES, WHO?

Cancer History (if applicable)

ARE YOU UNDER THE CARE OF AN ONCOLOGIST? (PLEASE CIRCLE)

YES NO

HAVE YOU EVER RECEIVED TREATMENT FOR CANCER? (PLEASE CIRCLE)

YES NO

ARE YOU CURRENTLY RECEIVING TREATMENT? (I.E. CHEMOTHERAPY OR RADIATION) (PLEASE CIRCLE)

YES NO

IF NOT, WHEN WAS YOUR LAST TREATMENT? (MM/DD/YY)

Additional Medical Information

SERIOUS INFECTIONS (I.E. TB, MONO, PNEUMONIA, CHRONIC BRONCHITIS, ETC.)

ALLERGIES

HAVE YOU HAD LONG VISITS OR LIVED IN A FOREIGN COUNTRY? (PLEASE CIRCLE)

YES NO

IF YES, WHICH COUNTRY, AND HOW LONG AGO?

DO YOU USE... (PLEASE CIRCLE)

CIGARETTES?

COFFEE?

ALCOHOL?

RECREATIONAL DRUG(S)?

HOW DO YOU FEEL AFTER DRINKING COFFEE? (PLEASE CIRCLE)

NO EFFECT

RACING HEARTBEAT

HANDS SHAKE

LIGHT-HEADED FEELING

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Additional Medical Information (continued)

TIME YOU RETIRE (SLEEP) **TIME YOU WAKE-UP**

DO YOU HAVE PROBLEMS... (PLEASE CIRCLE) **GETTING TO SLEEP?** YES NO **STAYING ASLEEP?** YES NO

DO YOU REMEMBER NIGHTLY DREAMS? (PLEASE CIRCLE) YES NO

YOUR BLOOD TYPE

EXERCISE (HOURS PER WEEK) (PLEASE CIRCLE) 1 2 3 > 3 HOURS PER WEEK

WEIGHT: HAVE YOU EXPERIENCED CHANGES IN WEIGHT (INCREASE/DECREASE) DURING THE PAST 6 MONTHS?
(PLEASE CIRCLE) YES NO IF YES, BY ABOUT HOW MUCH?

HOW IS YOUR APPETITE?

HAVE YOU EXPERIENCED ANY RECENT NAUSEA OR VOMITING? YES NO

DO YOU SUFFER FROM PAIN? (PLEASE CIRCLE) YES NO
IF YES, PLEASE BRIEFLY DESCRIBE

HAVE YOU HAD ANY FEVERS OF NIGHT SWEATS DURING THE PAST WEEK? (PLEASE CIRCLE) YES NO

HOW DO YOUR BOWELS CURRENTLY WORK? (PLEASE CIRCLE)
REGULAR DIARRHEA PRONE CONSTIPATION PRONE BOTH
OTHER (PLEASE SPECIFY)

DOES GOING TO THE BATHROOM INTERFERE WITH YOUR SLEEP? (PLEASE ELABORATE)

ARE YOU CURRENTLY TAKING ANY PAIN KILLERS (PLEASE ELABORATE)

HOW MUCH WATER DO YOU DRINK PER DAY? (PLEASE ELABORATE)

How would you generally rate the occurrence of colds and flus that you have received throughout the years? Please circle all that applies to you. If you have been diagnosed with cancer, please rate the occurrence before your diagnosis.

- | | |
|-----------------------------|----------------------------|
| ALMOST NEVER | IT'S HARD FOR ME TO GET IT |
| THE TYPICAL 1-2 PER YEAR | LESS THAN 6 PER YEAR |
| MORE THAN 6 PER YEAR | ALWAYS SICK |
| OTHER (PLEASE EXPLAIN HERE) | |

How often do you receive the flu shot? Please circle all that applies to you.

- | | | | |
|--------------------|--------|-------|-------------------|
| NEVER | RARELY | OFTEN | ALMOST EVERY YEAR |
| (PLEASE ELABORATE) | | | |

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FINANCIAL POLICY

Updated August 2009

Dr. Walter Lemmo, ND is a licensed naturopathic physician registered with the College of Naturopathic Physicians of British Columbia. He provides his services through Lemmo Integrated Cancer Care Inc., a legal entity incorporated in the Province of British Columbia.

Consultations

First consultation (about 60 minutes):	\$ 150
Follow-up consultations (about 30 to 60 minutes):	\$ 100 per consultation
Phone consultation (about 60 minutes):	\$ 200 per consultation
Home visit:	\$ 470 per home visit

Extended Health Plans

Extended health insurance, where applicable, may cover all or a portion for the fees. At the end of each visit, you will be given a sales receipt to submit to your extended health insurance carrier. Most extended health insurance plans offered by large corporations will have some coverage for naturopathic services. Please check with your particular carrier for its policies on coverage.

Other Costs

All **tests, treatments** and **remedies** are **not** covered by MSP (costs will vary). A **24-hour notice** is required for cancellations or you will be billed \$30.00 for each missed visit. **NSF Cheques** are charged at \$20.00 as a processing fee charged for each NSF cheque. The clinic reserves the right to change fees at any time. Please contact the clinic directly by phone or email to receive the latest information.

Research

There may be noteworthy findings, treatment results or outcomes that occur under the supervision of Dr. Lemmo, which could benefit future patients and the scientific research community if they are made aware. By being a patient of Dr. Lemmo, you are asked to provide consent for Dr. Lemmo to potentially use certain aspects of your medical data for scientific research and the potential publication of such research. **In any event, your personal information, such as your name, address, and telephone number, would be kept strictly confidential as part of standard medical research guidelines.**

By signing the bottom of this policy, you are indicating that you have read and understood the above statements and agree to pay upon receiving the products and services as outlined.

PATIENT'S FULL NAME

SIGNATURE

DATE SIGNED (MM/DD/YY)

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Dr. Walter Lemmo, ND

MSP Billing No. 30179

RECORDS RELEASE FORM

TO (PHYSICIAN OR MEDICAL CENTRE)

Could you please release the records of patient (print name) _____ to the above address or fax number of Dr. Lemmo.

Patient Information

FULL NAME

DATE OF BIRTH (MM/DD/YY)

PERSONAL HEALTH NUMBER (PHN)

Request

COMPLETE RECORDS	YES	NO	
RECENT RECORDS	YES	NO	DURING THE LAST (PLEASE CIRCLE) 1, 2, 3, 4, 5, 6 MONTHS
WBC/ICBC REPORTS	YES	NO	
X-RAY/ULTRASOUND	YES	NO	
MRI/CT-SCAN/PET-SCAN	YES	NO	
LABORATORY	YES	NO	
OTHER	YES	NO	PLEASE SPECIFY

Notes

PATIENT SIGNATURE

PHYSICIAN SIGNATURE

DATE SIGNED (MM/DD/YY)

DATE SIGNED (MM/DD/YY)