

Patient intake

Complete all applicable sections. Save a copy before sending it to the clinic.

This packet combines the current online intake questions, the downloadable intake packet, and an optional records-release request. Fill it in your browser or PDF reader, then use Save or Download to keep a copy. Submit the saved PDF with any reports or other files through the clinic's approved intake channel.

GENERAL INFORMATION

FIRST NAME *

LAST NAME *

TODAY'S DATE (MM/DD/YYYY) *

BIRTH DATE (MM/DD/YYYY) *

HEALTH CARE NUMBER *

AGE *

GENDER

REFERRED BY *

CONTACT DETAILS

STREET ADDRESS *

UNIT / ADDRESS LINE 2

CITY *

PROVINCE / REGION *

POSTAL CODE *

PHONE *

EMAIL *

Your background

Tell us about your daily life and the reason for your visit.

EMERGENCY CONTACT

FIRST NAME *

LAST NAME *

RELATIONSHIP *

PHONE *

LIFESTYLE

OCCUPATION(S)

YEARS

HOURS / WEEK

EDUCATION - LAST DEGREE COMPLETED

Select one

- ☐ High school ☐ Bachelor's ☐ Master's ☐ Doctorate

STATUS

Select one

- ☐ Single ☐ Married ☐ Common law ☐ Other

NUMBER OF CHILDREN

NUMBER OF SIBLINGS

ELECTRONIC COMMUNICATION PREFERENCES

These choices are optional and separate. You may change or withdraw your consent by contacting the clinic. Please do not send sensitive medical details by email or text message.

MAY LEMMO CONTACT YOU BY EMAIL ABOUT APPOINTMENTS AND YOUR CARE?

Select one

- ☐ Yes ☐ No

MAY LEMMO CONTACT YOU BY SMS / TEXT MESSAGE ABOUT APPOINTMENTS AND YOUR CARE?

Select one

- ☐ Yes ☐ No

Reason for visit

Please describe your goals and relevant medical history.

ENROLMENT

REASON FOR YOUR VISIT *

WHAT DO YOU EXPECT FROM THIS VISIT? *

MEDICAL HISTORY

SURGERIES - INCLUDE APPENDIX, WISDOM TOOTH EXTRACTIONS, ETC. *

ACCIDENTS - MOTOR VEHICLE, TRAUMA, ETC. *

OTHER MEDICAL CONDITIONS

Medical history

Include names, doses and dates where you know them.

TREATMENTS AND MEDICINES

CURRENT MEDICATIONS *

CURRENT SUPPLEMENTS *

FAMILY HISTORY

MY FAMILY HAS A HISTORY OF... *

Select all that apply

- ☐ Cancer ☐ Heart disease ☐ Diabetes ☐ Allergies ☐ Stomach / intestinal ☐ Obesity
☐ Alcoholism ☐ Mental illness ☐ Depression ☐ Seizures ☐ None

SPECIFY CONDITION AND YOUR RELATIONSHIP TO THE FAMILY MEMBER

Care history

Your usual care team, cancer treatment and other conditions.

MEDICAL CHECKUP HISTORY

FAMILY DOCTOR FIRST NAME

LAST NAME

FAMILY DOCTOR PHONE

LAST GENERAL CHECKUP DATE

LAST DENTAL CHECKUP DATE

LAST EYE CHECKUP DATE

HAVE YOU SEEN A NATUROPATHIC DOCTOR BEFORE?

Select one

☐ Yes ☐ No

IF YES, NAME OF NATUROPATHIC DOCTOR

ONCOLOGY CARE

ARE YOU CURRENTLY UNDER THE CARE OF AN ONCOLOGIST? *

Select one

☐ Yes ☐ No

ONCOLOGIST FIRST NAME

LAST NAME

HAVE YOU EVER RECEIVED TREATMENT FOR CANCER? *

Select one

☐ Yes ☐ No

CURRENTLY RECEIVING CHEMOTHERAPY, RADIATION OR IMMUNOTHERAPY? *

Select one

☐ Yes ☐ No

IF APPLICABLE, DATE OF LAST TREATMENT

Additional medical information

Complete any questions that apply to you.

ADDITIONAL MEDICAL INFORMATION

SERIOUS INFECTIONS - TB, MONO, PNEUMONIA, CHRONIC BRONCHITIS, ETC.

ALLERGIES

HAVE YOU HAD LONG VISITS OR LIVED IN ANOTHER COUNTRY?

Select one

☐ Yes ☐ No

IF YES, WHICH COUNTRY AND HOW LONG AGO?

DO YOU USE...

Select all that apply

☐ Cigarettes ☐ Coffee ☐ Alcohol ☐ Recreational drugs

HOW DO YOU FEEL AFTER COFFEE?

Select all that apply

☐ No effect ☐ Racing heartbeat ☐ Hands shake ☐ Light-headed

Wellbeing

Your answers help us understand your current symptoms and routines.

SLEEP AND ACTIVITY

TIME YOU GO TO SLEEP

TIME YOU WAKE UP

DO YOU HAVE DIFFICULTY WITH SLEEP? *

Select one

- ☐ No ☐ Getting to sleep ☐ Staying asleep ☐ Both

DO YOU REMEMBER NIGHTLY DREAMS?

Select one

- ☐ Yes ☐ No

BLOOD TYPE (IF KNOWN)

EXERCISE HOURS PER WEEK *

SYMPTOMS

CHANGES IN WEIGHT DURING THE PAST 6 MONTHS? *

Select one

- ☐ Yes ☐ No

IF YES, ABOUT HOW MUCH?

HOW IS YOUR APPETITE?

HAVE YOU EXPERIENCED NAUSEA OR VOMITING? *

Select one

- ☐ Yes ☐ No

DO YOU SUFFER FROM PAIN? *

Select one

- ☐ Yes ☐ No

IF YES, BRIEFLY DESCRIBE YOUR PAIN

FEVERS OR NIGHT SWEATS DURING THE PAST WEEK? *

Select one

- ☐ Yes ☐ No

More about your health

Complete any details that apply to you.

DAILY HEALTH

HOW DO YOUR BOWELS CURRENTLY WORK? *

Select one

- ☐ Regular ☐ Diarrhea prone ☐ Constipation prone ☐ Both ☐ Other

IF OTHER, PLEASE SPECIFY

DO BATHROOM VISITS INTERRUPT YOUR SLEEP? PLEASE EXPLAIN.

ARE YOU CURRENTLY TAKING PAINKILLERS? PLEASE EXPLAIN.

HOW MUCH WATER DO YOU DRINK PER DAY?

HOW OFTEN HAVE YOU HAD COLDS OR FLU? *

Select all that apply

- ☐ Almost never ☐ Typical 1-2/year ☐ Less than 6/year ☐ More than 6/year
☐ Hard for me to get it ☐ Always sick ☐ Other

If you have been diagnosed with cancer, answer the colds-or-flu question for the time before your diagnosis.

IF OTHER, PLEASE EXPLAIN

HOW OFTEN DO YOU RECEIVE THE FLU SHOT? *

Select one

- ☐ Almost every year ☐ Often ☐ Rarely ☐ Never

HAVE YOU RECEIVED THE COVID-19 VACCINE?

Select one

- ☐ Yes ☐ No

Practice information

Read this statement and complete the acknowledgment below.

IMPORTANT INFORMATION ABOUT DR. LEMMO'S PRACTICE

Dr. Walter Lemmo is a licensed naturopathic physician (ND) with over 25 years of experience in integrative cancer care. Because our approach integrates experience-guided and evidence-informed naturopathic therapies with conventional cancer treatments, some members of the standard oncology community may have differing opinions or may not support all of Dr. Lemmo's recommendations.

We respect that there are many perspectives in cancer care. Our goal is not to create conflict or debate, but to support you in making informed choices that feel right for your situation. Dr. Lemmo encourages every patient to trust their own intuition and to choose the path that brings them the greatest sense of comfort and the least amount of fear and stress.

Collaboration with Your Oncology Team

Dr. Lemmo is always available to speak directly with any member of your healthcare team (oncologist, haematologist, nurse, pharmacist, nurse practitioner, medical doctor, naturopathic physician, etc.) if questions or concerns arise. Please have your team contact the office by telephone at the earliest opportunity. Email, social media, or mailed letters are not suitable for urgent clinical discussions.

By signing below, you confirm that you have read and understood this information.

I HAVE READ AND UNDERSTOOD THIS STATEMENT *

Check to acknowledge

☐ Yes

PATIENT'S FULL NAME *

SIGNATURE - TYPE FULL NAME *

DATE SIGNED *

Type your full legal name to sign this acknowledgment electronically, then save the completed PDF.

Financial policy

Updated July 2026. Please read and complete the separate choices and signature.

SERVICES AND FEES

All services are provided by Dr. Walter Lemmo, ND, and Lemmo Integrated Cancer Care Inc. in the Province of British Columbia, Canada. Dr. Lemmo is licensed by the College of Complementary Health Professionals of British Columbia (CCHPBC).

Governing Law: This agreement and all aspects of care are governed by the laws of British Columbia and Canada.

Consultations: First consultation (about 60 minutes): \$350. Follow-up consultations (about 30 to 60 minutes): \$225. Brief consultations: \$150.

Extended Health Plans: Extended health insurance, where applicable, may cover all or a portion of the fees. 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 \$50.00 as a processing fee 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 CONSENT

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 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 identification and contact information, would be kept strictly confidential as part of standard medical research guidelines.

I CONSENT TO PARTICIPATING IN RESEARCH *

Select one

☐ Yes ☐ No

By signing below, you indicate that you have read and understood this financial policy and agree to pay for the products and services outlined.

SIGNATURE - TYPE FULL NAME *

DATE SIGNED *

Records release request

Optional. Complete this page if Dr. Lemmo should request records on your behalf.

REQUEST DESTINATION

TO - PHYSICIAN OR MEDICAL CENTRE

Could you please release the records of the patient named below to Dr. Walter Lemmo, ND, at the address or fax number in this letterhead?

PATIENT INFORMATION

PATIENT FULL NAME

DATE OF BIRTH

PERSONAL HEALTH NUMBER

RECORDS REQUESTED

REQUEST

Select all that apply

- ☐ Complete records ☐ Recent records ☐ WCB / ICBC reports ☐ X-ray / ultrasound
☐ MRI / CT / PET scans ☐ Laboratory ☐ Other

RECENT RECORDS - LAST HOW MANY MONTHS?

OTHER - SPECIFY

NOTES

PATIENT SIGNATURE - TYPE FULL NAME

DATE SIGNED

PHYSICIAN SIGNATURE (IF REQUIRED)

DATE SIGNED