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www.effectivehealth.ca

Core Detoxification Intake Form

Name: _____
(First) (Initial) (Last)

Address: _____
(Street)

(City) (Province) (Postal Code)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____ Male Female
(Month/Day/Year)

How did you find out about our clinic? _____

If referred, please include name of referee: _____

Would you like to receive the clinic e-mail newsletter? Yes No

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Please list any allergies: _____

Consent for Liability of Cost

I hereby acknowledge and understand my liability of any costs incurred by myself at this office.

Consent for Treatment

I hereby authorize and grant permission to the technician at Effective Health Solutions to perform the Core Detoxification procedure as explained to me.

I acknowledge that this form has been explained to me and that I fully understand the contents of this form and its implications.

Patient's Name: _____

Patient's Signature: X _____ **Date:** _____