



YOUR HEALTH

Wellness Centre
200-1158 Winston Churchill Blvd
Oakville, ON L6J 0A3

Naturopathic Intake - Adult

Patient Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B) _____ (M) _____

Email: _____ (to receive appointment reminders)

Add me to the email newsletter (Our newsletter covers events at the clinic and highlights informative articles written by our therapists. You can unsubscribe from the newsletter at any time.)

Occupation: _____ How did you find out about us? _____

Emergency Contact: (Name) _____ (Relationship) _____ (Phone number) _____

Fee Schedule

Initial Assessment: \$160

45 minute follow-up: \$95

30 minute follow-up: \$80

TCM Acupuncture: \$65

Please Note: Nutraceuticals Prescribed by the ND are not included in the fee schedule and are the patient's responsibility to purchase. There is an onsite dispensary where most Nutraceuticals prescribed will be available. However you are in no way obligated to purchase them at the clinic and can go to your local health store to get them.

Payment is due at the time services are rendered. For your convenience, we accept cash, cheque, debit, Visa and Mastercard. This policy applies to all of our patients. We understand that unusual circumstances may arise and that payment in full at the time of service may not always be possible. Special payment needs should be discussed by the patient and a member of the business department. Payment plans are subject to approval by the administrator and your therapist. In such cases, you will receive a monthly statement showing all charges and payments. If you have not made payment in full, or made full financial arrangements with our office, your account will be reviewed for collection. If payment is not made on a bill from our office within forty-five (45) days after the date of the bill, interest may be charged to you on the balance of such bill commencing on the forty-fifth (45) day after the date of the bill. The interest rate will be eighteen percent (18%) per annum. Patients having health care coverage should remember that professional services provided are the patient's responsibility, not the insurance company. Our office does not file insurance claims for you; however, we would be happy to help you find the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

We require 24 hours notice if you are unable to make your scheduled appointment. After an initial warning, appointments cancelled with less than 24 hours notice will be charged in full, unless the appointment is rescheduled within 48 hours.

If you have any further questions regarding insurance, be certain to bring in your insurance book so we can determine your coverage and avoid confusion. We want your experience with YOUR HEALTH to be a pleasant one and we hope this information will help to make it so.

I have read the YOUR HEALTH Wellness Centre financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy. **I AGREE** to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as other applicable fees.

Patient Signature: _____

Date: _____



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Privacy Policy

Privacy of personal information is important to YOUR HEALTH. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be an open and transparent as to how we handle personal information.

Personal Information

Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender, and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and privacy protection protocols. Privacy protocols comply with the privacy legislation, standards of our regulatory body, The Board of Directors of Drugless Practitioners – Naturopathy (BDDT-N).

Staff Members

Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under The Board of Directors of Drugless Practitioners – Naturopathy (BDDT-N) Act
- To process payments and collect unpaid accounts
- For research purposes

Please do not hesitate to discuss our privacy policy with any member of our clinic staff.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent

I have reviewed the above information that explains how our clinic will use my personal information.

I agree that Your Health Wellness Centre can collect, use, and disclose my personal information as set out above in The Board of Directors of Drugless Practitioners – Naturopathy (BDDT-N) privacy code.

(Signature)

(Print name)

(Date)

(Signature of Witness)



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Are you currently receiving healthcare? If yes, where and from whom?

Medical Doctor? _____ Phone: _____

Previous Naturopathic care? _____ Phone: _____

Chiropractic Care? _____ Phone: _____

Other Practitioner? _____ Phone: _____

Other Practitioner? _____ Phone: _____

What are your health concerns, in order of importance to you:

State your main reason for your visit today.

1. _____
2. _____
3. _____
4. _____
5. _____

If you are female are you currently pregnant? Yes No

Medical History

How would you describe your general state of health? **Excellent** **Good** **Fair** **Poor**

What was your general state of health as a child? **Excellent** **Good** **Fair** **Poor**

Childhood Illnesses: (Please check)

- | | | |
|---|---|--|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Mono | <input type="checkbox"/> Diptheria |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Impetigo |
| <input type="checkbox"/> German measles | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> other _____ | |

Please indicate any serious conditions, illnesses (including psychiatric conditions) or injuries and any hospitalizations, along with approximate dates.



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Do you have any allergies or sensitivities (medicines, environmental, food etc.)? Please list substance with reaction:

Please list all medications (prescription, over the counter) and natural products (vitamins, minerals, herbs, homeopathics) you are currently taking:

Medication/Natural Product (please indicate brand)	Dose/quantity per day	Why are you taking this product?

List past medications and why they were prescribed:

Approximately how many times have you been treated with antibiotics? _____

List any X-rays, MRI/CT scans, blood work, screening tests or other studies that you have had in the past year.

What Immunizations have you had?

- | | | |
|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Flu shot |
| <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Polio |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> other _____ | |

Please indicate any adverse reactions you have experienced from an immunization:

Social history:

How much alcohol do you drink per day/week + what type? _____

Do you smoke? Y/N _____

If yes, when did you start? _____



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How many cigarettes do you smoke per day/week? _____

If you previously smoked, when did you quit? _____

How much caffeine do you drink per day/week (coffee, black tea, pop)? _____

Do you take any recreational drugs? What kind and how often? _____

Environment/Lifestyle

Occupation _____

Main Interests and Hobbies _____

Do you exercise regularly? Y N What do you do for exercise, how much, how often?

Are you exposed to significant tobacco smoke (work, home, etc.)? Y N

Are you frequently exposed to animals (work, pets, etc.)? Y N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

How would you describe the emotional climate of your home?

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Do you have any dietary restrictions (religious, vegetarian etc)?

Please specify: _____

Family History:

	Age	Health concerns (i.e high blood pressure, cancer, diabetes etc)	Cause of death if deceased	Age at death
Mother				
Father				
Sisters				
Brothers				
Children				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Review of Systems: For the following, check **Y** for yes or **P** for in the past

GENERAL

Poor sleep	<input type="checkbox"/> Y <input type="checkbox"/> P	Night sweats	<input type="checkbox"/> Y <input type="checkbox"/> P	Bleed/bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> P
Weight gain	<input type="checkbox"/> Y <input type="checkbox"/> P	Cravings	<input type="checkbox"/> Y <input type="checkbox"/> P	Loss/change in taste	<input type="checkbox"/> Y <input type="checkbox"/> P
Weight loss	<input type="checkbox"/> Y <input type="checkbox"/> P	Change in thirst	<input type="checkbox"/> Y <input type="checkbox"/> P	Loss/change in smell	<input type="checkbox"/> Y <input type="checkbox"/> P
Fatigue/weakness	<input type="checkbox"/> Y <input type="checkbox"/> P	Change in appetite	<input type="checkbox"/> Y <input type="checkbox"/> P	Excess sweating	<input type="checkbox"/> Y <input type="checkbox"/> P
Fever/chills	<input type="checkbox"/> Y <input type="checkbox"/> P	Low energy	<input type="checkbox"/> Y <input type="checkbox"/> P	Decreased sweating	<input type="checkbox"/> Y <input type="checkbox"/> P

SKIN HAIR AND NAILS

Rashes	<input type="checkbox"/> Y <input type="checkbox"/> P	Acne/boils	<input type="checkbox"/> Y <input type="checkbox"/> P	Itching	<input type="checkbox"/> Y <input type="checkbox"/> P
Eczema	<input type="checkbox"/> Y <input type="checkbox"/> P	Colour change	<input type="checkbox"/> Y <input type="checkbox"/> P	Lumps	<input type="checkbox"/> Y <input type="checkbox"/> P
Dry skin	<input type="checkbox"/> Y <input type="checkbox"/> P	Nail changes	<input type="checkbox"/> Y <input type="checkbox"/> P	Change in texture	<input type="checkbox"/> Y <input type="checkbox"/> P
Loss of hair	<input type="checkbox"/> Y <input type="checkbox"/> P	Change in moles	<input type="checkbox"/> Y <input type="checkbox"/> P	Skin cancer	<input type="checkbox"/> Y <input type="checkbox"/> P

RESPIRATORY

Cough	<input type="checkbox"/> Y <input type="checkbox"/> P	Bronchitis	<input type="checkbox"/> Y <input type="checkbox"/> P	Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> P
Phlegm/sputum	<input type="checkbox"/> Y <input type="checkbox"/> P	Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> P	Tuberculosis	<input type="checkbox"/> Y <input type="checkbox"/> P
Coughing blood	<input type="checkbox"/> Y <input type="checkbox"/> P	Difficulty breathing	<input type="checkbox"/> Y <input type="checkbox"/> P	Asthma	<input type="checkbox"/> Y <input type="checkbox"/> P
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> P	Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> P		

HEAD AND NECK

Headaches	<input type="checkbox"/> Y <input type="checkbox"/> P	Ringing in ears	<input type="checkbox"/> Y <input type="checkbox"/> P	Nose bleeds	<input type="checkbox"/> Y <input type="checkbox"/> P
Head injury	<input type="checkbox"/> Y <input type="checkbox"/> P	Impaired vision	<input type="checkbox"/> Y <input type="checkbox"/> P	Hay fever	<input type="checkbox"/> Y <input type="checkbox"/> P
Dizziness	<input type="checkbox"/> Y <input type="checkbox"/> P	Color/Night blindness	<input type="checkbox"/> Y <input type="checkbox"/> P	Facial pain	<input type="checkbox"/> Y <input type="checkbox"/> P
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> P	Discharge	<input type="checkbox"/> Y <input type="checkbox"/> P	Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> P
Goiter	<input type="checkbox"/> Y <input type="checkbox"/> P	Eye pain	<input type="checkbox"/> Y <input type="checkbox"/> P	Recurrent sore throat	<input type="checkbox"/> Y <input type="checkbox"/> P
Pain/stiffness	<input type="checkbox"/> Y <input type="checkbox"/> P	Tearing/dryness	<input type="checkbox"/> Y <input type="checkbox"/> P	Tooth pain	<input type="checkbox"/> Y <input type="checkbox"/> P
Ear infections	<input type="checkbox"/> Y <input type="checkbox"/> P	Blurry vision	<input type="checkbox"/> Y <input type="checkbox"/> P	Mercury fillings	<input type="checkbox"/> Y <input type="checkbox"/> P
Impaired hearing	<input type="checkbox"/> Y <input type="checkbox"/> P	Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> P	Jaw clicks/pain	<input type="checkbox"/> Y <input type="checkbox"/> P
Ear ache	<input type="checkbox"/> Y <input type="checkbox"/> P	Itching/redness	<input type="checkbox"/> Y <input type="checkbox"/> P	Tongue/mouth sores	<input type="checkbox"/> Y <input type="checkbox"/> P

CARDIOVASCULAR AND CIRCULATION

High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> P	Angina	<input type="checkbox"/> Y <input type="checkbox"/> P	Cold hands or feet	<input type="checkbox"/> Y <input type="checkbox"/> P
High Cholesterol	<input type="checkbox"/> Y <input type="checkbox"/> P	Irregular heartbeat	<input type="checkbox"/> Y <input type="checkbox"/> P	Swelling of feet/hands	<input type="checkbox"/> Y <input type="checkbox"/> P
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> P	Varicose veins	<input type="checkbox"/> Y <input type="checkbox"/> P	Numbness/tingling	<input type="checkbox"/> Y <input type="checkbox"/> P
Chest pain during exercise	<input type="checkbox"/> Y <input type="checkbox"/> P	Blood clots	<input type="checkbox"/> Y <input type="checkbox"/> P	Leg cramps	<input type="checkbox"/> Y <input type="checkbox"/> P
		Murmurs	<input type="checkbox"/> Y <input type="checkbox"/> P	Heaviness/Pain in legs	<input type="checkbox"/> Y <input type="checkbox"/> P

GASTROINTESTINAL

Trouble swallowing	<input type="checkbox"/> Y <input type="checkbox"/> P	Nausea	<input type="checkbox"/> Y <input type="checkbox"/> P	Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> P
Heart burn	<input type="checkbox"/> Y <input type="checkbox"/> P	Bloating	<input type="checkbox"/> Y <input type="checkbox"/> P	Constipation	<input type="checkbox"/> Y <input type="checkbox"/> P
Gas	<input type="checkbox"/> Y <input type="checkbox"/> P	Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> P	Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> P
Abominal pain	<input type="checkbox"/> Y <input type="checkbox"/> P	Undigested food in stool	<input type="checkbox"/> Y <input type="checkbox"/> P	Ulcers	<input type="checkbox"/> Y <input type="checkbox"/> P
Blood in stool	<input type="checkbox"/> Y <input type="checkbox"/> P	Mucous in stool	<input type="checkbox"/> Y <input type="checkbox"/> P	Chronic laxative use	<input type="checkbox"/> Y <input type="checkbox"/> P

How often do you have a bowel movement per/day? _____

ENDOCRINE

Generally feel hot	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Hypoglycemia (low blood sugar)	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Hypothyroid	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Generally feel cold	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Excessive thirst	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Hyperthyroid	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Excessive hunger	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N				

GENITO-URINARY

Pain on urination	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Frequent infections	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Sores on genitals	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Increased frequency	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Sexually transmitted infection (STI)	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Inability to hold urine	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Hesitancy	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N		
Blood in urine	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Urgency	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N		

WOMEN'S HEALTH

Age of first menses _____	Blood clots	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Difficulty conceiving	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Duration of menses _____	Bleeding between cycles	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Vaginal itching	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Length of cycle _____	Vaginal discharge	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Sexually active	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Date of last PAP exam _____	Birth control	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Pain during Intercourse	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Abnormal PAP	Type _____		STI	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Cervical Dysplasia	# of pregnancies _____		Sexual difficulties	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Irregular periods	# of live births _____		Breast lumps	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Painful menses	# of miscarriages _____		Nipple discharge	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Excessive flow	# of abortions _____		Breast pain	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
PMS				

MEN'S HEALTH

Hernias	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Sexually active	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Low sex drive	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Testicular pain	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Erectile difficulties	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Discharge or sores	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Testicular masses	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Ejaculatory problems	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Prostate disease	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N

MUSCULOSKELETAL

Joint pain/stiffness	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Broken bones	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Muscle spasms/cramps	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Joint swelling	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Back ache	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Weakness	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N				

NEUROLOGICAL & EMOTIONAL

Fainting	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Involuntary movement	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Seizures	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Loss of balance	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Loss of memory	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Concussion	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Irritability	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Poor concentration	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Panic attacks	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N
Mental illness	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N	Phobias	<input type="checkbox"/> Y <input type="checkbox"/> P <input type="checkbox"/> N		

Thank you for answering all the questions.

Complete answers to all of the questions are to your benefit for the most effective naturopathic treatment.

This is a confidential record of your medical history. Information contained here will not be released to any person except when you have authorized us to do so.

Informed Consent to Naturopathic Treatment

Naturopathic medicine is the treatment and prevention of diseases and disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used to stimulate the body's inherent healing capacity. A variety of treatment modalities may be used.

Traditional Chinese Medicine (TCM)

TCM includes acupuncture, as well as, the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of disposable, sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes moxa (a compressed herb), cupping therapy, or *guasha* is used over the skin at or near specific points on the body in order to stimulate the body's energy. Botanical formulas may be given in the form of pills, tinctures, herbal extract powders, or decoctions (strong teas) to be taken internally or used externally as a wash, poultice, salve, or fomentation.

Diet and Nutrition

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.

Botanical Medicine

Botanical Medicine is a plant-based medicine using herbal teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. These compounds are also used to boost the body's immune system and prevent disease.

Homeopathic Medicine

Homeopathy, developed in the 1700's, is based on the principle of "like cures like." A remedy is selected, which in its crude form would produce in a healthy individual the same symptoms found in a sick person suffering from the specific disease. Minute amounts of natural substances (plant, animal, mineral) are used to stimulate the body's innate ability to heal, as the aim is to change the body's energy levels that lie at the root of disease. Homeopathy is a powerful tool and effects healing on a physical and emotional level.

Physical Medicine

This includes the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation, therapeutic ultrasound, or heating lamps for the purpose of treating musculoskeletal and neurological problems. Hydrotherapy refers to the use of hot and cold- water applications to improve circulation and stimulate the immune system.

As Naturopathic Medicine is a holistic approach to health, lifestyle is considered relevant to most health problems. Your naturopathic doctor will help you identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment.

Your naturopathic doctor will take a thorough case history, do a screening physical examination and urine samples if necessary. If your case requires, the physical may include more specific examinations such as gynecological, breast, rectal, prostate or genital exams.



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Declaration and Consent to Treatment

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform your naturopath immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- Any existing nutritional supplements, herbs, or health food products
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, or injury from venipuncture, acupuncture or cupping
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa or cupping
- Muscle strains and sprains, disc injuries from spinal manipulation.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my naturopathic doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below):

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedure's at any time.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

I. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future from another licensed health care provider.

II. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

III. No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider.

IV. The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive at YOUR HEALTH Wellness Center and hereby authorize and consent to treatment.

Dated this _____ day of _____, 20____

Patient Name: (print) _____ (Signature) _____

Naturopathic Doctor: (print) _____ (Signature) _____