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)

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

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

Fee Schedule

Initial Assessment: $175 **45 minute follow-up:** $113 **30 minute follow-up:** $95 **Acupuncture:** $75

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 on 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 there is a charge of $20.00 for a second missed appointment. All subsequent missed appointments will then be billed at the regular fee.

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 College of Naturopaths - Ontario

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 College of Naturopaths - Ontario
- 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 College of Naturopaths - Ontario 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)

□ Chicken pox
□ Measles
□ German measles
□ Mumps
□ Mono
□ Whooping cough
□ Strep throat
□ other_____
□ Diptheria
□ Impetigo
□ Scarlet fever

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

_____

_____

_____

_____

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

_____

_____

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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?

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Haemophilus influenza B
- ☐ MMR (measles, mumps, rubella)
- ☐ Chicken pox
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ other_____
- ☐ Flu shot
- ☐ Polio
- ☐ Smallpox

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

_____

_____

<u>Social history:</u>

How much alcohol do you drink per day/week + what type? _____
Do you smoke? Y/N _____
If yes, when did you start? _____
How many cigarettes do you smoke per day/week? _____
If you previosuly 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? _____

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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 specifiy:_____

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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	□**Y** □**P**	Night sweats	□**Y** □**P**	Bleed/bruise easily	□**Y** □**P**
Weight gain	□**Y** □**P**	Cravings	□**Y** □**P**	Loss/change in taste	□**Y** □**P**
Weight loss	□**Y** □**P**	Change in thirst	□**Y** □**P**	Loss/change in smell	□**Y** □**P**
Fatigue/weakness	□**Y** □**P**	Change in appetite	□**Y** □**P**	Excess sweating	□**Y** □**P**
Fever/chills	□**Y** □**P**	Low energy	□**Y** □**P**	Decreased sweating	□**Y** □**P**

SKIN HAIR AND NAILS

Rashes	□**Y** □**P**	Acne/boils	□**Y** □**P**	Itching	□**Y** □**P**
Eczema	□**Y** □**P**	Colour change	□**Y** □**P**	Lumps	□**Y** □**P**
Dry skin	□**Y** □**P**	Nail changes	□**Y** □**P**	Change in texture	□**Y** □**P**
Loss of hair	□**Y** □**P**	Change in moles	□**Y** □**P**	Skin cancer	□**Y** □**P**

RESPIRATORY

Cough	□**Y** □**P**	Bronchitis	□**Y** □**P**	Shortness of breath	□**Y** □**P**
Phlegm/sputum	□**Y** □**P**	Pneumonia	□**Y** □**P**	Tuberculosis	□**Y** □**P**
Coughing blood	□**Y** □**P**	Difficulty breathing	□**Y** □**P**	Asthma	□**Y** □**P**
Wheezing	□**Y** □**P**	Emphysema	□**Y** □**P**		

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HEAD AND NECK

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

CARDIOVASCULAR AND CIRCULATION

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

GASTROINTESTINAL

Trouble swallowing	□Y □P	Nausea	□Y □P	Vomiting	□Y □P
Heart burn	□Y □P	Bloating	□Y □P	Constipation	□Y □P
Gas	□Y □P	Hemorrhoids	□Y □P	Diarrhea	□Y □P
Abominal pain	□Y □P	Undigested food in stool	□Y □P	Ulcers	□Y □P
Blood in stool	□Y □P	Mucous in stool	□Y □P	Chronic laxative use	□Y □P

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

ENDOCRINE

Generally feel hot	□Y □P	Hypoglycemia (low blood sugar)	□Y □P	Hypothyroid	□Y □P
Generally feel cold	□Y □P	Excessive thirst	□Y □P	Hyperthyroid	□Y □P
Excessive hunger	□Y □P				

GENITO-URINARY

Pain on urination	□Y □P	Frequent infections	□Y □P	Sores on genitals	□Y □P
Increased frequency	□Y □P	Kidney stones	□Y □P	Sexually transmitted infection (STI)	□Y □P
Inability to hold urine	□Y □P	Hesitancy	□Y □P		
Blood in urine	□Y □P	Urgency	□Y □P		

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WOMEN'S HEALTH

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

MEN'S HEALTH

Hernias □Y □P	Sexually active □Y □P	Low sex drive □Y □P
Testicular pain □Y □P	Erectile difficulties □Y □P	Discharge or sores □Y □P
Testicular masses □Y □P	Ejaculatory problems □Y □P	Prostate disease □Y □P

MUSCULOSKELETAL

Joint pain/stiffness □Y □P	Arthritis □Y □P	Broken bones □Y □P
Muscle spasms/cramps □Y □P	Joint swelling □Y □P	Back ache □Y □P
Weakness □Y □P		

NEUROLOGICAL & EMOTIONAL

Fainting □Y □P	Involuntary movement □Y □P	Depression □Y □P
Seizures □Y □P	Loss of balance □Y □P	Anxiety □Y □P
Loss of memory □Y □P	Concussion □Y □P	Irritability □Y □P
Poor concentration □Y □P	Mood swings □Y □P	Panic attacks □Y □P
Mental illness □Y □P	Phobias □Y □P	

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.

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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 acupuncture or cupping
• Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa or cupping

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) _____