Naturopathic Family Practice of Niagara
ADULT INTAKE FORM

GENERAL INFORMATION

First name:_____ Last name:_____
Today's date (D/M/Y):____/____/_____
Age:_____ Date of Birth (D/M/Y):____/____/_____ Gender: Male_____ Female_____
□Married □Separated □Divorced □Widowed □Single □Partnership
Address:_____
City: _____Postal Code:_____
Email Address:_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
May I leave a message? Y / N Which phone number(s)? Home / Work / Cell
Emergency Contact Name: _____Phone:_____
Relationship to Emergency Contact:_____
How did you hear about the **Naturopathic Family Practice of Niagara?**
_____
If referred, by whom:_____
Other Healthcare providers who you are seeing:
Name: 1._____ 2._____ 3._____
Title: _____ _____ _____
Phone: _____ _____ _____

CURRENT HEALTH CONCERNS

What are your most important health concerns? Please list in order of importance:

1.
2.
3.
4.
5.
6.

If you are female, are you currently pregnant? Y / N
How would you describe your current state of health? Excellent / Good / Fair / Poor
Current weight:_____ Current height:_____ Date of last physical exam:_____

CONTEXT OF CARE REVIEW

What expectations do you have from this visit?

What long term expectations do you have from working with our Naturopathic Family Practice?

What expectations do you have from me personally as your Naturopathic Doctor?

On a scale from 0-10, 10 being 100% committed, what is your present level of commitment to addressing any underlying causes of your health concerns that relate to your lifestyle?_____.

What behaviours or lifestyle habits do you currently engage in that you believe enhances your health?

What behaviours or lifestyle habits do you currently engage in that you believe are self-destructive?

What barriers do you foresee in making lifestyle changes and adhering to any therapeutic protocols that I may present to you?

Do you have a support network? If so, who?_____

What do you love to do?

MEDICAL HISTORY

Please indicate any past medical illnesses, diagnosis, medical test results, hospitalizations, injuries and/or trauma, along with the approximate dates:

Do you have any known allergies? Examples: medicine, food, environmental, chemicals or other.

Current Medications: (please include all prescriptions, over-the-counter medicines, vitamins/minerals, herbal preparations, homeopathic remedies, etc.)

Past Medications:

How many times have you been treated with antibiotics? _____

Please place a check mark if you use any of the following:

□ Aspirin/Tylenol □ Laxatives □ Antacids □ Diet Pills

□ Alcohol (amount per day, week or month): _____

□ Tobacco (form and amount per day, week or month):_____

□ Caffeine (form and amount/day): _____

□ Recreational drugs (type and how often):_____

Please indicate what immunizations you have had:

□ DPT (Diptheria, Pertussis, Tetanus) □ MMR (Measles, Mumps, Rubella)

□ Gardasil/Cervarix (HPV Vaccine) □ Haemophilus influenza B

□ BCG (Tuberculosis) □ Varivax/Varilrix (Chicken Pox)

□ Hepatitis □ Polio

□ Flu Vaccine □ Pneumococcal Conjugate (Meningitis/Pneumonia)

□ Meningococcal C Conjugate (Meningitis) □ Other: _____

Did you have any adverse reactions to the immunization(s)? _____

DIET

Do you have any food allergies or intolerances? Please list:_____

_____

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

_____

Describe a typical day's diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snack(s) (and how often):_____

Beverages (and how often):_____

FAMILY HISTORY

Which family member?	Which family member?
□ Allergies_____	□ Asthma_____
□ Heart Disease_____	□ High Blood Pressure_____
□ Cancer_____	□ Diabetes_____
□ Depression_____	□ Other Mental Illness_____
□ Drug Abuse/Alcoholism_____	□ Kidney Disease_____
□ Other_____	□ I don't know my family medical history

LIFESTYLE AND ENVIRONEMENT

Occupation:_____Hours per week:_____

Do you exercise regularly? Y / N 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?

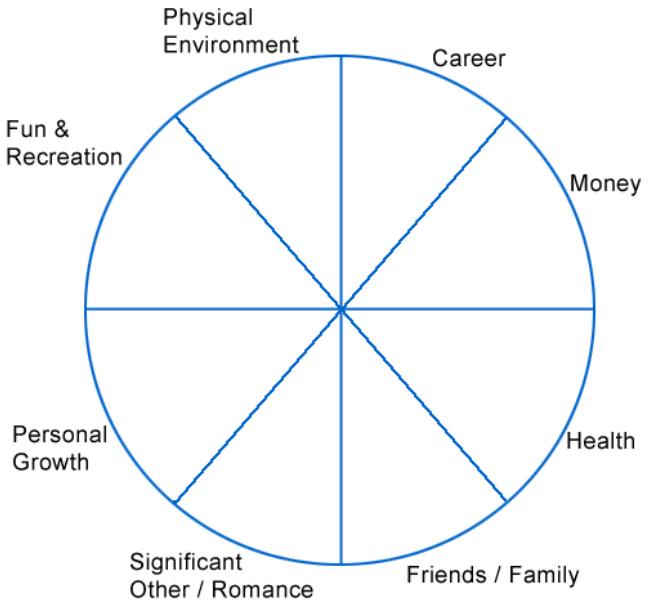
List any major stressors in your life right now:

Has there been an event in your life that you have not fully recovered from?

Is there anything else that you feel is relevant to your health?

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you. For example, if you are 75% satisfied in your career, shade ¾ of the career section from the centre radiating outwards. Do the same for each area.



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REVIEW OF SYSTEMS:

Please check off any condition that you have experienced in the past or present:

Skin: □ rashes □ eczema □ psoriasis □ acne □ itching □ lumps □ dry □ moist □ easy bruising □ colour changes	**Nails:** □ colour changes □ fungal infections □ brittle □ hangnails □ vertical/horizontal lines	**Head:** □ migraines □ headaches □ dizziness	**Eyes:** □ pain □ tearing dryness □ blurring □ redness □ discharge □ itching □ cataracts □ glaucoma
Ears: □ impaired hearing □ earache □ dizziness □ discharge □infections □ ringing	**Nose & Sinus:** □ frequent colds □ nose bleeds □ stuffiness □ hay fever □ sinus problems	**Mouth & Throat:** □ frequent sore throat □ gum problems □ hoarseness □ dental cavities □ loss of taste	**Neck:** □ lumps □ swollen glands □ pain or stiffness □ enlarged thyroid
Lungs: □ cough □ phlegm □ spitting up blood □ wheezing □ difficulty breathing □ shortness of breath □ pain on breathing	**Cardiovascular:** □ heart disease □ high blood pressure □ murmurs palpitations □ chest pain	**Peripheral Vascular:** □ deep leg pain □ cold extremities □ varicose veins □ extremity swelling/ulcers	**Urinary:** □ pain □ nightly urination □ inability to hold urine □ blood in urine □ urgency □ infections
Upper Gastrointestinal: □ heartburn □ indigestion □ nausea □ vomiting □ belching □ passing gas □ stomach pain	**Lower Gastrointestinal:** □ constipation □ diarrhea □ blood in stool □ mucous in stool □ hemorrhoids □ black stools	**Musculoskeletal:** □ joint pain/stiffness □ muscle pain/stiffness □ weakness □ back pain □ broken bones	**Neurologic:** □ fainting □ seizures □ paralysis □ numbness/tingling □ loss of balance □ muscle weakness □ involuntary movement □ speech problems □ memory loss
Endocrine: □ fatigue □ heat/cold intolerance □ thyroid problems □ excess: thirst/hunger/sweating	**Women's Health:** □ fibrocystic breasts □ breast lumps □ breast tenderness □ nipple discharge □ vaginal discharge □ vaginal itching □ difficulty conceiving # of live births:_____ # abortions:_____ # of miscarriages:____ Date of last PAP:_____ **Women's Menstrual Cycle:** □ painful periods □ PMS □ excessive menstrual flow □ irregular periods Age of menarche:_____ Cycle length:_____		**Men's Health:** □ hernias □ testicular masses/pain □ discharge from penis □ enlarged prostate
Sexual Health: Are you currently in a relationship? Y / N Are you sexual active? Y / N Do you use contraceptive(s)? Y / N What form of Contraceptive(s)?_____ Describe your sexuality: Heterosexual / Homosexual / Bisexual Do you experience pain or discomfort during intercourse? Y / N			**Sleep:** □ difficulty falling asleep □ frequent waking. **Hours asleep**: _____ Do you wake rested? Y/ N

Thank you for completing this form.

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PAYMENT AGREEMENT & CANCELLATION POLICY

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

Payment Agreement:

- Payment is always due at the time of service.
- Your naturopathic visits are not covered by OHIP.
- We do not bill insurance companies directly. However, we will gladly provide you with a receipt of all necessary information for you to submit to your insurance company to request reimbursement.
- We accept the following forms of payment: cash, cheque, debit card, visa and mastercard.
- NSF cheques will receive an additional $25.00 fee.
- Naturopathic visits are exempt from HST.
- Laboratory testing and supplements are not included in the fees below. Prices vary and some fees are subject to HST.

Fee schedule: prices effective January 1, 2020

Visit Type	Approximate Visit Length	Fee
ADULT:		
1st Visit	50 minutes	$180
2nd Visit	50 minutes	$155
CHILDREN/PEDIATRIC (0-13 years of age)		
1st Visit	50 minutes	$155
2nd Visit	50 minutes	$155
SUBSEQUENT		
Regular follow-up	25 minutes	$80
Long follow-up	50 minutes	$155
MEDICAL RECORDS		
First 1-5 pages		$30.00
After first 1-5 pages		$0.50 per page

Phone Consultations:

- We bill for phone consultations. They require the same time and expertise as office visits.
- Billing for phone consultations is, however, at the doctor's discretion. Your doctor may choose not to bill you if the nature of the phone consultation is uncomplicated, such as requiring clarification on your treatment plan and/or prescription. For phone consultations requiring extra time and evaluation, you will receive a bill for the time required.

Extended appointments when required:

- We believe in taking the time to cover all of your concerns without rushing you. The doctor will do her best to keep to the original appointment time, however, issues or concerns may occasionally arise that require additional time. We bill for the time spent with the doctor if the appointment extends beyond the time allotted.

On-Time Policy:

- Your time is valuable to us and we take pride in seeing you on-time. Should you arrive late, you will be seen for the remaining time allocated to your scheduled appointment; however, you will be billed the full amount of time that we reserved for you.

Cancellation Policy:

- Patient visits require the doctor to block out large time slots, making last-minute cancellations and rescheduling of visits very problematic. We spend an inordinate amount of time and energy with each patient because we are committed to providing the highest quality of naturopathic health care.
- We kindly ask that you provide the office with a minimum of 2-business days notice. This allows other patients to benefit from an available appointment.
- **Cancellations with less than 2-business days notice, or no-show appointments are billed for the FULL APPOINTMENT FEE.**

As a courtesy, we are happy to provide you with an email reminder.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above.

_____	_____	_____
Signature	Print Name	Date

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INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of diseases. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and perform a medical physical examination. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams. If your case requires laboratory blood tests, your Naturopathic Doctor may refer you to a Medical Doctor or an appropriate lab where additional fees may or may not apply.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parenteral therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa.
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by the Naturopathic Doctor prior to manipulating the neck.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

I understand:

- That the **Naturopathic Family Practice of Niagara** does not guarantee treatment results.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have to the best of his/her ability.
- That I am responsibly to pay the fees for naturopathic services and any products from the dispensary at the time of the visitation.
- I have reviewed the Payment Agreement & Cancellation Policy. This has also outlined the fee schedule to me.
- That I am not obligated to purchase products from the **Naturopathic Family Practice of Niagara** dispensary and that I may choose to purchase items elsewhere.
- I am free to withdraw my consent and to discontinue treatment at any time.

Patient Name (please print)_____

Signature of Patient or Guardian: _____ Date:_____

Naturopathic Doctor: _____Dr. Jennifer Cox, ND # 1812

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PATIENT CONSENT FORM
FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of the **Naturopathic Family Practice of Niagara**, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

All staff members of the **Naturopathic Family Practice of Niagara** and **Niagara Orthopaedic Institute** who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information. In order to protect your privacy of personal information, we ensure that:

- Only necessary information is collected about you.
- We only share your information with your consent.
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols.
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

The **Naturopathic Family Practice of Niagara** will collect, use and disclose information about you for the following purposes:

- To assess your health concerns, provide healthcare and advise you of treatment options.
- To establish and maintain contact with you.
- To remind you of upcoming appointments.
- To communicate with other treating health-care providers.
- To allow us to efficiently follow-up for treatment, care and billing.
- To complete claims for insurance purposes.
- To invoice for goods and services, process credit card payments and to collect unpaid accounts.
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse and reporting diseases and individuals who may be an imminent threat to harm themselves or others.

I have read and understand how the **Naturopathic Family Practice of Niagara** will use my personal information and the steps in which the staff at both the **Naturopathic Family Practice of Niagara** and **Niagara Orthopaedic Institute** is taking to protect my information. I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

_____ _____ _____

Signature Print Name Date

Release of Personal Information: This is for your Naturopathic Doctor to discuss your case with a mutual healthcare provider.

I hereby fully authorize the Naturopathic Doctor, Jennifer Cox, to exchange medical and/or other information necessary with the healthcare provider(s) listed below. I understand that this information will be used to provide me with the most individualized and optimal healthcare treatment and will be confidential (Name/Title):

1._____ 2._____ 3._____

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