

## **Adult New Patient Intake Forms**

I would like to welcome you to the Naturopathic Medical Services offered at the Holistic Clinic. My goal is to help you understand factors that may be affecting your health and to develop strategies to improve your health and well-being. Please complete these forms as thoroughly as possible, as your responses help in assisting recommendations to support your wellness goals. Please bring the completed forms with you for your first visit.

Please also bring the following in to your first visit (if you have it):

- Any recent bloodwork (within the past year)
  - If you do not have a copy we can request a copy from the lab company, hospital or your MD.
- Any supplements, medications or remedies that you are currently taking. Please include:
  - Brand
  - Amount you are taking
  - When you take it
  - Why you are taking it.

I look forward to our meeting.

Sincerely,

Dr. Maureen MacDonald ND 1758

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Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ **Mr.** **Mrs.** **Ms.** **Miss**

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
mm/dd/yyyy

Marital Status: \_\_\_\_\_ Live with: \_\_\_\_\_

Address:

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Street & Apt/House Number City Province Postal Code

**Contact Information**

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Business Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name & Relationship

How did you hear about us?: \_\_\_\_\_

Would you like to receive e-mail newsletters? Yes No

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**Health Care Providers**

Primary Health Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Practice Name/Location: \_\_\_\_\_

Health Card # \_\_\_\_\_ (for the purpose of Release of Records)

Are you under the care of a medical specialist/alternative care provider? Yes No

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

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**Allergies/Sensitivities:** Are you allergic/sensitive to medications, herbs, foods, animals, or any other substance?

- |                         |            |                   |               |
|-------------------------|------------|-------------------|---------------|
| No Known Drug Allergies | Penicillin | Hydromorphone     | Antibiotics   |
| Bees/Wasps/Insects      | NSAIDS     | Chemotherapeutics | Immunotherapy |
| Sulfa Drugs             | Insulin    | Aspirin           | Wheat/gluten  |
| Dairy                   | Soy        | Citrus            | Grains        |
|                         |            |                   | Nuts: _____   |

Other Allergies/Sensitivities: \_\_\_\_\_

What happens to you during a reaction?

What makes it better? \_\_\_\_\_

How often do these reactions occur? \_\_\_\_\_

Have you ever been hospitalized or needed to go to the emergency room from a reaction:    Yes    No

**Current Health Concerns**

Chief Health Concerns/What Brought You Here?:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What expectations do you have from **THIS VISIT** to the clinic?

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What LONG TERM expectations do you have working with a Naturopathic Doctor?

What is your present level of commitment to address any underlying causes of your symptoms to your lifestyle? (1 = Low Importance; 10 = High Importance)

1            2            3            4            5            6            7            8            9            10

Factors needing to be addressed/considered for the development of your treatment plan? (i.e. shift worker)

### Behaviour and Lifestyle

Things you do that you'd consider supportive of your health/well-being:

Areas of your health/well-being that you'd like to work on/think are NOT supportive?:

**What is your SOCIAL SUPPORT NETWORK like?**

**Who are the key members of your social support network?**

**What is your diet like now?** (Please describe a typical day)

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**Is this different from how you have eaten in the past?** If yes, when did you make the changes & what did you change from?

**Alcohol:** Drinks per week: \_\_\_\_\_ Beverage Preference: \_\_\_\_\_

Drinks per day: \_\_\_\_\_ Habit Description: \_\_\_\_\_

**Water:** Glasses per day: \_\_\_\_\_ (please select what type you consume most frequently)

- Filtered    Reverse Osmosis    Bottled    Tap    Distilled    Alkalinized  
 Tonic    Soda Water

**Juice:** Yes    No    If yes – type and frequency: \_\_\_\_\_

**Coffee:** Yes    No    # per day: \_\_\_\_\_ How do you take your coffee?

**Tea:** Yes    No    # per day: \_\_\_\_\_ How do you take your tea?

**Other Regularly Consumed Beverages:**

**Smoking/Tobacco:** How much? \_\_\_\_\_ How long? \_\_\_\_\_

**Recreational Drugs:** How much? \_\_\_\_\_ How long? \_\_\_\_\_

**Current Medications: (Prescriptions & Over The Counter)**

Medication	Reason for Drug	Dose	Duration

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Any medications used for more than 5 years of your life, which you have not mentioned? For example, oral contraceptives, IUD, antidepressants, antianxiety medication, etc.:      Yes      No

If yes: \_\_\_\_\_

Number of times on Antibiotics in the PAST 10 YEARS & reason:

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**Current Supplements:**

Supplements & Brand	Reason for Taking	Dose	Duration of Use

**Past Medical History (please select all that apply):**

- |                |                     |                 |                      |
|----------------|---------------------|-----------------|----------------------|
| Allergies      | Childhood Illnesses | Migraines       | Autoimmune Disorders |
| Alcoholism     | Depression          | Rheumatic Fever | Osteoporosis         |
| Anemia         | Diabetes            | Seizures        | Skin disorders       |
| Anxiety        | Heart Disease       | Stroke          | Chicken Pox/Mumps    |
| Arthritis      | High Cholesterol    | Thyroid Disease | Obesity              |
| Asthma         | High Blood Pressure | Tuberculosis    |                      |
| Cancer         | Infectious Diseases | Whooping Cough  |                      |
| Celiac Disease | Measles             | Kidney Problems |                      |

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**Hospitalizations/Surgeries:**

**Do you ever get any of the following? (please select all that apply)**

- |                    |                    |               |                     |
|--------------------|--------------------|---------------|---------------------|
| Cankers            | Cold Sores         | Easy Bruising | ringing in the Ears |
| Frequent Heartburn | Diarrhea           | Constipation  | Post-Nasal Drip     |
| Bronchitis         | Frequent colds/flu |               |                     |

Muscle Cramps and Spasms (what parts are most regularly affected): \_\_\_\_\_

**Sleep/Waking Schedule:**

Bedtime: \_\_\_\_\_ Waking Time: \_\_\_\_\_ Snooze Button: \_\_\_\_\_

**Insomnia:** Hard Time Falling Asleep: Yes No Hard Time Staying Asleep: Yes No

Do you get up to urinate? Yes No How often?: \_\_\_\_\_ What time?: \_\_\_\_\_

**Bowel Movements:** Frequency \_\_\_\_\_(per day/per week)

Quality: Easy to pass: Yes No \_\_\_\_\_ Blood/Mucous: Yes No \_\_\_\_\_

**Please select any of the following that you take:**

- |                             |                       |  |          |              |
|-----------------------------|-----------------------|--|----------|--------------|
| Antacids (Rolaids/TUMS)     | Cough/cold medicine   | Flu Vaccine  |          |              |
| Aspirin                     | Tylenol               | Advil  | Naproxen |              |
| Diet pills                  | Sleeping Pills: _____ |  |          |              |
| Benadryl                    | Reactine              | Aerius   | Claritin | Other: _____ |
| Cortisone Cream/Pills       |                       |  |          |              |
| Yeast Infection Medications |                       | Oral Contraceptives/Hormone Replacement Therapy_____ |          |              |

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Is there anything else Dr. Maureen MacDonald, ND needs to be aware of?

**Family History**

Please be as detailed as possible. Please include/describe parents, siblings, aunts, uncles and grandparents:

**General (Please select all that apply):**

- |            |                     |                 |                      |
|------------|---------------------|-----------------|----------------------|
| Allergies  | Childhood Illnesses | Migraines       | Autoimmune Disorders |
| Alcoholism | Depression          | Rheumatic Fever | Osteoporosis         |
| Anemia     | Diabetes            | Seizures        | Kidney Problems      |
| Anxiety    | Heart Disease       | Stroke          | Chicken Pox/Mumps    |
| Arthritis  | High Cholesterol    | Thyroid Disease | Obesity              |
| Asthma     | High Blood Pressure | Tuberculosis    | Measles              |
| Cancer     | Infectious Diseases | Whooping Cough  | Celiac Disease       |

Family Member	Current Age	Age at Death	Health Problem or Cause of Death
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

Dear New Patient,

Welcome to the Holistic Clinic. We use the principles and practice of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal itself and to improve quality of life and health through natural means. Please sign and return this form to the Holistic Clinic at your first visit.

### **Statement of Consent**

As a patient of this practice, I have read the information and understand that the medical care is based on Naturopathic medical and other supportive principles and practices. I acknowledge that my naturopathic doctor endeavours to provide the best possible diagnosis and course of treatment, but that no warranty is made with respect to any treatment, action, or medical advice given, because many factors are important in determining actual results. I also recognize that even the gentlest of therapies might have complications (in certain physiological conditions; or in very young children; or those on multiple medications). The information that I have provided is complete and includes all health concerns including possibility of pregnancy; and all medications, including over-the-counter drugs and supplements. The possible health risks of some naturopathic medical treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations.

I also acknowledge that I have the right to accept or reject this medical care of my own free will and choice. I give permission and consent to Dr. Maureen MacDonald to provide naturopathic medical consultation, assessment and/or treatment.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

### **Appointments**

Please schedule your appointments, including pick-up of prescribed products, in advance. Please plan to arrive for appointments on time. Visits that begin late due to a patient's late arrival will be charged the full visit fee.

#### **Initial Appointment**

On your first visit, Dr. MacDonald will listen to your concerns and ask you for more details so she can form a better understanding of all your interrelated health factors. She will perform a complaint-oriented physical exam to provide objective information about your health concerns. The initial assessment will last approximately 90 minutes.

#### **Follow-Up Appointments**

The frequency of follow-ups will depend on the therapies recommended by Dr. MacDonald, as well as how long you've had the condition being treated. Acute illnesses, such as a cold or flu, will resolve much quicker than a chronic condition, such as diabetes. Follow-up visits will last approximately 30-60 minutes, depending on your care plan.

#### **Cancelled & Missed Appointments**

Please ensure to give at least one business day cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on the same day or for missed appointments, a \$40 missed appointment fee will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the Naturopathic doctor.

### **Privacy Policy & Confidentiality**

Privacy of your personal information is very important. We are committed to collecting, using and disclosing your personal information responsibly. All staff members 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 appropriate use and protection of your information. Our privacy protocols comply with privacy legislation (PHIPA) and standards of our regulatory body, the Board of Directors of Drugless Therapy - Naturopathy.

Everything that you communicate directly or indirectly to your Naturopathic doctor is confidential unless you give written permission to disclose information to a third party. Confidentiality is respected at all times. It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to: 1) report incidents of child abuse (physical, sexual or emotional) and neglect; 2) comply with a court ordered subpoena; 3) prevent harm to yourself or another person should such plans be disclosed; 4) report a health professional who has sexually abused a patient.

### **In Case of Emergency**

Emergency services are not available at the Holistic Clinic. In case of an emergency, the appropriate emergency team will be contacted.

### **Bloodwork**

Please be aware that any bloodwork requisitions prescribed by Dr. MacDonald are NOT covered by OHIP. Full payment for the bloodwork invoice is required before a requisition can be issued. Prior to proceeding, we will provide a detailed quote outlining the specific tests Dr. MacDonald recommends.

### **Supplements**

Dr. MacDonald offers a number of high-quality supplements. Some are harder to find in the local area, and others are more specific for the needs of her patients. You are under no obligation to purchase supplements here; however, we offer competitive pricing and keep stock on-hand for your convenience.

### **Naturopathic Fee Schedule**

<b>Initial Consultation (90 minutes)</b>	\$350	<b>Acupuncture (30 minutes)</b>	\$100
<b>Follow-Up Consultation</b>		<b>Intravenous (IV) Therapy</b>	
60 minutes	\$300	Sitting Fee	\$90
45 minutes	\$225	Cost of IV Bag	\$60-250
30 minutes	\$150	<i>*depending upon ingredients used in the IV bag</i>	
15 minutes	\$75		

Payment for services is due in full at the end of each visit and a receipt will be given when payment is received. Please retain this receipt for your insurance claim or income tax claims, if applicable. Extended Health Insurance plans often offer coverage for naturopathic medicine. Plans and policies differ, so please check with your insurance provider regarding your specific coverage and claim procedures.

Fees may be paid by Debit, Cash, Cheque, or Credit Card. Please note that refunds are not available for medical services rendered, included lab tests performed and products that have been sold. No HST is charged on in-office services or Canadian sourced laboratory testing.

**I have read, understood, and agree to the contents herein.**

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_