Dear New Patient,

Thank you for the confidence and commitment you are demonstrating through your decision to pursue Naturopathic health care. You only have one life and one body, so congratulations for taking a step towards health. The benefits of optimal health will be proportional to the efforts and dedication that you put into your daily choices. You have the option to feel better, live healthier, look and act younger and live longer. It is found that lasting improvements in one's health take place in the presence of heightened focus, dedication and education.

As Naturopaths, we commit to helping you achieve your health goals through consultation, laboratory testing and educational material.

Your careful consideration of each of the enclosed forms will enhance my efficiency and accuracy, and ensure that we get the most out of our consultation time.

The package should take between 30-60min to complete. Please leave yourself enough time to fill out the diet survey, as it should to be reflective of a typical week. If you would like your package reviewed before your appointment, please drop it off at the office ahead of time, otherwise bring all the completed forms with you to your initial visit.

Please all of the medications and supplements that you are currently taking with you to your initial appointment. If you need further clarification on any of the material in the package, please feel free to call the office at 519-772-0292 or email us at info@vibrant-living.ca or at our individual contacts below.

Thank you for your time, and we look forward to working with you to achieve your health goals.

Robin Walsh BASc, ND robin@vibrant-living.ca
Laura Stix BSc, ND laura@vibrant-living.ca
Vanessa Cowlen, Manager vanessa@vibrant-living.ca

Office Policies

To facilitate the efficiency of the office, and to ensure that you will derive the maximum benefit for the care provided, the following office policies have been established:

1. In order to keep accounts to a minimum full payment is required at the time of your visit. We accept cash, cheque, debit, Visa and Mastercard. Thank you for your cooperation.

2. If at all possible, we have a 24 hour cancellation policy in effect in the event that you cannot make your appointment so that someone on the waiting list could be accommodated. We understand that there are extenuating circumstances, which will be taken into consideration; however missed appointments will be billed for 100% of the appointment fee. Our answering machine is available during off hours to take any messages.

3. With the number of patients that are thoroughly interviewed, timing is crucial. For the respect and convenience of out clients and for the efficiency of the clinic we are required to keep scheduled appointments on time. However, complications and emergencies do arise on both ends, which again will be taken into consideration. Please note that when you arrive late for your appointment, only the balance of time that was booked for you can be used.

4. We reserve the right to discharge any case where,
    - The Naturopath feels that the case is beyond the scope of practice of this clinic
    - The patient refuses to cooperate with the recommendations mutually agreed upon

5. Telephone consultations provide a professional service and such may be subjected to a fee on the discretion of the Naturopathic Doctor.

Robin Walsh BASc, ND
Laura Stix BSc, ND

NATUROPATHIC PATIENT INTAKE

PATIENT INFORMATION

Date _____

Name _____ Sex: M F
Age _____ Date of Birth _____ (day/month/year)
Address _____
_____
Phone (home) _____ (work) _____ May we leave messages? Y N
Occupation _____ Full time or Part time? _____
Marital status _____ Name of Spouse _____ No. of children _____
Email: _____
Name(s) of other health care providers _____

EMERGENCY CONTACT

Name _____ Relationship _____
Phone (home) _____ (work) _____ (cell) _____
Address _____

How did you hear about the clinic? _____
Would you like to join our free e-health newsletter : Y N

CURRENT HEALTH INFORMATION

What is your chief concern about your health? _____
_____

Please list any other health concerns (physical, emotional or mental) that you would like to address:

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

MEDICATIONS

Please list all **prescribed or over the counter medications** you are presently taking. Indicate the name of the drug, dosage, frequency and how long you've taken it.

_____

_____

_____

Have you ever had a bad reaction to any medication? _____

How many courses of antibiotics have you had in the past 10 years? _____

Please list any vitamins/minerals, herbs or homeopathic remedies that you are taking.

_____

_____

_____

Are you allergic to any medications or other substances? Y N

If yes, please list: _____

LIFESTYLE FACTORS

Health Habits	***Exercise***
Tobacco:	5-7 days per week
Cigarettes: #/day _____	3-4 days per week
Cigars: #/day _____	1-2 days per week
Alcohol:	45 min or more duration per/workout
Wine: #glasses/d or wk _____	30-45 minutes duration per workout
Liquor: #ounces/d or wk _____	Less than 30 minutes
Beer: #glasses/d or wk _____	Walk - #days/wk _____
Caffeine:	Run, jog, other aerobic - #days/wk
Coffee: #6 oz cups/d _____	_____
Tea: #6 oz cups/d _____	Weight lift - #days/wk _____
Soda w/caffeine: #cans/d _____	Stretch - #days/wk _____
Other sources _____	Other _____
Water: #glasses/d _____	

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

What areas of your life contribute most to your stress (please circle)?
Work Health Family Money Marriage Other:_____

DIET
Food Allergies/Sensitivities
_____

Check all that apply
Vegan
Vegetarian
Celiac/Gluten Intolerant
Lactose Intolerant

PAST MEDICAL HISTORY
Please list the most significant stressful or traumatic events of your life (include childhood).
1. _____
2. _____
3. _____

Have you ever been diagnosed with a serious illness? When?
_____
_____

What hospitalizations or surgeries have you had? When did they occur?
_____
_____
_____

Have you ever had any serious accidents? Indicate injuries, when it occurred, and treatment.
_____
_____

Environmental Factors

Have you ever or do you work in a toxic environment?	Y	N
Do you Smoke, or are their Smokers in your house?	Y	N
Do you use Conventional Cleaning Products?	Y	N
Do you have wall to wall carpeting in your house?	Y	N
Have you ever had mould or a wet basement?	Y	N
Do you dryclean your clothes?	Y	N
Do you have a sensitivity to chemical smells (ie perfume)?	Y	N
Do you live near a garbage dump?	Y	N
Do you live within ½ km of power lines?	Y	N
Do you or have you ever had mercury fillings?	Y	N
Do you drink filtered water?	Y	N
Do you eat organic, hormone free or free range meats?	Y	N
Do you try and consume organic foods?	Y	N
Do you use natural skin care products (ie shampoo etc)	Y	N

CHILDHOOD ILLNESSES

Eczema_____ Asthma _____Frequent ear infections or colds_____

Were you a colicky baby?	Y	N	
Were you breastfed?	Y	N	Until What Age?
Are you Immunized?	Y	N	If so any reactions?
Were you born premature	Y	N	
Was your birth vaginal or csection			

FAMILY HISTORY ***Family Health History (Parents and Siblings)*** Arthritis Asthma Alcoholism Alzheimer's disease Cancer Depression Diabetes Drug addiction Eating disorder Genetic disorder	Glaucoma Heart disease Infertility Learning disabilities Mental illness Migraine headaches Neurological disorders (Parkinson's, paralysis) Obesity Osteoporosis Stroke Suicide Other _____

To Achieve My Health Goals, I am willing to:

□ do what is necessary
□ do anything but change diet
□ do anything but exercise

REVIEW OF SYSTEMS

Please circle any conditions which you are presently causing you a problem. Please checkmark those conditions, which were a problem to you in the past.

Skin
Rashes
Eczema
Psoriasis
Hives
Acne
Boils
Change in mole
Skin cancer
Dry skin
Itchy skin

Eyes
Near sighted
Far sighted
Eye pain
Double vision
Blind spot
Glaucoma
Cataracts
Blurry vision
Dry eyes
Itchy eyes
Tearing
Red eyes
Discharge

Head
Headache
Migraine
Trauma to head
Excessive hair loss
Dandruff

Peripheral Vascular Disease
Extremity swelling
Varicose veins
Spider veins
Extremity numbness
Extremity coldness
Phlebitis
Raynodes syndrome

Cardiovascular
High blood pressure
High cholesterol
Angina
Heart murmur
Chest pains
Heart palpitations
Swelling of the ankles
Abnormal heart tests
Do you like your job Y N

Urinary
Frequent urination
Pain/burning
Increased frequency
Increased urgency
Incontinence
Kidney stones
Hesitancy
Strong odor
Cloudy urine
Bloody urine

Ears
Ringing
Impaired hearing
Earache
Discharge
Wax build up
Itchy

Neurological
Fainting
Seizures
Tingling/numbness
Involuntary movement
Loss of balance
Speech problems
Loss of memory
paralysis

Musculoskeletal
Joint pain/stiffness
Joint swelling
Osteoarthritis
Rheumatoid arthritis
Muscle cramps
Backache
Neck stiffness/pain
Foot pain
Sprain joint easily
Heel spur

Upper Respiratory
Frequent colds
Frequent sore throat
Tonsillitis
Swollen neck and glands
Sinusitis
Nasal discharge
Post nasal drip
Seasonal allergies
Nose bleeds
Coughing
Sputum
Hoarseness
Wheezing
Asthma
Spitting up blood
Shortness of breath
Pain on breathing
Difficulty breathing
Bronchitis
Pneumonia
Tuberculosis

Endocrine
Thyroid problems
Heat/cold intolerance
Excess sweating
Hypoglycemia
Chronic fatigue
Hormone therapy
Diabetes
Seasonal depression
Shift work

Gastrointestinal
Food allergies
Heartburn
Hernia
Nausea
Vomiting
Excessive belching
Excessive passing gas
Bloating
Jaundice
Liver disease
Gallbladder disease
Gallstones
Ulcer
Indigestion
# of bowel movements/day loose stools
hard stools
mucous in stool
blood in stool
black, tarry stool
yellow, pale stool
greenish stool
irritable bowel syndrome
colitis
crohn's disease
rectal bleeding
hemorrhoids
anal fissure
diarrhea
abdominal pain
stomach pain
Eating disorder
Explain _____
Motor vehicle accident
How Many _____
When

Blood/Lymphatic
Anemia
Easy bruising
Easy bleeding
Past transfusions
Lymph node swelling
Lymphatic disease
Blood disease

Emotional
Depression
Anxiety
Mood swings
Nervousness
Panic attacks
Phobia
Irritable
Angry
Insomnia
worrier

Males Only
Prostate problems
Prostate surgery
Hernia
Testicular masses
Discharge or sores
Venereal disease
Sexual difficulties

Female Only
Have your periods stopped Y N
Hysterectomy Y N
Why?
Birth Control Y N
Type?
Age of menses _____yrs
Average length of cycle _____days
days of menstruation_____

irregular cycles
bleeding between periods
PMS
Symptoms_____
_____
_____

painful menses
excessive flow
fibroids
ovarian cysts cervical dysplasia
cervical/uterine cancer
ovarian cancer
vaginal discharge
venereal disease
pain on intercourse
hot flashes
night sweats
estrogen replacement_____
pregnancies _____
#miscarriages_____
#abortions
breast lumps
breast tenderness
nipple discharge
sexual difficulties
Last PAP

Declaration and Consent to Treatment

I) This is to acknowledge that I have been informed and understand that:

i) any treatment advise provided to me as a client of a Naturopathic Doctor working for Vibrant Living is not mutually exclusive from any treatment or advise that I may now be receiving or may in the future receive from another licensed health care provider

ii) I am at liberty to seek or continue medical care from physicians or other health care providers who are qualified to practice in Ontario

iii) The Naturopathic Doctor working at Vibrant Living has not suggested to me to refrain from seeking or following the advice of another licensed health care practitioner

II) I declare that I have received a full and complete explanation of the treatment and or services that I will receive from the Naturopathic Doctor working at Vibrant Living, and hereby authorize and consent to treatment

III) I agree to pay the full account at the time of each visit or treatment

IV) I recognize that results are not guaranteed, and that even the gentlest of therapies potentially have complications in certain physiological conditions, in very young children or those on multiple medications. The slight health risks of Naturopathic treatments include, but are not limited to; aggravation of a preexisting symptom, allergic reactions to supplements or herbs, pain, fainting, bruising or injury from acupuncture needles.

Dated _____

Client Name _____

Client Signature _____

Signature of Treating Naturopathic Doctor

_____

□ Robin Walsh BASc, ND
□ Laura Stix BSc, ND

Patient Consent Form for Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of our clinic, 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 be as open as possible about the way we handle your personal information.
In this clinic, Robin Walsh, N.D. is the Privacy Information Officer.

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 the appropriate use and protection of your information.

Our privacy policy is available for your review upon request. It outlines what our clinic is doing to 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.

How Our Clinic Collects, Uses and Discloses Patient Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information.

The clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- 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 billings
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy, acting under the authority of the Drugless Practitioners' Act.
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

I have reviewed the above information that explains how your clinic will use my personal information and the steps your clinic is taking to protect my information.

I agree that Vibrant Living can collect, use and disclose personal information about:

_____
(print full name of patient)

as set out above in the information about the clinic's privacy policies.

_____
Signature of Patient

_____
Date

Fee Schedule - As of March 1, 2015

Naturopathic Care

**These services are not currently covered by OHIP, but are covered by extended health care plans
**GST not included

Initial Consult	$180.00
Naturopathic Follow Up	$80.00
Naturopathic Review	$40.00
45 Min Appt	$95.00
Naturopathic Reevaluation	$120.00 (required after being absent from care for over 1 yr)
Acupuncture	$45.00-80.00
Missed Appointment	100% of the appt fee if 24 hrs notice was not given

Lab Services

Zinc Tally	$3.00
Koenisburg Test	$8.00
Urinary Indican	$20.00
Urinary Chemstrip	$4.00
Oxidata	$15.00

Hair Analysis, Salivary Hormone Testing, Food Allegy Testing – prices vary based on tests

I have read and fully understand the above description of this fee system and agree to honour it

.

_____

Client/Guardian's Signature

_____

Date

Diary for: _____ **Date Started:** _____

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast (Inc Beverages)							
Snack							
Lunch (Inc Beverages)							
Snack							
Dinner (Inc Beverages)							
Snack							
Exercise							