NATUROPATHIC INTAKE FORM

PATIENT INFORMATION

Name: _____ Date of Birth (m/d/y): _____

Complete Address_____ Date: _____

Email: _____ Sex: M F Age: _____

Telephone Cell: _____ Home: _____ Work: _____

Emergency contact Name: _____ Phone: _____ Relation: _____

Medical Doctor: Name: _____ Phone & Fax (if avail):_____

Occupation and Company: _____

Do you have health insurance with Naturopathic Medical Coverage? ❑ Yes ❑No

How did you hear about our clinic? _____

Do you give us permission to add you to our mailing list to receive monthly newsletters containing recipes and health articles with the option of unsubscribing? ❑ Y ❑ N

HEALTH INFORMATION

Please list your specific **health concerns** in order of importance to you: Date of Onset:

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

Please list your most **stressful** life experiences (physical or psychological):

1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____

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WWW.WILLOWWELLNESSCLINIC.COM

CONTEXT OF CARE REVIEW

What three (3) expectations do you have from this visit?

1. _____

2. _____

3. _____

What ***long term*** expectations do you have of your naturopathic doctor?

_____

What is your present level of **commitment** to address any underlying causes of your signs/symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 1 2 3 4 5 6 7 8 9 10 100%

In your everyday life, your present **faith/spiritual practices** are (10 = very important):

0% 1 2 3 4 5 6 7 8 9 10 100%

Rate your **stress** level (10 = high)

0% 1 2 3 4 5 6 7 8 9 10 100%

What factors most contribute to your stress?

❑ Health ❑ Work ❑ Money ❑ Family ❑ Marriage ❑ Other:_____

Please describe the emotional climate of your home:

_____

What is your blood type? ❑ A+ ❑ B+ ❑ O+ ❑ AB+ ❑ A- ❑ B - ❑ O- ❑ AB-

NATURAL SUPPLEMENTS & DRUG MEDICATIONS

Please list all **current** supplements such as vitamins/minerals, herbs, or homeopathic remedies that you take on a regular basis.

Natural Supplements (name and brand)	Dose/day	For how long?	Reason for Use
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please list all your **current** pharmaceutical medications (prescription and over-the-counter).

Drug Medications	Dose/day	For how long?	Reason for Use
1.			
2.			
3.			
4.			
5.			
6.			

Are the medications well tolerated? ❑Y ❑N If no, please list the adverse reaction or side effect and from what medication:

Did you have any adverse reaction to any of the childhood vaccinations? ❑Y ❑N If yes, please explain.

_____

In the last 10 years, approximately how many courses of antibiotics have you taken? _____

MEDICAL HISTORY

Please indicate if you have had any of the following **diagnostic tests** performed:

	Notable finding:		Notable finding:
Thyroid Panel ❑Y ❑N		Cholesterol ❑Y ❑N	
Liver Panel ❑Y ❑N		Hormone level ❑Y ❑N	
Complete Blood Count ❑Y ❑N		EKG ❑Y ❑N	
Blood Sugar test ❑Y ❑N		Chest x-ray ❑Y ❑N	
Colonoscopy ❑Y ❑N		Mammography ❑Y ❑N	

Please list any past **surgeries or hospitalizations, dental work and past injuries** (ie. Broken bones, joint sprains, burns, falls, car accidents etc.) with the approximate dates:

1. _____ _____

2. _____ _____

3. _____ _____

FAMILY HISTORY

Please indicate whether any family members have had any of the following illnesses:

	Relation		Relation
❑ Alcohol/Drug abuse		❑ Diabetes	
❑ Alzheimer's		❑ Heart disease	
❑ Arthritis		❑ Hypertension	
❑ Asthma		❑ Kidney disease	
❑ Cancer		❑ Osteoporosis	
❑ Depression		❑ Stroke	
❑ Other mental illness		❑ Thyroid condition	

LIFESTYLE

	Quantity/day
Drink water ❑Y ❑N (distilled ❑ reverse osmosis ❑ spring ❑ tap ❑)	
Drink coffee ❑Y ❑N (regular ❑ decaf ❑)	
Drink alcohol ❑Y ❑N (if yes, please detail what kind and how much)	`
Drink pop ❑Y ❑N (diet ❑ regular ❑)	
Use artificial sweetener (splenda, aspartame etc.) ❑Y ❑N	
Do you smoke ❑Y ❑N	
Exposed to tobacco smoke? (2nd hand smoke) ❑Y ❑N	
Exposed to animals ❑Y ❑N	
Exposed to toxins (heavy metals, mold etc.) ❑Y ❑N	
Eat salmon ❑Y ❑N , tuna ❑Y ❑N	
Recreational drug use ❑Y ❑N	
Dietary restrictions ❑Y ❑N	Vegan? Vegetarian? Other?

Please list all allergies (food, medication, environmental): _____

_____

Do you exercise? ❑Y ❑N If yes, how often and what exercise do you enjoy? _____

Please describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you eat quickly, standing up, or on the run? ❑Y ❑N

Anything else I should know about you:

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

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 try to be as open and transparent as possible about the way we handle your personal information.

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 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 College of Naturopaths of Ontario (CONO).

HOW OUR CLINIC COLLECTS, USES, AND DISCLOSES PATIENTS' PERSONAL 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.

This 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 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 comply with legal and regulatory requirements or our regulatory body, The College of Naturopaths of Ontario (CONO) acting under the authority of the Naturopathy Act
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic with all regulatory requirements
- To comply generally with the law

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 this office can collect, use and disclose personal information as set out above in the information about the clinic's privacy policies.

_____ _____
Name of Patient & Name of Legal Guardian Print Name of Witness

_____
Signature of Patient or Legal Guardian

_____ _____
Date Signature of Witness

DECLARATION AND CONSENT TO TREATMENT

Even natural therapies have the potential to cause adverse reactions. To help reduce this possibility, it is very important that you inform your naturopathic doctor of; any disease process that you are suffering from, if you are on any medication or over the counter drugs, if you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding.
Despite intensive training and precautionary measures, there is always the possibility of health risks from natural therapies. These include but are not limited to:

Aggravation of pre-existing symptoms or minor to severe allergic reactions to supplements, herbs or homeopathics.
Pain, bruising, injury, fainting or tissue damage from venipuncture, bodywork, acupuncture, cupping, biopuncture or B12 injections; 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 injures from spinal manipulation. The potential for stroke is a concern in neck manipulation, but tests will be done to screen for this possibility. Clinical research has shown that stroke-like occurrences are rare – approximately 1 in 1.5 million manipulations.

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 any time 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 judgement 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 procedures 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 receive from another licensed health care provider.
II. I am at liberty and encouraged to seek or continue medical care from other Health Care providers, such a General Medical Practitioner's or Specialists.
III. No employee, consultant or anyone else under the Clinic's direction 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 Dr. Cecilia de Martino, ND may be different than those usually offered by a medical doctor or other licensed health care provider.

Parents/Guardians
I AGREE that I am solely responsible for the safety of my child/children while on the premise of Willow Wellness Clinic. Children are to be supervised at all times and never left un-attended by the parent.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive by Dr. Cecilia de Martino, ND and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, laboratory testing, cost of supplements and remedies, administrative fees as well as other applicable fees.

_____ _____
Full Patient Name (please print) & Legal Guardian Naturopathic Doctor

_____ _____
Signature of Patient or Legal Guardian Date of Consent

BASIC CLINIC FEE SCHEDULE

	Adult (7 yrs +)	Child (6 and under)
Initial Intake	$185 (60-90 min)	$140 (60 min)
60 minute follow-up visit	$144	
45 minute follow-up visit	$113	$92
30 minute follow-up visit	$83	$72
15 minute follow-up visit	$47	$42
Long visit (75 min)	$170	

CANCELLATION POLICY

Willow Wellness Clinic has part-time reception and requires adequate notice for cancellations in order to make appointment times available to other clients.
If you are unable to attend a scheduled appointment, please call the office or email us during business hours (519-804-6949). If you leave a voicemail, please include your name and the date and time of your appointment.

Cancellation of an appointment requires at **least two (2) business days notice**. Failure to give proper notification will result in a cancellation fee of 50% of the cost of the scheduled consultation.

***Appointments missed without notification will be subject to the full visit cost.**

RETURN POLICY

- Supplements (products) cannot be returned even if they are unopened because we cannot verify how the product was stored.
- Any labs purchased cannot be returned or refunded.

In the unlikely event of an adverse reaction, the manufacturer will be contacted to determine if a refund can be issued.

Any returns and refunds are subject to a **5% charge** on the amount returned due to incurred POS fees and time.

I, _____ have read and I understand the cancellation and return policies. I acknowledge that if I do not follow these policies I will incur a charge.

_____ _____
Signature Date