WELCOME TO NDCARE NATUROPATHIC SERVICES

OUTLINE OF PROCEDURES FOR NEW PATIENTS

STEP 1: **INTAKE FORMS**

In order to obtain an accurate health history and provide the best possible Naturopathic care, we ask that you complete these Naturopathic Intake Forms and sign the last page for your initial appointment with Dr. Andresen. All information gathered is treated on a strictly confidential basis as required by law and our privacy policy. Please feel free to ask us any questions.

STEP 2: **INTIAL NATUROPATHIC VISIT (PART I) – MEDICAL HISTORY & ASSESSMENT** (60 MIN.)

There are two parts to your initial naturopathic consultation – an assessment visit and a treatment plan overview visit. The assessment visit lasts 60 minutes and includes a full medical history intake, comprehensive physical examination, random glucose testing and standard urinalysis. If needed, previous lab test results will be requested by fax from your medical doctor. Typically, some treatment recommendations are made during this session and then the full plan is reviewed at the complimentary follow up visit.

STEP 3: **INITIAL NATUROPATHIC VISIT (PART II) - SUMMARY OF ASSESSMENT & TREATMENT PLAN OVERVIEW** (30 MIN.)

At the end of your 60 minute assessment, you will book your 30 minute Treatment Plan Overview appointment **(at no additional expense**). During this session, Dr. Andresen will discuss her assessment, review the outcome of any previous recommendations made and go through next steps for treatment. In addition, an optional complimentary Vitamin B12 injection can be administered.

CONTACT INFORMATION

Date:_____ Name: _____

Address:_____

City:_____Postal Code:_____

Primary Phone:_____Secondary Phone:_____

Email:_____

Date of Birth (DD/MM/YYYY): _____Age: _____

Emergency Contact Name & Phone Number:_____

Name of Family Physician:_____

How did you hear about us? □ Internet Search □ Health Practitioner Referral
□ Clinic Signs □ Brochure □ Friend/Family
□ Other _____

Would you like to receive Dr. Andresen's monthly "Health Tips" newsletter by email? □ Yes □ No

CURRENT HEALTH CONCERNS	
PLEASE LIST YOUR CURRENT HEALTH CONCERNS <u>IN ORDER OF MOST IMPORTANCE</u> TO YOU:	
1.	5.
2.	6.
3.	7.
4.	8.

PATIENT NAME_____ DATE: _____

LIFESTYLE INFORMATION	
RATE YOUR CURRENT ENERGY LEVEL (PAST 2 WEEKS)	LEAST 1 2 3 4 5 6 7 8 9 10 MOST
RATE YOUR CURRENT MOOD OVERALL (PAST 2 WEEKS)	WORST 1 2 3 4 5 6 7 8 9 10 BEST
WEIGHT CHANGES IN THE PAST YEAR?	□ NO □ YES INCREASED/DECREASED _____ LBS
HOW ACTIVE IS YOUR LIFESTYLE?	□ SEDENTARY □ MODERATELY ACTIVE □ ACTIVE
DO YOU HAVE ANY DIETARY RESTRICTIONS?	□ VEGETARIAN □ VEGAN □ OTHER_____
HOW MANY COLDS HAVE YOU HAD IN THE PAST YEAR?	□ none □ 1-2 □ 3-5 □ 5+
HOW MANY HOURS OF SLEEP EACH NIGHT?	_____HOURS
ANY TROUBLE GETTING TO SLEEP?	□ NO □ YES
ANY TROUBLE STAYING ASLEEP?	□ NO □ YES
HOW MANY ROUNDS OF ANTIBIOTICS HAVE YOU HAD OVER YOUR LIFETIME?	□ 0 □ 1-5 □ 5-10 □ 10+
FREQUENCY OF BOWEL MOVEMENTS?	_____PER DAY OR _____PER WEEK
HOW MUCH OF THE FOLLOWING DO YOU HAVE:	
WATER	_____ GLASSES PER DAY
COFFEE	_____CUPS PER DAY
TEA	_____CUPS PER DAY
POP	_____CANS PER DAY
JUICE	_____GLASSES PER DAY
ALCOHOL	_____DRINKS PER DAY_____ PER WEEK
ARTIFICIAL SWEETENERS	_____PACKETS PER DAY
CIGARETTES	_____PER DAY_____PER WEEK
RECREATIONAL DRUGS	_____PER DAY_____PER WEEK
WHAT IS YOUR OCCUPATION?	
HOW MANY HOURS PER WEEK DO YOU WORK?	_____HOURS
DO YOU ENJOY YOUR JOB?	
DO YOU DO SHIFT WORK?	□ NO □ YES

PLEASE LIST ALL FOOD AND LIQUIDS CONSUMED <u>YESTERDAY</u> (WITH TIME OF DAY):

TIME		TIME	
	BREAKFAST		AFTERNOON SNACKS
	MORNING SNACKs		DINNER
	LUNCH		EVENING SNACKS

PATIENT NAME_____ DATE: _____

MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAMINATION:_____/_____/_____HEIGHT ft in. **WEIGHT** lbs

DATE OF LAST BLOOD TESTING DONE BY MD OR ND: _____/_____/_____

PLEASE LIST ALL ALLERGIES (FOOD, ENVIRONMENTAL, MEDICATIONS):

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

PLEASE LIST ALL CURRENT MEDICATIONS THAT YOU ARE TAKING, THE DAILY DOSE AND DURATION OF USE:

MEDICATION NAME	DOSE	HOW OFTEN	FOR HOW LONG	REASON
1.				
2.				
3.				
4.				
5.				

PLEASE LIST ALL CURRENT SUPPLEMENTS THAT YOU ARE TAKING, THE DAILY DOSE AND DURATION OF USE:

SUPPLEMENT NAME	DOSE	HOW OFTEN	FOR HOW LONG	REASON
1.				
2.				
3.				
4.				
5.				

HAVE YOU BEEN HOSPITALIZED IN THE PAST? N Y – IF YES, PLEASE DESCRIBE:

TYPE OF ILLNESS OR SUGERY	HOSPITAL	CITY	YEAR

PLEASE LIST ANY PAST INJURIES:

TYPE OF INJURY	HOW DID IT HAPPEN?	YEAR

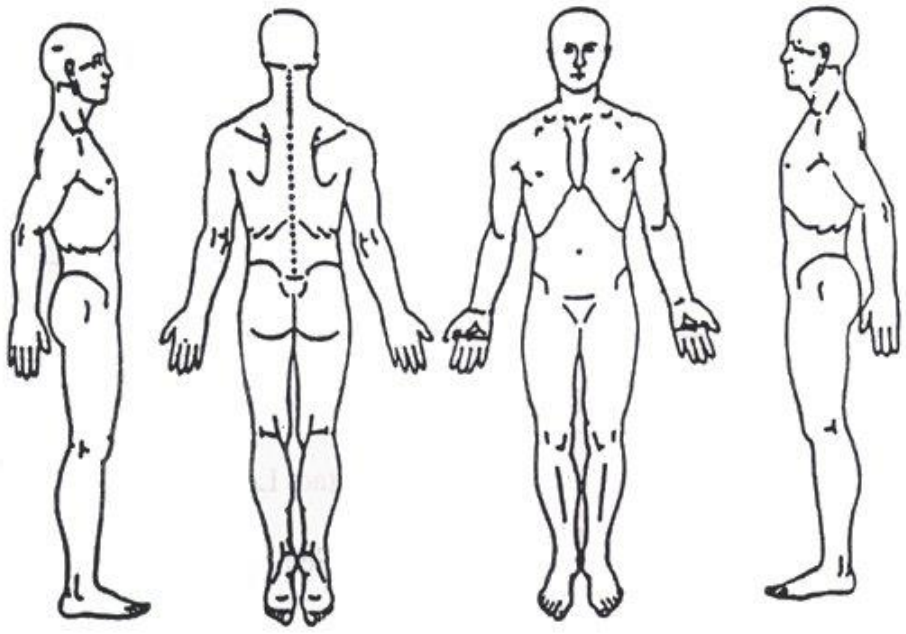
PLEASE INDICATE WHICH OF THE FOLLOWING TESTS YOU HAVE HAD IN THE PAST 5 YEARS:

			RESULTS:
COLONOSCOPY/ SIGMOIDOSCOPY	Y	N	_____
ENDOSCOPY	Y	N	_____
PELVIC ULTRASOUND	Y	N	_____
ABDOMINAL ULTRASOUND	Y	N	_____
MRI	Y	N	_____
CT SCAN	Y	N	_____
EKG/EEG	Y	N	_____

PATIENT NAME_____ DATE: _____

DO YOU HAVE ANY MUSCLE OR JOINT PAIN? Y N

IF YES, PLEASE INDICATE WHERE ON THE FOLLOWING DIAGRAM:



PLEASE CHECK THE FOLLOWING AS RELATED TO YOUR MEDICAL HISTORY:

CHILDHOOD ILLNESSES	IMMUNIZATIONS	X-RAYS
□ ASTHMA	□ DPT	□ TEETH
□ CHICKEN POX	□ FLU SHOT	□ STOMACH
□ ECZEMA	□ HEMOPHILUS INFLUENZA B	□ GALLBLADDER
□ FREQUENT EAR INFECTIONS	□ TETANUS BOOSTER	□ BACK
□ FREQUENT COLDS	□ SMALLPOX	□ CHEST
□ MEASLES	□ CHICKEN POX	□ NECK
□ RUBELLA (GERMAN MEASLES)	□ HEPATITIS A	□ COLON
□ MUMPS	□ HEPATITIS B	□ EXTREMITIES
□ POLIO	□ MMR	□ OTHER _____
□ RHEUMATIC FEVER	□ POLIO	
□ SCARLET FEVER	□ OTHER_____	
□ WHOOPING COUGH		
□ OTHER_____	LIST ANY ADVERSE REACTIONS:	

PATIENT NAME_____ DATE: _____

WOMEN'S HEALTH			
DO YOU STILL EXPERIENCE A MENSTRUAL CYCLE?	□ YES □ NO	WHEN WAS YOUR LAST MENSTRUAL CYCLE?____/_____/_____	
IS YOUR MENSTRUAL CYCLE REGULAR?	□ YES □ NO	AVG. LENGTH OF FLOW_____DAYS MONTHLY CYCLE _____DAYS	ANY SPOTTING BETWEEN CYCLES? □ YES □ NO
DO YOU EXPERIENCE ANY PMS SYMPTOMS?	□ YES □ NO	PLEASE SPECIFY:	
WHICH DO YOU USE?	□ TAMPONS □ PAD □ DIVA CUP	HOW OFTEN DO YOU CHANGE THEM/IT ON YOUR HEAVIEST DAY?	EVERY _____HOUR(S)
HAVE YOU EVER BEEN PREGNANT?	□ YES □ NO	# PREGNANCIES_____ # BIRTHS _____	# MISCARRIAGES_____ # ABORTIONS _____
HAVE YOU EVER HAD A URINARY TRACT INFECTION?	□ YES □ NO	IF YES, HOW MANY?_____	DATE OF LAST INFECTION____/___/_____
HAVE YOU EVER HAD A YEAST INFECTION?	□ YES □ NO	IF YES, HOW MANY?_____	DATE OF LAST INFECTION____/___/_____
YEAR OF LAST PAP SMEAR?	_____	ANY ABNORMAL PAP TESTS? □ YES □ NO WHEN?_____	
HAVE YOU EXPERIENCED ANY OF THE FOLLOWING BREAST RELATED CONCERNS?	□ PAIN □ LUMPS □ INFECTIONS □ CYSTS □ DISCHARGE □ NO CONCERNS		

MEN'S HEALTH		
DO YOU CURRENTLY EXPERIENCE ANY OF THE FOLLOWING URINARY CONCERNS?	□ PAIN □ FREQUENCY □ INCOMPLETE VOIDING □ NO CONCERNS	
DO YOU HAVE REGULAR PROSTATE EXAMS?	□ YES □ NO	DATE OF LAST EXAM:_____/_____/_____
HAVE YOU EVER HAD ANY OF THE FOLLOWING	□ TESTICULAR PAIN □HERNIA □ STD □ DISCHARGE □ SORES □ NONE	

PLEASE INDICATE IF ANY OF YOUR IMMEDIATE FAMILY MEMBERS HAVE EXPERIENCED ANY OF THE FOLLOWING:

HEALTH CONDITION	MOTHER	FATHER	GRAND-PARENT	SIBLING	CHILDREN
CANCER	□	□	□	□	□
DEPRESSION	□	□	□	□	□
ANXIETY	□	□	□	□	□
DIABETES	□	□	□	□	□
HIGH BLOOD PRESSURE	□	□	□	□	□
OSTEOPOROSIS	□	□	□	□	□
STROKE OR HEART ATTACK	□	□	□	□	□
HIGH CHOLESTEROL	□	□	□	□	□
DRUG ABUSE/ ALCOHOLISM	□	□	□	□	□
ARTHRITIS	□	□	□	□	□
SUICIDE	□	□	□	□	□
THYROID ILLNESS	□	□	□	□	□

PATIENT NAME_____ DATE: _____

PLEASE CIRCLE THE FOLLOWING WHICH YOU HAD IN THE PAST (P) OR THAT YOU CURRENTLY HAVE (C) :

GENERAL SYMPTOMS	CARDIOVASCULAR	GASTROINTESTINAL
P C HEADACHES	P C LOW BLOOD PRESSURE	P C NAUSEA
P C MIGRAINES	P C HIGH BLOOD PRESSURE	P C VOMITING
P C HEAD INJURY	P C CONGESTIVE HEART FAILURE	P C ABDOMINAL CRAMPING
P C FEVER	P C HEART ATTACK	P C CONSTIPATION
P C CHILLS	P C STROKE	P C DIARRHEA
P C SWEATS (NIGHT OR DAY)	P C VARICOSE VEINS	P C EXCESSIVE THIRST
P C DIZZINESS	P C HARDENING OF ARTERIES	P C EXCESSSIVE HUNGER
P C FAINTING	P C ANKLE SWELLING	P C PASSING GAS
P C LOSS OF SLEEP	P C POOR CIRCULATION	P C BLOATING
P C ANXIETY	P C IRREGULAR HEART BEAT	P C BURPING
P C LOSS OF WEIGHT	P C SHORTNESS OF BREATH	P C HEARTBURN/ REFLUX
P C NUMBNESS IN EXTREMITIES	P C CHEST PAIN	P C BAD BREATH
P C PAIN IN EXTREMITIES	P C PACE MAKER	P C PROBLEM SWALLOWING
P C ALLERGIES	P C ANEMIA	P C HEMORRHOIDS
P C DEPRESSION	P C PALPITATIONS	P C JAUNDICE
P C CHRONIC FATIGUE	P C LOW IRON	P C CROHN'S DISEASE
P C CONVULSIONS		P C ULCERATIVE COLITIS
P C CLAUSTROPHOBIA		P C DIVERTICULITIS
P C HAIR LOSS		P C ULCER(S)
P C MALE PATTERN HAIR		P C VOMITING BLOOD
GROWTH IN WOMEN		P C BLOOD IN STOOL
P C BRITTLE HAIR		P C MUCUS IN STOOL
P C FEEL COLD OFTEN		P C YELLOW/ GREEN STOOL
P C FEEL HOT OFTEN		P C GREY STOOL
		P C BLACK STOOL
		P C STOOL IN PELLETS
		P C UNDIGESTED FOOD IN STOOL
		P C STRAIN WITH BOWEL MOVEMENT

EYES, EARS, NOSE & THROAT	MUSCLE & JOINT	REPRODUCTION/ GENITOURINARY
P C FREQUENT COLDS	P C BACK PAIN	P C PREGNANCY
P C MERCURY TOOTH FILLINGS	P C STIFF NECK	P C INCONTINENCE
P C STREP THROAT	P C SHOULDER PAIN	P C FREQUENT URINATION
P C ENLARGED GLANDS	P C KNEE PAIN	P C PAINFUL URINATION
P C ENLARGED THRYOID	P C HAND PAIN	P C BLOOD IN URINE
P C HOARSENESS	P C JAW PAIN	P C CLOUDY URINE
P C GLAUCOMA	P C MUSCLE CRAMPING	P C REDUCED URINE FLOW
P C FAILING VISION	P C MUSCLE SPASMS	P C KIDNEY INFECTION
P C CATARACTS	P C HERNIA	P C KIDNEY STONES
P C EYE PAIN	P C SPINAL CURVATURE	P C PROSTATE TROUBLE
P C EAR PAIN	P C ARTHRITIS	P C GENITAL SORES
P C EAR DISCHARGE	P C OSTEOPOROSIS	P C PMS
P C DEAFNESS	P C FIBROMYALGIA	P C MENOPAUSE
P C NASAL DRAINAGE	P C TENDONITIS	P C MENSTRUAL CRAMPS
P C NOSE BLEEDS	P C BURSITIS	P C ENDOMETRIOSIS
P C SINUS INFECTION	P C GOUT	P C PELVIC INFLAMMATORY DISEASE
P C CONGESTION	P C SPINAL CORD INJURY	P C HYSTERECTOMY
P C HAY FEVER	P C SWOLLEN JOINTS	P C OVARIAN CYST(S)
	P C MUSCLE WEAKNESS	P C UTERINE FIBROIDS
		P C FERTILITY CONCERNS

PATIENT NAME_____ DATE: _____

SKIN	OTHER	ENDOCRINE
P C HIVES / ALLERGIC REACTION	P C HIV/AIDS	P C DIABETES
P C ACNE	P C HEPATITIS	P C HYPER OR HYPOTHYROIDISM
P C ITCHING	P C HERPES	P C HYPOGLYCEMIA
P C BRUISING EASILY	P C CANCER	**RESPIRATORY**
P C DRYNESS	P C TUBERCULOSIS	P C ASTHMA
P C PSORIASIS	P C EPILEPSY	P C EMPHYSEMA
P C ECZEMA	P C MULTIPLE SCLEROSIS	P C CHRONIC COUGH
P C WARTS	P C PARKINSON'S DISEASE	P C DIFFICULTY BREATHING
P C COSMETIC SURGERY		P C SPITTING UP BLOOD
P C MOLE CHANGES	OTHER_____	P C BRONCHITIS
P C BOILS		P C SPITTING UP PHLEGM

INFORMED CONSENT TO TREATMENT

Naturopathic Medicine is the treatment and prevention of disease 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 generally used in order to stimulate the body's inherent healing capacity. Dr. Tara Andresen, ND will take a thorough case history, perform a physical examination, including a breast exam and urinalysis if indicated.

It is very important that you inform your Naturopathic Doctor immediately of any disease that you are suffering from and any prescription 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:

- Allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Rare pain, bruising or injury from acupuncture or B12 injections.
- Fainting or puncturing of an organ with acupuncture needles.
- Aggravation of pre-existing symptoms.

I understand:

- That a record will be kept of health services provided to me. This record is kept confidential and will not be released to others unless so directed by myself or unless the law requires it. If required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers.

- That treatment results are not guaranteed. I do not expect my Naturopathic Doctor to be able to anticipate all risks and complications. I understand that my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions that I may have. With this knowledge, I voluntarily consent to Naturopathic care. I intend for this consent form to cover the entire course of treatment and understand that I am free to withdraw my consent at any time.

Patient Name (please print)

Signature Patient or Guardian Date

Naturopathic Doctor ND Signature

SOURCE CENTRE GENERAL POLICIES

On your first visit, it is required that you fill out health history forms which should be updated yearly with any address or health changes that your practitioner should be aware of. Your practitioner will review this information with you and ask questions to ensure that you receive the treatment that meets your needs. Ongoing progress reports will be attached to your file on a regular basis.

Cancellation/Missed Appointment Policy

If you are unable to make an appointment, we request that you call 24 hours in advance. If you do not call to cancel or if you do not show up for your appointment, a cancellation fee will be charged. The fee for cancellations is equal to 50% the normal rate. If you book within the 24hr time frame, this policy becomes effective immediately. ***All cancellation fees are subject to HST.*

Lateness Policy

Your appointment reserves the specified time for your visit (60 minutes, 90 minutes etc.). If you arrive late for your appointment, you will be charged the full amount of your booked appointment but only receive treatment equal to the time remaining.

Cell Phones/Pagers within the Centre

Please understand that to achieve an environment of quiet and relaxation we ask that you turn off your cell phone, pager or other electronic devices.

Email Etiquette and Consent

We strive to keep in touch with our clients by all media available, the most common of which being Email. We ask that you keep the following in mind when using email to communicate with us:

1. E-mail is not appropriate for urgent or emergency problems, including last minute cancellations.
2. E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
3. E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee. If you do not receive a response, do not assume that we have actually received the message.
4. There is no way to assure the privacy of e-mail on a shared computer or e-mail account.
5. All e-mail correspondence will become a part of your medical record at the clinic.
6. It is extremely important to include your name and the name of your practitioner on every e-mail sent to the Source Centre.

By signing this document, you are confirming that you have read and understood the above information about the use of email to communicate matters pertaining to your health and healthcare, and understand the issues inherent in this use.

Consent to Terms of Services (Summary)

Providing you with the highest level of service is our business and we take this very seriously. Please take a minute to review our Terms of Services on our website so you are aware of what you may expect from us. In order for us to ensure you receive the highest level of care, we ask that you respect these Terms.
http://www.sourcecentre.ca/about/more/terms-service/

Privacy Policy Consent

As of January 1st, 2004, the Canadian Federal Government's Personal Information Protection and electronic Document Act (PIPEDA), was created. This privacy law requires your knowledge and consent before we may collect your personal information, except in rare circumstances. This means we want you to understand what we do with personal information we obtain about you. Our full Privacy Policy is available at your request and is posted on our web site at http://www.sourcecentre.ca/about/more/privacy/

Collection of Personal Information (Summary)

In order to provide you a health service we must collect some personal information, including but not limited to: telephone number, address, occupation, health history, prescriptions, involvement in other healthcare, etc. This information will be kept strictly confidential and will not be disclosed to any third party with the exception of the following: with your direct written consent, a medical emergency while you are on the premises, when required by law (i.e. court subpoena) or during regulated healthcare assessment purposes for quality assurances.

Please review our full Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. If you have any questions or concerns about the Privacy Policy, it is your responsibility to address them immediately with your practitioner.

Sharing of Personal Health Information with other Source Centre Practitioners

I consent to Source Centre practitioners, whose care I am under, sharing personal health information amongst themselves with regards to my care, for the purpose of enhanced clinical outcomes Y ❍ N ❍

By signing this Source Centre General Policy form, you are indicating that you have read and consented to all of these policies and that you have had a chance to read, and agree to, our Privacy Policy and our Terms of Service. If there is anything you do not understand in any of the above, please talk to us immediately.

I agree that I have read and understood all the policies, and I have been given a chance to ask any questions I have about the Privacy Policy and Terms of Services and that they have been answered to my satisfaction.

Signature _____

Client Name _____ Date_____

Signature of parent or Guardian (for anyone under the age of 18):

Signature _____

Guardian/Parent Name _____ Date_____