Pinewood Natural Health Centre

220 Duncan Mill Road, Unit 110
Toronto, Ontario M3B 3J5
(416) 656-8100

1295 Wharf Street, Unit 11
Pickering, Ontario L1W 1A2
(905) 427-0057

Nutrition Intake Form

Name: _____

Date: _____ Age: _____ Date of Birth:_____

Referred by:_____ Male ☐ Female ☐

Address:_____

Email:_____ Home Phone _____ Cell Phone _____

☐ Yes, I'd like to receive monthly newsletters of specials from Pinewood by email.

Please answer each of the following questions. Use the back of the page for additional space.

What is your reason for seeking nutritional counseling?

_____

What are your main health concerns?_____

_____

Have you ever been diagnosed with an ailment related to your main health concern(s)?

_____

Are you currently seeing or have you recently seen a:

Naturopath ☐ Chiropractor ☐ Holistic Nutritionist ☐
Homeopath ☐ Osteopath ☐ Energy Therapist ☐
Massage Therapist ☐ Dietician ☐

What is your current level of stress?

Minimal ☐ Average ☐ Considerable ☐ Unbearable ☐

What are the major causes of your stress?

☐financial ☐career ☐personal ☐marriage ☐health
☐family ☐spiritual ☐unfulfilled expectations
☐other (please elaborate) _____

How does your stress manifest itself? _____

_____

Do you use any coping mechanisms? _____

What do you do for exercise? (Indicate type, frequency and time) _____

_____

How many hours on average do you sleep daily? (include naps) _____

What time do you go to sleep? _____ Awaken? _____

For office use only:

REV: March-28-13

Do you awaken feeling rested? Yes ☐ No ☐

What is your occupation? _____
Do you enjoy your work? Yes ☐ No ☐ Sometimes ☐
How many hours each day do you work? _____
At what times do you start and end work? _____

Do you smoke? Yes ☐ No ☐ If yes, how much and for how long?
_____
If no, does anyone in your household or workplace smoke? Yes ☐ No ☐

Do you wish to gain weight? ☐ lose weight? ☐ how much? _____

How many hours, on average, do you spend each day:
Driving _____ Watching TV _____ Reading _____ In front of computer _____

What are your interests and hobbies? _____
_____

Do you vacation regularly? Yes ☐ No ☐
When was your last vacation? _____

For office use only:

MEDICAL HISTORY:
Are you currently taking any medication? Yes ☐ No ☐
List Reason(s) _____

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages: _____
_____
_____
Do you have any allergies or sensitivities? If so, please list:
_____
Do you have any silver-mercury fillings? Yes ☐ No ☐

Have you ever been diagnosed with an illness? Explain _____
_____

Hospitalized? Reason _____

How often do you have a bowel movement? _____
Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐
Related to particular food or circumstances? _____
Do you have loose bowel movements? Yes ☐ No ☐ Occasionally ☐
Related to particular food or circumstances? _____

FAMILY HISTORY:
Hereditary Diseases: Use "F" for father, "M" for mother, "S" for sibling, "G" for grandparent, "O" for others

_____ Heart Disease	_____ Diabetes	_____ Allergies
_____ Hypertension	_____ Arthritis	_____ Mental Illness
_____ Intestinal Disease	_____ Osteoporosis	_____ Alcoholism

_____ Kidney Dysfunction _____ Ulcers _____ Asthma
_____ Gall Bladder Problems _____ Cancer, type: _____
Other (please list) _____

FEMALES:
Are you or could you be pregnant? Yes ☐ No ☐
Are you pre-menopausal or menopausal? Yes ☐ No ☐
Are you experiencing any menopausal symptoms? Yes ☐ No ☐
If yes, please specify _____
Have you had a bone density test? Yes ☐ No ☐
If yes, what was the result? _____

DIETARY HABITS:
How many times a day do you eat:
Main Meals _____ Times of day: _____
Snacks _____ Times of day: _____
Do you eat meals: With family☐ Home alone ☐On the run ☐
Restaurant ☐ Fast food ☐
Do you feel there are restrictions to your diet due to the preferences of others -
Family, roommates, etc? Yes ☐No ☐ If yes, explain _____
_____
How many ½ cup servings of each do you typically eat daily:
_____ Fruit: Fresh ☐ Dried ☐ Canned ☐
_____ Vegetables: Cooked ☐ Raw ☐
_____ Whole Grains
_____ Protein: Type _____
_____ Dairy Products: Type _____
_____ Other: Specify _____

Give examples of your typical meals:
Breakfast: _____
_____
Lunch: _____
_____
Dinner: _____
_____
Snacks: _____
_____

Do you eat or use (indicate "1" for rarely, "2" for regularly, "3" for often)
☐Aluminum pans ☐Margarine ☐Candy
☐Microwave ☐Fried foods ☐Processed/refined foods
☐Luncheon meats ☐Chocolate ☐Fast foods
☐Nutra Sweet/Aspartame

Please indicate how many cups of the following you drink per day:
____ Bottled or spring water ____ Tap water ____ Cow's milk *(1% or 2%)*
____ Fresh fruit juices ____ Beer ____ Non-dairy milk
____ Fruit juices *(prepared)* ____ Red wine ____ Tea
____ Fresh vegetable juices ____ White wine ____ Green/herbal tea

For office use only:

REV: March-28-13

____ Soft drinks *(regular)* ____ Other alcoholic ____ Coffee
____ Soft drinks *(diet)* other (specify) _____

Are you a: ☐meat eater ☐vegetarian ☐vegan
How often do you eat meat? ☐daily ☐3-5/week ☐once/week or less
How often do you consume dairy products? ☐daily ☐3-5/week ☐once a week or less
What are your favourite foods? _____
How often do you eat them? _____
Do you avoid certain foods? If so, why?
_____
_____

Do you experience any symptoms if meals are missed? Explain:
_____
Do you experience any symptoms after meals? Explain:
_____

Comments: _____
_____
_____
_____
_____
_____

For Office use only:

CLIENT STATEMENT:
I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being, and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Date: _____

Signature: _____

Name: (please print) _____

I grant permission for Karen Gilman, Holistic Nutritionist at the Pinewood Natural Health Centre, to be able to access my patient files to review diagnostic and blood test results as they relate to the nutritional consultation. YES☐ NO ☐

Thank you for your cooperation.

All information contained on this form will be kept strictly confidential.

Privacy Information Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, the Privacy Information Officer is:

Michael Rahman N.D.

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 all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office 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 protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses and Discloses patients' Personal Information

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

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services
- To communicate with other treating health-care providers, including specialists and referring doctors
- To allow us to maintain communication and contact with you to distribute healthcare information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- To comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the practice.
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages, if any

- To prepare materials for the Health Professions Appeal and Review Board (HPARB).
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirement
- 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 for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

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

I know that your office has a Privacy Code, and I can ask to see the code at any time.

I agree that Pinewood Natural Health Centre can collect, use and disclose personal information about

_____ as set out above in the information about the office's privacy policies.
(Patient's Name)

Signature _____

Print Name _____

Date _____ Witness _____

☐ This consent was discussed and any questions or concerns have been addressed. _____
Practitioner's Signature

Privacy Information Sheet

How to Access the Privacy Process in Our Office

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your information.

Our privacy information officer can be reached at:

Pinewood Natural Health Centre
220 Duncan Mill Road, Unit 110
Toronto, ON
M3B 3J5
416 656-8100 (tel)
416 656-8107 (fax)
email: toronto@pinewoodhealth.ca

Our privacy information officer will attempt to answer any questions or concerns that may arise. If you have a concern and/or wish to make a complaint to us about our privacy practices, including asking questions about the contents of your charts or records, you must make your request in writing. Please send it to our office's Privacy Information Officer by surface mail, fax, or email.

Our Privacy Information Officer will promptly acknowledge receipt of your complaint in writing, and will ensure that it is investigated thoroughly. You will be provided with a formal decision in writing, and the reason for the decision. If you are dissatisfied with the decision, you may seek further information from the Privacy Commissioner of Canada. We have included all the necessary contact information listed below.

Postal Address:	General Inquiries:
Privacy Commissioner of Canada	Phone: 613-995-8210
112 Kent Street	Toll Free: 1-800-282-1376
Ottawa, ON K1A 1H3	Fax: 613-947-6850

Our privacy policies and procedures comply with federal legislation called the Personal Information Protection and Electronic Documents Act (PIPEDA). This very complex law does provide some exceptions to the privacy principles that are too detailed to outline here. Our privacy code sets out this office's commitment to protecting your private health and personal information. It is available on request by asking any of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.