



**Adult Intake Forms – Information letter**

Dear Patient:

We would like to take this opportunity to welcome you to our clinic, and to commend you for taking responsibility for your health. Naturopathic medicine is based on the principle of the body’s own ability to heal, and we at Pinewood Natural Health Centre utilize natural therapeutic measures which are supportive of the body’s inherent healing capabilities.

Please complete the questionnaire provided as honestly and precisely as possible, for every small detail is important, as it will aid us in our assessment of your mental, emotional, and physical well-being.

<b>Our Naturopathic Fee Schedule is As Follows:</b>	<b>ADULTS</b>	<b>SENIORS/STUDENTS</b>	<b>CHILD</b>
Initial Consultation (60 mins.)	\$200.00	\$190.00	\$150.00
Physical Exam (45 mins.)	\$125.00	\$120.00	\$110.00
Subsequent Visit (30 mins.)	\$85.00	\$80.00	\$75.00
Telephone consults (each 10 mins.)	\$28.35	\$26.65	\$25.00
Hair Analysis	\$95.00	---	
Acupuncture	\$75.00	\$70.00	---
Electromagnetic Field Therapy	\$20.00	----	
B 12 Injections	\$15.00		
Nebulized Glutathione	\$30.00		
Ear Lavage	\$25.00		
<b>N.B. – H.S.T. must be added to the above fees.</b>		<b>FEES ARE SUBJECT TO CHANGE WITHOUT NOTICE.</b>	

The first visit (approximately one hour) concentrates on your main concerns; the second visit (approximately forty-five minutes) entails an assessment of your condition, its treatment, and a physical examination; and, subsequent visits (approximately one-half hour) concentrate on the progress of your treatment.

This medical practitioner endeavors to provide the best possible diagnosis and course of treatment. However, many factors will be important in determining actual results. Therefore, no representation or warranty is made with respect to any treatment, action, or application of medical advice or information given.

We are pleased to inform you that our clinic is equipped with a dispensary for your convenience.

Some insurance companies cover naturopathic treatment, and we advise you to make inquiries concerning this with your company.

If you are unable to attend a scheduled appointment, please cancel 48 hours prior to the appointment, for we may provide care to another patient during the allotted time. If 24 hours’ notice is not given, there will be a fee charged for a missed appointment.

We request that patients who have outstanding balances, at any one time, of \$100.00 or greater pay these in full before further services are rendered. Also, returned cheques (e.g. N.S.F.) will be charged a \$50.00 administrative fee.

Thank you, again, for your commitment and for choosing Pinewood Natural Health Centre as your complimentary health care provider.

Naturopathically Yours,

Saveria A. Zambri, B.S.c., N.D., F.C.A.H., C.C.H., RS Hom (NA)  
 Doctor of Naturopathic Medicine



Adult Intake

File No: \_\_\_\_\_

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

Address: \_\_\_\_\_ Marital Status: \_\_\_\_\_

\_\_\_\_\_ Res. Tel: \_\_\_\_\_

Age: \_\_\_\_ Date of Birth: \_\_\_\_\_ Email Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Bus. Tel: \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Tel: \_\_\_\_\_

Are you Currently Under His/Her Care? \_\_\_\_\_ If "yes". for what? \_\_\_\_\_

Emergency contact Name: \_\_\_\_\_ Tel: \_\_\_\_\_

How or by whom were you referred to this clinic? \_\_\_\_\_

Have you been treated by a Naturopath before? Yes \_\_\_\_\_ No \_\_\_\_\_

If "yes", by whom? \_\_\_\_\_ When? \_\_\_\_\_

Why? \_\_\_\_\_

What is your chief complaint? \_\_\_\_\_

What are your other complaints (if any) \_\_\_\_\_

Family Medical History

Father: \_\_\_\_\_

Mother: \_\_\_\_\_

Sister(s): \_\_\_\_\_

Brother(s): \_\_\_\_\_

Children: \_\_\_\_\_

Spouse: \_\_\_\_\_

Other: \_\_\_\_\_



Patient's Medical History

List here:

When?

_____	_____
_____	_____
_____	_____
_____	_____

Immunizations & Reactions, if any: \_\_\_\_\_

Current Medications

Please circle any of the following medications you are taking:

chemotherapy  
radiation  
laxatives  
tobacco

recreational drugs  
appetite suppressants  
diuretics (water pills)  
aspirin / tylenol

tranquilizers  
pain relievers  
sleeping pills  
antacids

Please list any prescription medications, over-the-counter medications, vitamins or other supplements you are taking:

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

Please circle if you use any of the following:

alcohol  
cigarettes  
fried foods  
fast foods  
margarine

carbonated beverages  
candy / refined sugars  
saccharine (sweet & low)  
aluminum pans  
luncheon meats

tap water  
spring water  
distilled water  
coffee  
tea

Habits

Exercise? \_\_\_\_\_ Types: \_\_\_\_\_ How often? \_\_\_\_\_

Average 6-8hrs. sleep? \_\_\_\_\_ Sleep well? \_\_\_\_\_ Awaken rested? \_\_\_\_\_

Enjoy your work? \_\_\_\_\_ Eat 3 meals / day? \_\_\_\_\_

Excessive salt intake? \_\_\_\_\_ Excessive stress in life? \_\_\_\_\_



**\*\* Please circle any condition you have now. Put a "P" beside any condition you've had in the past.**

**A. General Symptoms**

- Wt. \_\_\_\_\_ Ht. \_\_\_\_\_
- Fatigue/Weakness
- Fever
- Chills
- Sweats
- Loss of Weight
- Weight Gain
- Anemia
- Past Blood Transfusions
- Easy Bruising/Bleeding
- Lymph Node Swelling
- Food Allergies
- Drug Allergies
- Depression
- Phobias
- Insomnia
- Anxiety
- Alcohol Abuse
- Drug Abuse

**B. Skin**

- Rashes
- Eczema
- Psoriasis
- Acne
- Itchy
- Dryness/Moisture
- Oily
- Hair Changes
- Nail Changes
- Temperature Changes
- Lumps
- Colour Changes
- Mole Changes

**C. Head**

- Headache
- Dizziness
- Head Injury
- Migraines

**D. Ears**

- Impaired Hearing
- Earaches
- Ringing
- Loss of Balance
- Dizziness
- Vertigo
- Infections
- Discharge

**E. Eyes**

- Impaired Vision
- Glaucoma
- Cataracts
- Double Vision
- Bothered By Sun
- Eye Pain
- Itching
- Redness
- Tearing
- Dryness
- Blurring
- Discharge

**F. Nose & Sinuses**

- Freq. Colds/Flu
- Nose Bleeds
- Hayfever
- Sinus Problems
- Congestion
- Pneumonia
- Discharges

**G. Mouth & Throat**

- Freq. Sore Throats
- Freq. Throat Infections
- Loss of Taste
- Sore Tongue/Mouth
- Cankers
- Gum Problems
- Stomatitis
- Dental Cavities/Fillings

**H. Neck**

- Lumps
- Pain or Stiffness
- Enlarged Glands
- Enlarged Thyroid

**I. Respiratory**

- Cough
- Wheezing
- Asthma
- Bronchitis
- Pleurisy
- Tuberculosis
- Sputum
- Difficulty Breathing
- Emphysema

**J. Cardiovascular**

- Heart Disease
- Chest Pain
- Heart Murmur
- High Blood Pressure
- High Cholesterol
- Purplish/Bluish Skin
- Palpitations/Fluttering
- Ankle Swelling
- Rheumatic Fever

**K. Gastrointestinal**

- Trouble Swallowing
- Increase / Decrease Thirst
- Increase / Decrease Appetite
- Nausea
- Vomiting
- Heartburn
- Indigestion
- No. of Bowel Movem'ts. / day
- Constipation
- Diarrhea
- Blood in Stool
- Rectal Bleeding
- Hemorrhoids
- Abdominal Pain
- Hernias
- Belching / Passing Gas
- Ulcer
- Jaundice
- Liver Disease
- Gall Bladder

**L. Urinary**

- Pain Before/During/After Urination
- Increased Frequency
- Urgency
- Hesitancy
- Inability to Hold Urine
- Blood in Urine
- Frequent Infections
- Kidney Disease
- Kidney Stones



M. Male Reproductive

- Hernia
- Testicular Mass
- Testicular Pain
- Low Libido
- Sexually Active
- Sexual Difficulties
- Prostate Disease
- Venereal Disease
- Discharge
- Sores

N. Female Reproductive

- Age Menses Began
- Length of Cycle
- Average number of days of menses
- Last menstrual period
- Irregular Cycles
- Painful Menses
- Bleeding Between Menses
- Excessive Flow
- P.M.S.
- Low Libido
- Sexually Active
- Sexual Difficulties
- Pain During Intercourse
- Venereal Disease
- Birth Control
- Pregnancies
- Miscarriages
- Abortions
- Difficulty Conceiving
- Vaginal Discharge
- Vaginal Itching
- Vaginal Yeast Infections
- Menopausal Symptoms
- Last PAP & Result
- Breasts
- Self Examination
- Pain / Tenderness
- Lumps
- Nipple Discharge
- Breastfeeding

O. Musculoskeletal

- Joint Pain / Stiffness
- Joint Swelling
- Arthritis
- Backache
- Broken Bones
- Muscle Spasms / Cramps
- Muscle Weakness

P. Peripheral Vascular

- Deep Leg Pain
- Cold Hands / Feet
- Varicose Veins
- Thrombophlebitis
- Extremity:  Numbness
- Coldness
- Swelling
- Ulcers
- Tingling

Q. Neurologic

- Fainting
- Seizures / Convulsions
- Loss of Memory
- Speech Problems
- Involuntary Movement
- Paralysis

R. Endocrine

- Heat Intolerance
- Cold Intolerance
- Thyroid Problem
- Diabetes
- Hypoglycemia
- Hormone Therapy

S. Infectious Diseases

- Hepatitis A
- Hepatitis B
- Hepatitis C
- HIV
- AIDS

Thank you for taking the time to fill out this questionnaire.



## **PROVISIONAL ONE PAGE DEFINITION OF NATUROPATHIC MEDICINE**

**Naturopathic medicine is a distinct system of primary health care - an art, science, philosophy and practice of diagnosing, treating and preventing disease. What distinguishes naturopathic medicine is that its practice is based on its underlying principles. Naturopathic medicine's techniques include modern and traditional, and scientific and empirical methods. The following principles are the foundation for naturopathic medical practice:**

### **Principles**

#### **The Healing Power of Nature [*Vis Medicatrix Naturae*]**

Naturopathic medicine recognizes an inherent healing ability in the body which is ordered and intelligent. Naturopathic physicians act to identify and remove obstacles to recovery, and facilitate and augment this healing ability.

#### **Identify and Treat the Causes [*Tolle Causam*]**

The naturopathic physician seeks to identify and remove the underlying causes of illness, rather than to eliminate or merely suppress symptoms.

#### **First Do No Harm [*Primum Non Nocere*]**

Naturopathic medicine follows three principles to avoid harming the patient. (a) Utilize methods and medicinal substances which minimize the risk of harmful side effects; (b) Avoid when possible the harmful suppression of symptoms; (c) Acknowledge and respect the individual's healing process using the least force necessary to diagnose and treat illness.

#### **Doctor as Teacher [*Docere*]**

Naturopathic physicians educate the patient and encourage self-responsibility for health. They also acknowledge the therapeutic value inherent in the doctor-patient relationship.

#### **Treat the Whole Person**

Naturopathic physicians treat each individual taking into account physical, mental, emotional, genetic, environmental, social and other factors. Since total health also includes spiritual health, naturopathic physicians encourage individuals to pursue their personal spiritual path.

#### **Prevention**

Naturopathic physicians emphasize the prevention of disease - assessing risk factors and hereditary susceptibility to disease, and making appropriate interventions to prevent illness. Naturopathic medicine strives to create a healthy world in which humanity may thrive

### **Practice Naturopathic Methods**

Naturopathic medicine is defined by principles rather than by methods or modalities. Diagnostic and therapeutic methods are diverse, and will continue to evolve as knowledge of health and disease evolves.

#### **Scope of Practice**

Our current scope of practice covers the full practice of medicine excluding major surgery and the use of most legend drugs. This includes but is not limited to the following diagnostic and therapeutic modalities as taught in naturopathic medical schools: nutritional science, natural hygiene, botanical medicine, naturopathic physical medicine including the therapeutic application of water, heat, cold, air, earth and light; oriental medicine, homeopathy, counseling, naturopathic obstetrics (natural childbirth), minor surgery, public health, immunization and all methods of laboratory and clinical diagnosis.



**INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES**

Patient Name \_\_\_\_\_ File No. \_\_\_\_\_  
 Address \_\_\_\_\_ Phone No. \_\_\_\_\_  
 \_\_\_\_\_ Attending ND: \_\_\_\_\_

**RECOMMENDED THERAPEUTIC PROCEDURE(S)**  
 (Including those by referral to another practitioner)

- |  |   |
|--|---|
| _____ Nebulized Glutathione                  | _____ Chinese Herbal Medicines                      |
| _____ Therapeutic Ultrasound                 | _____ Hydrotherapy                                  |
| _____ Diathermy                              | _____ B 12 Injections                               |
| _____ Electromagnetic Field Therapy          | _____ Reiki   |
| _____ Naturopathic Manipulation              | _____ Ear Lavage                                    |
| _____ Soft Tissue Manipulation/Counterstrain | _____ Dietary Recommendations/Lifestyle Counselling |
| _____ Craniosacral Therapy                   | _____ Nutritional Supplementation                   |
| _____ Acupuncture/Acupressure/Acumed         | _____ Botanical Medicine                            |
|  | _____ Homeopathy                                    |

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedure(s) described above and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the therapeutic procedure(s) with respect to the nature of the procedure, expected benefits, potential risks, side effects and financial costs; the likely consequences of having the procedure(s) and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily consent / withhold my informed consent for the recommended therapeutic procedures(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

_____ Patient or Lawful Representative Signature	_____ Date Signed
_____ Witness Signature	_____ Witness Relation to Patient
_____ Witness Address	_____
_____ Witness Phone No.	_____ Attending N.D.



**INFORMED CONSENT TO NATUROPATHIC DIAGNOSTIC PROCEDURES**

Patient Name \_\_\_\_\_ File No. \_\_\_\_\_  
 Address \_\_\_\_\_ Phone No. \_\_\_\_\_  
 \_\_\_\_\_ Attending ND: \_\_\_\_\_

**RECOMMENDED DIAGNOSTIC PROCEDURE(S)**  
 (Including those by referral to another practitioner)

- |   |  |
|---|--|
| _____ Urinalysis  | _____ Peak Flow Meter                        |
| _____ Breast Exam   | _____ Muscle Testing                         |
| _____ Physical Examination                                    | _____ Chinese (TCM) Tongue & Pulse Diagnosis |
| _____ Hair Analysis   |  |
| _____ Blood Draw / Venipuncture – Blood Tests (Specify) _____ |  |

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic procedure(s) described above and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the diagnostic procedure(s) with respect to the nature of the procedure, expected benefits, potential risks, side effects and financial costs; the likely consequences of having the procedure(s) and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily consent / withhold my informed consent for the recommended diagnostic procedures(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

_____ Patient or Lawful Representative Signature	_____ Date Signed
_____ Witness Signature	_____ Witness Relation to Patient
_____ Witness Address _____	_____
_____ Witness Phone No. _____	_____ Attending N.D.





## **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. \_\_\_\_\_ Primary ND's Signature



**STATEMENT OF ACKNOWLEDGEMENT**

Each person seeking care in this office should understand that the doctors are Naturopathic, NOT Medical doctors! If standard medical diagnosis or treatment is required, it must be obtained from a licensed medical doctor.

Naturopathy uses non-invasive methods for the assessment of bodily dysfunction, and natural therapeutics for their correction. Each patient must sign this document before any treatment will be rendered. Your signature acknowledges the following:

1. You have read all the foregoing information and you understand that the ultimate responsibility for your health is your own.
2. You are in agreement with the commitments of this clinic, and you agree to abide by the clinic and its financial policies.
3. You understand that the practitioners in this clinic work within the Naturopathic scope of practice, are not medical doctors, and employ some methods which are not orthodox medical practice.
4. You understand that treatment here and/or referred to other health practitioners is based upon the assessment, and laboratory testing.
5. While changes in dietary habits are not a prerequisite for treatment, you understand the failure to follow sound nutritional and exercise programs could undermine the expected results.
6. You are not an agent of any private, local, county, provincial, or federal agency attempting to gather information without so stating your intentions.
7. You are accepting or rejecting this care of your own free will and choice.
8. You accept full responsibility for any fees incurred during care and treatment, and you agree to fully discharge this responsibility at the time of your visit, unless prior arrangements have been made.

I, \_\_\_\_\_,  
HAVE READ, UNDERSTOOD AND ACKNOWLEDGE THE ABOVE STATEMENTS.

\_\_\_\_\_  
DATE SIGNATURE WITNESS



**DECLARATION AND RELEASE**

I, \_\_\_\_\_ of the following address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

ACKNOWLEDGE AND DELCARE THAT I have been given the options of seeking/continuing conventional medical care from a qualified medical doctor and I have been properly informed that naturopathic treatment and medical treatment are not mutually exclusive.

I confirm that there has been no suggestion made to me by Saveria A. Zambri B.S.c., N.D., F.C.A.H., C.C.H., RS Hom (NA) or anyone under her direction or control to refrain from seeking or following conventional medical attention.

I understand that conventional medicine and drugless naturopathic medicine are different kinds of therapies that utilize different modalities of treatment.

I agree to pay my account after every visit.

Therefore, I do hereby authorize and consent to treatment by Saveria A. Zambri, B.S.c., N.D., F.C.A.H., C.C.H., RS Hom (NA).

DATED AND SIGNED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Patient, Parent, or Guardian Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Witness Name

\_\_\_\_\_  
Signature