PINEWOOD NATURAL HEALTH CENTRE 1295 Wharf St. Unit 11, Pickering, ON L1W 1A2 Tel: 905.427.0057 Fax: 905.837.8009
Saveria A. Zambri, B.S.c., N.D., F.C.A.H., C.C.H., RS Hom (NA)

Pediatric 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 the 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.

Our Naturopathic Fee Schedule is As Follows:	**ADULTS**	**SENIORS/STUDENTS**	**CHILD**
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		
N.B. – H.S.T. must be added to the above fees.		**FEES ARE SUBJECT TO CHANGE WITHOUT NOTICE.**	

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 the 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

Pediatric Intake

File No:_____

Child's name:_____ Age:_____ Date of Birth: _____

Mother's Name:_____ Father's Name:_____

Sex:_____ Grade:_____ Email Address:_____

Home Address:_____ Home Tel:_____

_____ Bus. Tel:_____
Postal code

Name of Medical Doctor:_____ Tel: _____

How or by whom were you referred to this clinic? _____

Has this child been treated by a Naturopath before? Yes_____No_____

If "yes", by whom?_____When?_____

Why?_____

Presenting Complaint:_____

Other Complaints (if any)_____

Family Medical History

Father:_____

Mother:_____

Sister(s): _____

Brother(s):_____

Maternal Grandparents:___ _____

Paternal Grandparents:_____

Aunt(s):_____

Uncle(s):_____

Others:_____
_____

Child's Medical History

List here: When?

_____ _____

_____ _____

_____ _____

_____ _____

Immunizations & Reactions, if any:

Measles_____ DPT_____ Smallpox_____

Mumps_____ MMR_____ Diphtheria_____

Polio_____ Tetanus_____ Influenza_____

Other (list):_____

Current Medications

Please checkmark any following medications this child is taking:

	Now	Past		Now	Past
Tempra			Antibiotics		
Aspirin			Antihistamine		
Tylenol			Decongestant		

Others (list):_____
Allergies to Medicine (list):_____

Mother's Pregnancy History

Number of previous pregnancies:_____ Number of miscarriages: _____
Number of abortions (if applicable):_____
Complications of any of the above: _____

Mother's age at child's birth:_____
Mother's health during pregnancy:

Bleeding_____ Physical or emotional Trauma_____
Nausea_____ Cigarettes,Alcohol,Drug Intake_____
Illnesses_____ Thyroid roblems_____
High Blood Pressure_____ Weight Gain_____
Diabetes_____ Medications_____

Birth History

Term: Full_____ Premature_____ Late_____ Wt. at Birth_____

Length of labour:_____ Complications?_____

Has your child had any of the following problems?

Jaundice_____ Ear Infections_____ Seizures/Convulsions_____

Colic_____ Tonsillitis_____ Birth Defects_____

Blue Baby_____ Cerebral Palsy_____ Birth Injuries_____

Others
(list)_____

Allergies (list)_____

Child's sleep patterns (first year):_____

Feeding: Breastfed?_____ How long?_____ Formula_____ Milk/Soy_____

Age began solid foods & in what order:_____

Food intolerances (if any):_____

List foods child likes & dislikes:

Likes_____ Dislikes_____

_____ _____

_____ _____

Age began: Sitting _____ Crawling_____
Walking _____ First Words_____
Cut first tooth _____ Trained for urine_____
Trained for BM_____

Diet
Please describe your child's "typical daily diet":

_____

_____

Review of Systems

Please circle any condition this child has presently.
Please place the letter P beside a condition this child has had in the past.

A. General Symptoms
__Fatigue/Weakness
__High fevers
__Chills
__Night Sweats
__Loss of Weight
__Weight gain
__Anemia
__Easy Bruis'g/Bleed'g
__Anxiety/Nervousness
__Unusual Fears
__Cries Easily
__Nightmares
__Sleep Problems
__Motion/Car Sickness

B. Skin
__Sinus Problems
__Chronic Rash
__Hives
__Eczema
__Psoriasis
__Itchy
__Acne
__Hair Changes
__Nail Changes

C. Head
__Cradle Cap
__Dandruff
__Freq. Headaches
__Migraines
__Head Injury

D. Ears
__Hearing Loss
__Impaired Hearing
__Earaches
__Infections
__Dizzy Spells
__Ringing
__Discharge

E. Eyes
__Impaired Vision
__Eye Pain
__Itching
__Redness
__Tearing
__Dryness
__Blurring
__Glazed
__Bothered by Sun
__Discharge

F. Nose & Sinuses
__Frequent Colds/Flus
__Nose Bleeds
__Hayfever
__Congestion
__Discharge

G. Neck
__Lumps
__Pain/Stiffness
__Enlarged Glands

H. Mouth & Throat
__Frequent Sore Throats
__Frequent Throat Infections
__Loss of Taste
__Sore Tongue/Mouth
__Cankers & Sores
__Bleeding Gums
__Dental Cavities/Fillings
__Breath/Body Odour
__Salivation

I. Respiratory
__Cough
__Wheezing
__Asthma
__Bronchitis
__Pneumonia
__Tuberculosis

Review of Systems (cont'd)

J. Cardiovascular
__Congenital Heart Defect
__Heart Murmur
__Chest Pain
__Rheumatic Fever

K. Gastrointestinal
__Stomach Aches
__Increased/Decreased Thirst
__Increased/Decreased Appetite
__Nausea
__Vomiting
__Diarrhea
__Constipation
__No. of BMs/day
__Belching/Passing Gas
__Hernias

L. Urinary
__Pain Before/During/After Urination
__Burning Before/ During/After Urination
__Increased Frequency
__Urgency
__Hesitancy
__Inability to Hold Urine
__Wets the Bed
__Infections
__Blood in Urine
__Kidney Disease

M. Musculoskeletal
__Joint Pain or Stiffness
__Broken Bones
__Muscle Spasms or Cramps
__Muscle Weakness
__Flat Feet

N. Peripheral Vascular
__Cold Hands or Feet
__Extremity:___Numbness
___Coldness
___Tingling

O. Neurologic
__Fainting
__Loss of Memory
__Involuntary Movements
__Paralysis
__Speech Problems

P. Endocrine
__Heat Intolerance
__Cold Intolerance
__Diabetes
__Hypoglycemia

Q. Habits
__Plays Well Alone
__Plays Well With Other Children
__Plays Well With Adults
__Shy
__Clings
__Upset Easily
__Frustrated Easily
__Destructive
__Independent

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

_____ Therapeutic Ultrasound

_____ Diathermy

_____ Electromagnetic Field Therapy

_____ Naturopathic Manipulation

_____ Soft Tissue Manipulation/Counterstrain

_____ Craniosacral Therapy

_____ Acupuncture/Acupressure/Acumed

_____ Homeopathy

_____ Chinese Herbal Medicines

_____ Hydrotherapy

_____ B 12 Injections

_____ Reiki

_____ Ear Lavage

_____ Dietary Recommendations/Lifestyle Counselling

_____ Nutritional Supplementation

_____ Botanical Medicine

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

_____ Breast Exam

_____ Physical Examination

_____ Hair Analysis

_____ Peak Flow Meter

_____ Muscle Testing

_____ Chinese (TCM) Tongue & Pulse Diagnosis

_____ 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

CONSENT FORM FOR THE TREATMENT OF A MINOR

I, _____ ,

do hereby authorize _____ ,

Doctor of Naturopathy, to examine and administer Naturopathic health care to my

_____ (indicate relationship to above signed),

_____.
(name of child)

Dated in Toronto, in the Province of Ontario, this _____ day of _____ , 20____ .

Signed: _____

Witness: _____