

ADULT NATUROPATHIC INTAKE FORM

Patient Name: _____ Date: _____

Medical History:

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations (along with approximate dates).

Do you have any allergies (to foods, medicines, environmental, etc.)? Please explain:

Please list all current medications:

Prescription Drugs	Over-The-Counter Drugs	Supplements (vitamins, etc)	Herbal medicines	Homeopathic medicines

Please list past prescription medications:

How many times have you taken antibiotics? _____ In the past year? _____

Do you frequently use any of the following? (Please Circle)

Aspirin Laxatives Antacids Diet pills Birth control pill / injection

Alcohol (how much/day or week) _____ Tobacco (form and amount/day) _____

Caffeine (form and amount/day) _____ Recreational drugs
 (what and how often) _____

Please indicate with an (X) what immunizations you have had:

DPT (diphtheria, pertussis, tetanus)		Tetanus booster (when?): _____	
MMR (measles, mumps, rubella)		"Flu"	
Hepatitis A		Haemophilus influenza B	
Hepatitis B		Polio	
Smallpox		other: _____	

Any adverse reactions to immunizations? Y N

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) Y N

Diet:

Do you have any food allergies or intolerances? Please list.

Do you have any dietary restrictions (religious, vegetarian/vegan, etc)?

Describe a typical day's diet:

Breakfast	Lunch	Dinner	Snacks

How frequently do you consume a serving of the following food groups? (Indicate if per day or per week)

Meats (beef, pork, chicken)		Wheat (pasta, bread, pastries, etc.)	
Dairy (Milk, cheese, ice cream, cottage cheese, yoghurt)		Other grains (rice, oats, barley, millet, rye)	
Eggs		Raw/Uncooked Vegetables (salads, carrots, etc.)	
Fruits		Cooked vegetables (frozen vegetables, potatoes, etc.)	
Juices: What types?		Nuts (peanuts, almonds, cashews, walnuts, etc.)	

Family medical history:

Indicate if a close relative (parent, child, sibling, grandparent) has had any of the following:

Condition	Who?	Condition	Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug/alcohol abuse	
High blood pressure		Kidney disease	
Cancer		Diabetes	
Autoimmune disease		Other	

Environment:

List your hobbies:

What do you do for exercise and how often?

Are you exposed to significant tobacco smoke (work, home, socially)? Y N

Are you frequently exposed to animals (work, pets, etc)? Y N

How is your home heated?:

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Y N
Please describe.

How would you describe the emotional climate of your home?

Please rate the level of stress at your work, or in other aspects of your life (scale: 1-10): _____

Please describe the nature of your stress:

How well do you handle these stresses?

If applicable, indicate any painful or distressed areas with a *number* and *describe the numbered area* in the space provided (ex. Type of pain/sensation, temperature, rashes, growths, scars, infections, etc.)

1. _____

 2. _____

 3. _____

 4. _____

 5. _____

 6. _____

Is there anything that you feel is important that has not been covered?



Consent Form for Collection, Use and Disclosure of Personal Information

The Naturopathic Doctor, as named above, understands the importance of protecting your personal information and is committed to collecting, using, and disclosing your personal information responsibly. The Doctor will try to be as open and transparent as possible about the way your personal information is handled.

The privacy policy adheres to the Personal Health and Information Protection Act 2004 (PHIPA), and outlines what the Doctor is doing to ensure that:

- Only necessary information is collected about you;
- She only shares 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 Board of Directors of Drugless Therapy – Naturopathy.

The Naturopathic Doctor 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 treatment, care and billing
- To assist your insurance company and completing claims
- To comply with the legal and regulatory requirements of your regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners Act*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply generally with the law
- To allow potential purchasers, practice brokers, or advisors to conduct an audit in preparation for a practice sale

I have reviewed the above information and I agree that Dr. Christine Dychangco N.D. can collect use and/or disclose personal information about _____ as set out above in the information regarding the privacy policy. (Patient Name)

Patient or Guardian Name

Patient or Guardian Signature

Date

Witness Signature

PHYSIOPLUS HEALTH GROUP CANCELLATION POLICY

We require a **minimum of 2 business days** notice for cancellation of an appointment. This will enable us to fill the time slot you have vacated with another patient in need of our care.

The cancellation fee is equal to the full fee for the appointment time you have booked.

We understand that last minute changes in your schedule are sometimes impossible for you to avoid. However, we must charge a cancellation fee equal to **the full fee for the appointment time reserved for you.**

Should you arrive late for your appointment or request to leave early, the full fee for the appointment time you have booked will also apply.

We will attempt to remind you of your appointment a day or two in advance, however please note that we provide this service as a **courtesy**. Please **do not** rely on these calls to keep track of your appointments. A cancellation fee equal to the full fee for the appointment time reserved for you will also apply for missed appointments.

Please Note: We understand that your time is valuable and therefore make every effort to keep our schedule running on time. Due to the nature of our work, unexpected delays sometimes occur. Please be assured that under these circumstances you will still receive your full treatment time. Thank you for helping us to maintain a high level of service for all our clients.

I understand the above and agree to abide by this policy:

Patient/Guardian or Parent Signature

Date

PAYMENT POLICY & INSURANCE COVERAGE

Fees for Osteopathic treatment, Physiotherapy and Massage Therapy treatments, and orthotics are covered by most extended health care plans. Each plan can vary greatly as to the amount covered **per treatment** and the **yearly maximums** covered. As the policy holder, **it is your responsibility** to contact your insurance company and confirm the **exact** details of your coverage. Our front desk staff would be happy to assist you with any questions regarding your insurance coverage for our services.

Naturopathy Fee Structure: Initial Visit -----\$130.00 (1- 1 ½)
Second Visit ----- \$90.00 (45 min)
Subsequent Visits ----- -\$90.00 (45 min)
----- \$65.00 (30 min)

Payment is due in full by **cash, debit, Visa, MasterCard, or cheque** at the end of each treatment session.

A receipt with all the required information will be provided to you, which you can then submit to your insurance company for re-imburement.

I understand the above and agree to abide by this policy:

Patient or Guardian/Parent Signature

Date