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NATUROPATHIC HEALTH EVALUATION FORM – ADULT

WELCOME AND CONGRATULATIONS ON YOUR COMMITMENT TO HEALTH AND WELL-BEING! WE LOOK FORWARD TO GUIDING YOU TOWARDS YOUR HEALTHIEST AND MOST INSPIRED LIFE.

Please take the time (allow 30 mins or more) to thoroughly and thoughtfully complete your naturopathic health evaluation form and submit it back to the clinic 24 hours prior to your 1 st appointment. This information will be kept strictly confidential.

GENERAL INFORMATION

First Name:	Middle Name:	Last Name:
Date of Birth (d/m/y):	Age:	Gender: M/F
Home Address:	Province:	Suite/Apt:
City:	Work #:	Postal Code:
Home Phone #:	**Circle your preferred method**	Cell #:
Email:	**of contact**	

Emergency Contact

Name: Relation: Home Phone #: Work #:

Family Physician

Name: Phone #:

How did you hear about our Clinic (e.g. website, word of mouth, walking by)?

Were you referred by anyone? Y/N – If yes, by whom?

Have you ever seen a naturopathic doctor before? Y/N – If yes, whom? How long ago?

HEALTH CONCERNS

What are your current **primary health concerns**? Please list in order of importance to you and complete the following.

Health Concern	e.g. Headaches
Onset?	e.g. 2 years ago
Makes Better?	e.g. lying down, heat, physical pressure
Makes Worse?	e.g. bright light, caffeine
Triggers?	e.g. too long between meals, low pressure before a storm
Treatment Goal?	e.g. reduce frequency

Health Concern	
Onset?	
Makes Better?	
Makes Worse?	
Triggers?	
Treatment Goal?	

Health Concern	
Onset?	
Makes Better?	
Makes Worse?	
Triggers?	
Treatment Goal?	

Health Concern	
Onset?	
Makes Better?	
Makes Worse?	
Triggers?	
Treatment Goal?	

HEALTH HISTORY

Please circle those **health conditions** you are currently experiencing. Please mark with a P those health conditions you have only experienced in the past. For current health conditions, please note month/year of onset/diagnosis.

	METABOLIC & HORMONAL (excluding reproductive)
	Type 1 Diabetes
	Type 2 Diabetes
	Metabolic Syndrome
	Obesity
	Hypothyroidism
	Hashimoto's Thyroiditis
	Hyperthyroidism
	Hyperparathyroidism
	Cushing's Syndrome
	Addison's Disease
	Inherited Metabolic Disorder
	Other:
	CIRCULATORY, BLOOD & LYMPH
	High Cholesterol
	High Blood Pressure
	Angina
	Heart Attack
	Stroke
	Congestive Heart Failure
	Transient Ischemic Attacks
	Heart Infection
	Arrhythmia
	Heart Valve Diseases
	Peripheral Venous Insufficiency
	Varicose Veins
	Deep Vein Thrombosis
	Intermittent Claudication
	Raynaud's Syndrome
	Iron Deficient Anemia
	B12/Folate Anemia
	Thalassemia
	Sickle-Cell Disorder
	Aplastic Anemia
	Diss. Intravascular Coagulation
	Haemophilia
	High Cholesterol
	Other:
	IMMUNE (GENERAL/OTHER)
	Common Variable Immunodef'y
	Multiple Chemical Sensitivities
	Sarcoidosis
	Anaphylatic Allergy Reaction
	Specify:
	Environmental Allergy
	Specify:
	Food Allergy
	Specify:
	Drug Allergy
	Specify:
	Other:
	RESPIRATORY
	Chronic Sinusitis
	Chronic Rhinitis
	Nasal Polyps
	Sleep Apnea
	Asthma
	Chronic Bronchitis
	Emphysema
	Pneumonia
	Tuberculosis
	Other:
	EARS & EYES
	Otitis Externa (recurrent)
	Otitis Media (recurrent)
	Labyrinthitis
	Meniere's Disease
	Tinnitus
	Ruptured Ear Drum
	Glaucoma
	Cataracts
	Conjunctivitis (recurrent)
	Macular Degeneration
	Retinal Detachment
	Other:
	SKIN, HAIR & NAILS
	Eczema/Atopic Dermatitis
	Psoriasis
	Rosacea
	Shingles
	Vitiligo
	Onychomycosis (nail fung infxn)
	Other:
	GASTROINTESTINAL
	Gingivitis
	Periodontitis
	Chronic Gastritis
	Gastric or Duodenal Ulcer
	GastroEsophageal Reflux Dz
	Celiac Disease
	Lactose Intolerance
	Irritable Bowel Syndrome
	Crohn's Disease
	Ulcerative Colitis
	Diverticulitis
	Colon Polyps
	Hemorrhoids
	Anal Fissures
	Appendicitis
	Hiatal/Inguinal
	Hernia
	Pancreatitis
	Hepatitis
	Liver Cirrhosis
	Liver Failure
	Gallbladder Stones
	Other:
	URINARY
	Bladder Infections (recurrent)
	Interstitial Cystitis
	Nephritic Syndrome
	Nephrotic Syndrome
	Kidney Failure
	Kidney Stones
	Kidney Infection
	Other:
	MUSCULOSKELETAL & CONNECTIVE TISSUE
	Osteoarthritis
	Osteoporosis
	Sciatica
	Fibromyalgia
	Rheumatoid Arthritis
	Systemic Lupus Erythematous
	Sjorgen's/Sicca Syndrome
	Other:
	NEUROLOGICAL
	Chronic Fatigue Syndrome
	Migraine
	Dementia
	Alzheimer's Disease
	Parkinson's Disease
	Huntington's Disease
	Multiple Sclerosis
	ALS
	Epilepsy
	Cerebral Palsy
	Trigeminal Neuralgia
	Bell's Palsy

	Other:
MENTAL & BEHAVIOURAL	
	Addiction/substance abuse
	Specify:
	Depression
	Anxiety
	Phobias
	Specify:
	Insomnia
	Bipolar Disorder
	Schizophrenia
	Suicide Attempts
	Bulimia
	Anorexia
	Personality Disorder
	ADD/ADHD
	Autism
	Other:
CANCER	
	Lung Cancer
	Breast Cancer
	Colon Cancer
	Prostate Cancer
	Melanoma

	Other:
MALE GENITAL/REPRO	
	Benign Prostatic Hyperplasia
	Prostatitis/Infection
	Infertility
	Erectile Dysfunction
	Sexually Transmitted Disease(e.g.HIV, chlamydia, gonorrhea)
	Specify:
	Hydrocele
	Torsion of Testes
	Testicular Mass
	Orchitis
	Other:
	Other:
	Other:
FEMALE GENITAL/REPRO	
	PMS
	Dysmenorrhea (painful periods)
	Amenorrhea (absent periods)

	Polycystic Ovarian Syndrome
	Infertility
	Candida/Yeast Infxn (recurrent)
	Sexually Transmitted Disease(e.g.HIV, chlamydia, gonorrhea)
	Specify:
	Endometriosis
	Fibroids
	Fibrocystic Breasts
	Mastitis
	Other:
	Gestational Diabetes
	Preeclampsia/Eclampsia
	Post-Partum Depression
	Other:
	Other:
	Other:
	Other:

Type of birth control?
Are you currently sexually active? Y/N
Sexual preference?

Women Only:

Average number of days bleeding?	
Average length of cycle (e.g. 28 days)? – Date last menses began?	
Are you currently pregnant?	Y/N
Are you trying to become pregnant?	Y/N
Number of pregnancies?	
Number of live births?	
Number of vaginal births?	
Number of caesarean sections?	
Number of miscarriages?	
Number of abortions?	
Are you currently breastfeeding?	Y/N
Are you peri-menopausal?	Y/N/Unsure
If yes, please list your symptoms?	
Are you menopausal/post-menopausal?	Y/N/Unsure
If yes, at what age did you become menopausal?	
What were/are your symptoms?	

Please check if you had any of the following **illnesses during childhood** and mark them with an asterisk (*) if they were severe/involved complications.

Yes		Yes		Yes	
	Chicken Pox		Meningitis		Polio
	Diphtheria		Mumps		Other:
	Measles		Rheumatic Fever		Other:

Please circle if you have experienced and provide year of **injury, surgery and hospitalization**.

	INJURY
	Back
	Neck
	Head
	Broken/Fractured Bones
	Specify:
	Strains/Sprains
	Specify:
	Other:
	SURGERY
	Angioplasty or Stenting
	Appendectomy

	Cholecystectomy (gall bladder)
	Coronary Artery Bypass
	Dental (e.g. root canal)
	Specify:
	Hernia
	Hysterectomy – full (ovaries
	removed) or partial?
	Joint Replacement
	Specify:
	Mastectomy

	Pacemaker
	Tonsillectomy
	Tympanostomy/Ear tubes
	Tubal Ligation
	Vasectomy
	Other:
	HOSPITALIZATION
	Specify Reason:
	Specify Reason:
	Specify Reason:
	Specify Reason:

Please circle if you have had, provide **last test/exam** date and note any abnormal/significant findings.

Year	Diagnostic Test/Exam	Findings?	Year	Diagnostic Test/Exam	Findings?
	Full Physical			Liver Panel	
	Complete Blood Count			Hepatitis B or C	
	Lipid Panel			Breast Exam	
	Cardiac Stress Test			Mammogram	
	ECG/EKG			Bone Density	
	Fasting Blood Glucose			Digital Rectal/Prostate	
	Colonoscopy			PSA	
	Fecal Occult Blood			PAP Smear	
	Upper Endoscopy			HIV	
	Upper GI Series			Syphilis	
	Lower GI Series			Other:	

HEALTH CARE Medications

Have you had prolonged or regular use of NSAIDs (e.g. Aspirin, Advil, Motrin)?	Y	N
Have you had prolonged or regular use of Tylenol?	Y	N
Have you had prolonged or regular use of Steroids (e.g. Prednisone)?	Y	N
Have you had prolonged or regular use of Acid Blocking Drugs (e.g. Zantac, Prilosec)?	Y	N
Have you had prolonged or regular use of Laxatives (e.g. Metamucil, Dulcolax)?	Y	N
Have you had prolonged or regular use of Antibiotics?	Y	N
Have you had prolonged use of the Oral Contraceptive Pill?	Y	N
Have you had prolonged use of Hormone Replacement Therapy?	Y	N

Please list all current medications (e.g. prescription, over-the-counter):

Medication	Dose	For What Condition?	Since When?

Please list major medications used in the past 10 years:

Medication	Dose	For What Condition?	When?

Vaccinations

Please check whether you have or have not had the following vaccinations.

Yes	No	Unsure		Yes	No	Unsure	
			MMR (measles, mumps, rubella)				Varicella (chicken pox)
			DPT (diptheria, pertussis, tetanus)				Influenza (flu)
			Tetanus booster				Meningitis
			IPV (inactivated polio virus)				HPV (human papilloma virus)
			Hepatitis A				Other (e.g. HINI flu)
			Hepatitis B				Specify:

Natural Health Products

Please list all current natural health products (herbs, vitamins, supplements, homeopathics):

Product & Brand	Dose	For What Condition?	Since When?

Health Care Treatment

Please list all current health care treatments (e.g. chiropractic, physiotherapy, counseling):

Treatment & Practitioner Name	Frequency	For What Condition?	Since When?

Please describe any significant side effects caused by your medications, vaccinations, natural health products or other health care treatment:

DIET

Please list any **food sensitivities or intolerances** (e.g. dairy, soy, wheat, gluten, corn, eggs, yeast, shellfish, fatty/greasy foods, caffeine, alcohol, monosodium glutamate, aspartame).

Please list any **dietary restrictions** (e.g. religious, vegetarian, vegan, low carbohydrate, low sodium, diabetic).

Please identify any **particular diet** (e.g. Atkins, Zone, Weight Watcher's) you currently follow.

Do you typically eat three meals a day? Y/N
Please describe a typical day's diet.
Breakfast:
Lunch:
Dinner:
Snacks:
Water (amount):
Other non-alcoholic beverages (kind and amount):
How often do you eat junk/fast food (e.g. candy bars, fries) each week?
How often do you eat sugary snacks/dessert each week?
How often do you eat processed/packaged food each week?

Do you eat/drink things sweetened artificially (e.g. with aspartame)? Y/N – If so, what?

Height:	Current weight:	Weight 1yr ago:	Usual weight:
	Maximum weight:	Minimum weight:	Desired weight:

Do you have regular weight fluctuations of >10lbs? Y/N
Have you ever had a nutritional consultation? Y/N – Was it helpful? Y/N
What changes have you made to your diet or eating habits to improve your health?

LIFESTYLE

Exercise:

Please describe your current exercise program.

Type	Activity	Frequency (per wk)	Duration (mins)
Cardiovascular			
Strength			
Flexibility			
Other			

Interests/Hobbies/Leisure Activities:

What are your main interests, hobbies, leisure activities (e.g. film, gardening, hiking)?

Stress/Relaxation:

Scale: 0=no stress, 10=extraordinary stress	
How would you rate the current level of stress in your life?	
What is your greatest current source of stress (e.g. work, family, finances)?	
How would you rate the level of stress in your life in the past year?	
How well do you generally deal with stress?	
What do you do to relax (e.g. go for a walk, meditate, have a drink)?	

Sleep:

When do you typically go to bed and rise from bed?	
In that time, how many hours of sleep do you think you are getting?	
Do you have difficulty falling asleep?	Y/N
Do you have difficulty staying asleep?	Y/N
Do you toss and turn throughout the night?	Y/N
Do you have difficulty waking?	Y/N
Do you do shift work?	Y/N
Do you fly or travel a lot?	Y/N

Energy:

Scale: 0=absolutely no energy, 10=boundless energy	
How would you rate your average energy level throughout the day?	
When during the day do you have the least energy?	
How would you rate your energy at that time?	
When during the day do you have the most energy?	
How would you rate your energy at that time?	
Do you have enough energy to complete your daily tasks (e.g. work, make meals, watch kids)?	Y/N
Do you have enough energy to do more than your daily tasks (e.g. exercise, socialize)?	Y/N

Substance Use:

Caffeine:	
How many cups (250ml) of caffeinated tea do you drink a day?	
How many cups of caffeinated coffee do you drink a day?	
How much caffeinated pop do you drink per day?	
Alcohol:	
How many alcoholic drinks do you have per week? (1 drink=5oz wine, 12oz beer, 1.5oz liquor)	
How long have you been drinking this amount of alcohol?	
Have you used alcohol in the past?	Y/N
If so, at what frequency?	
Tobacco:	
Do you use tobacco products?	Y/N
What kinds?	
If you do not or have not used tobacco, please skip the following questions.	
How many cigarettes do you smoke per day?	
How many years have you been smoking?	
If you successfully quit smoking, how long ago did you do so?	
If you have not successfully quit smoking, how many times have you attempted?	
Recreational Drugs:	
Do you use recreational drugs?	Y/N
If you do not or have not used drugs, please skip the following questions	
What kinds?	
At what frequency?	
Have you used recreational drugs in the past?	Y/N
If so, at what frequency?	

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Environmental Exposures

Are you frequently exposed to animals?	Y/N
Are you (or have you been) exposed to damp or moldy conditions?	Y/N
Are you (or have you been) regularly exposed to second hand smoke?	Y/N
Have you had regular or significant exposures to:	
Herbicides/pesticides?	Y/N
Organic solvents?	Y/N
Heavy metals?	Y/N
UV?	Y/N
Radiation?	Y/N
Other? - please specify:	
Do you regularly drink from plastic bottles or warm food in plastic containers?	Y/N
Do you regularly dry clean your clothing?	Y/N
Do you live in a new or old home?	
Do you consider your home a healthy physical environment?	Y/N
If not, why not?	
Do you consider your workplace a healthy physical environment?	Y/N
If not, why not?	
What is your primary source of drinking water?	Y/N
Have you traveled outside of Canada in the last 5 years?	Y/N
If so, where?	
Did you suffer any sickness during your travels?	Y/N
If so, what?	
Have you camped in the past 5 years?	

If you have noticed a negative impact of specific environmental exposures on your health, please describe here:

SOCIAL HISTORY

Do you have a significant other in your life (e.g. husband, partner)?	Y/N
If yes, what is their name?	
How long have you been together?	
How would you describe your relationship?	
Have you ever been divorced?	Y/N
Have you been widowed?	Y/N
Do you have children?	Y/N

If you do have children, please provide the following information:

Name:	Name:	Name:	Name:
Age:	Age:	Age:	Age:

Who lives in your household?	
How would you describe the emotional climate of your home?	
Who/what are your sources of social support (e.g. family, church)?	
Who/what is your primary source of social support (e.g. sister)?	
Do you feel you have adequate social support in your life?	Y/N
Are you currently working?	Y/N
If so, please specify:	
Do you generally enjoy your work?	Y/N
If you are not working, is this by choice? Y/N	
Do you do volunteer work? Y/N	
If yes, please specify:	Y/N
Are you involved in any community groups, clubs, etc? Y/N	Y/N
If yes, please specify:	Y/N

FAMILY HEALTH HISTORY

Please list the **health conditions your family members have experienced**, note their age at diagnosis in brackets ()beside their condition, and if deceased, their age at death.

Relation	Health Conditions (please use the previous table listing possible health conditions as a reference)	If Deceased, Age at Death
Mother	e.g. type 2 diabetes (55yoa), heart disease (60yoa)	70yoa
Mother		
Father		
Brother		
Sister		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Maternal Aunt		
Maternal Uncle		
Paternal Aunt		
Paternal Uncle		
Child		
Child		

REVIEW OF SYMPTOMS BY SYSTEMS

Please circle whether you have experienced the following **health symptoms**. Please mark with a P those symptoms you have only experienced in the past. For current health symptoms, please note month/year of onset.

	GENERAL, METABOLIC & HORMONAL (excluding reproductive)
	Hypoglycemia
	Intense thirst
	Intense hunger/appetite
	Changes – thirst/appetite
	Poor appetite
	Overweight
	Weight gain
	Underweight
	Weight loss
	Low body temperature
	Cold hands & feet
	Cold intolerance
	Chills
	High body temperature
	Heat intolerance
	Fever
	Easy/spontaneous sweating
	Night sweats
	Physical fatigue/exhaustion
	Mental fatigue/exhaustion
	Lack of energy/tiredness
	Difficulty sleeping
	Tired upon waking
	Daytime sleepiness/ drowsiness
	Other:
	Other:
	CIRCULATORY SYSTEMS, BLOOD & LYMPH
	Chest tightness/pain
	Heart palpitations/fluttering
	Irregular heart rate
	Low blood pressure
	Swelling in ankles/feet
	Purple/blue finger/toenails
	Cold hands/feet
	Leg cramps
	Deep leg pain
	Extremity (arms, hands, legs,
	feet) numbness
	Extremity ulcers
	Varicose veins/vein pain
	Easy bleeding or bruising
	Lymph node swelling
	Lymph node tenderness
	Other:
	Other:

	RESPIRATORY SYSTEM
	Cough (recurrent)
	Copious/discoloured sputum
	Spitting/coughing up blood
	Wheezing
	Pain on breathing
	Shortness of breath (SOB)
	without exertion
	SOB with exertion
	SOB at night
	SOB lying down
	Snoring
	Other:
	Other:
	NOSE, SINUSES, THROAT & NECK
	Impaired sense of smell
	Stuffiness/difficulty breathing through nose
	Colds (frequent)
	Post-nasal drip
	Nosebleeds
	Sinus congestion/pain
	Sore throat (recurrent)
	Hoarseness
	Laryngitis
	Enlarged thyroid/goiter
	Trouble swallowing
	Swollen/tender lymph nodes on neck
	Stiffness/pain in neck
	Other:
	Other:
	MOUTH
	Decreased sense of taste
	Bad breath
	Lips dry, peeling
	Cold sore
	Canker sore
	Tooth pain
	Numerous mercury fillings
	Grinding/clenching teeth
	Other:
	Other:
	HEAD, EARS & EYES
	Headache
	Facial discomfort/pain
	Facial numbness
	Dizziness/vertigo
	Impaired hearing

	Required to use hearing aid
	Ringing in ears
	Earache/infection
	Fullness in ears
	Ear discharge
	Impaired vision
	Required to wear
	glasses/contacts
	Blurred vision
	Double vision
	Blind spot
	Night “blindness”
	Eye pain
	Eye tearing
	Eye dryness
	Eye redness
	Eye itching
	Eye discharge
	Sensitivity to sunlight
	Other:
	Other:
	SKIN, HAIR & NAILS
	Dry skin
	Moist (clammy) skin
	Rough skin
	Itchy skin
	Skin colour change/
	discolouration
	Rashes
	Hives
	Acne/cysts/boils
	Warts
	Change in mole
	Dandruff
	Loss of head hair
	Loss of body hair
	Dry, brittle hair
	Dry, brittle nails
	Malformed nails
	Other:
	Other:
	DIGESTIVE SYSTEM
	Heartburn/reflux
	Belching
	Nausea
	Vomiting
	Vomiting blood
	Abdominal bloating
	Abdominal discomfort/pain
	Abdominal
	cramping/indigestion

	Gas/flatulence (excessive)
	Diarrhea
	Constipation
	Change in bowel habits
	Rectal bleeding
	Black, tarry stool
	Yellow skin (jaundice)
	Other:
	Other:
	URINARY SYSTEM
	Burning on urination
	Discomfort/pain on urination
	Increased freq of urination
	Increased frequency at night
	Urgency
	Inability to hold urine/leaking
	Hesitancy
	Weak urine stream
	Dribbling after urination
	Blood in urine
	Other:
	Other:
	MUSCULOSKELETAL SYSTEM
	Muscle pain
	Muscle stiffness
	Muscle spasms/cramps
	Lower back pain
	Pain at night
	Tendonitis
	Joint pain
	Joint stiffness
	Joint swelling
	Joint redness
	Joint deformity
	TMJ (jaw) discomfort/pain
	Other:
	Other:
	NERVOUS SYSTEM
	Light-headed
	Fainting
	Clumsiness
	Loss of balance/frequent falls
	Numbness/tingling

	Trembling/tremor
	Muscle weakness
	Muscle paralysis
	Speech problems
	Involuntary movement
	Seizure/convulsions
	Poor memory
	Other:
	Other:
	MENTAL & BEHAVIOURAL
	Sadness
	Lack of motivation
	Difficulty concentrating
	Nervousness/tense
	Irritability
	Mood swings
	Suicidal thoughts
	Hallucinations/delusions
	Other:
	Other:
	MALE GENITAL/REPRO
	Penile discharge
	Sores on penis
	Penile pain
	Difficulty obtaining/ maintaining erection
	Painful erection
	Difficulty ejaculating
	Premature ejaculation
	Absence of/minimal ejaculate
	Testicular or scrotal pain
	Testicular or scrotal swelling
	Poor/reduced libido
	Other:
	Other:
	FEMALE GENITAL/REPRO
	Premenstrual
	Breast swelling/tenderness
	Abdominal bloating
	General fluid retention
	Cravings
	Change in sleep
	Tiredness/fatigue
	Sadness
	Irritability

	Mood swings
	Other:
	Other:
	Menstrual
	Painful menses/cramps
	Heavy menses
	Clots in blood
	Scanty menses
	Bleeding between menses
	Infrequent menses
	Cycle length too long/short
	Cycle length irregular
	Difficulty conceiving
	Other:
	Other:
	Vaginal discharge
	Malodorous discharge
	Coloured discharge
	Vaginal itching
	Vaginal dryness
	Pain during intercourse
	Hot flashes/flushes
	Night sweating
	Decreased libido
	Inability to orgasm
	Other:
	Other:
	BREASTS
	Nipple discharge
	Nipple inversion
	Tenderness throughout cycle
	Cysts/lumps (armpits also)
	Texture change (e.g. dimpled)
	Shape change (e.g. puckered)
	Inflammation/redness
	Other:
	Other:
	Other:
	Other:
	Other:
	Other:

If you have any concerns (e.g. time commitment, significant financial restrictions) please note them here:

THANK YOU for investing your time in completing this health care evaluation. Please submit your form back to Healing Foundations Naturopathic Clinic 24 hours before your initial consultation. We sincerely look forward to meeting and working with you to achieve better health and well-being.

INFORMED CONSENT TO THE TREATMENT

Please note that this form must be signed prior to the rendering of any treatment or service.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors are regulated primary health care providers who 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.

Your Naturopathic Doctor (ND) will take a thorough case history, perform a physical examination and may order blood and urine testing. If your case requires, the physical may include more specific examinations such as gynecological, breast, rectal, or genital exams.

It is very important that you inform your Naturopathic Doctor immediately of any illness from which your suffering and any medications/over-the-counter drugs that you are taking. You will receive information about your diagnosis and/or treatment, alternative courses of action, costs, and expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There is some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to: Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short. Some patients may experience allergic reactions to supplements and herbs. Please advise your ND of any known or suspected allergies. Pain, bruising or injury from acupuncture; fainting or puncturing of an organ with acupuncture needles. Your ND is trained to handle emergencies should the need arise.

I do hereby voluntarily grant my informed consent for the recommended diagnostic procedure(s) and/or therapeutic procedure(s)/plan. I intend for this consent to allow for these diagnostic procedure(s) and/or therapeutic procedure(s)/plan to be performed by my primary ND (indicated below), and by other NDs (listed below) in the office, if necessary, for scheduling reasons or for continuity of care. I intend this consent form to cover the entire course of treatment

☐ Dr. Heidi McGill ☐ Dr. Kaitlyn Zorn

I _____ **, understand and agree:**
patient

- That **my primary** ND, Healing Foundations Naturopathic Clinic does not guarantee treatment results.
- Take responsibility to address any questions/concerns I have regarding treatment prior to commencement
- To take responsibility for the fees incurred in the naturopathic treatment.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- That I am free to withdraw my consent in full or in part, and to discontinue treatment at any time.

We believe in staying connected with you by sending a monthly e-newsletter, which provides practical, safe and effective health tips on how to naturally care for yourself and loved ones - includes health related articles written by your ND's and osteopathic practitioner, current research on health related topics that matter to you and clinic news and information.

- ❑ Check here if you prefer to **NOT** receive this kind of contact from us.

Signature of Patient	**Print Name**	**Date**
Signature of Attending ND	, ND **Print Name**	**Date**

PRIVACY POLICY

Privacy of personal information is important at the Healing Foundations Naturopathic (hereafter: "the clinic"). In providing you with quality naturopathic care, we are committed to collecting, using and disclosing personal information responsibly. We strive to be as transparent as possible about the way we handle your personal information.

In this office, _Your Primary ND acts as the privacy officer.

To help you understand how we are protecting your information, we have outlined how the clinic is using and disclosing your information.

Your information will be disclosed 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 send you newsletters and other information
- ✓ To remind you of upcoming appointments
- ✓ To communicate with other health-care providers
- ✓ To allow us to efficiently follow-up for treatment, care and billing
- ✓ To complete claims for insurance purposes
- ✓ To invoice for goods and services
- ✓ To process credit card payments
- ✓ To collect unpaid accounts
- ✓ To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse and reporting diseases and individuals who may be an imminent threat of harm to themselves or others
- ✓ To use for educational and research purposes (this includes case summaries, photographs, lab results and other pertinent medical information).

Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances.

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

PATIENT CONSENT TO THE COLLECTION AND USE OF PERSONAL INFORMATION:

I, **(*patient:*)**_____ have reviewed the above information that explains how the clinic will use my personal information. I agree that the clinic can collect, use and disclose personal information about me as set out in the clinic's privacy policy, described above.

Signature of Patient	**Print Name**	**Date**