UNION WELLNESS CENTRE
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Please complete the enclosed forms and questionnaire and return them to our office at least three days prior to your scheduled appointment. This will allow your healthcare practitioner to review them before your initial visit.

Please ensure that you have received all of the forms listed below. It is important to fully complete the questionnaire and to review and sign all other forms.

Client Health History _____

Consent To Treatment _____

Policies and Procedures _____

Privacy Consent Form _____

Fee Schedule _____

Daily Lifestyle Journal _____

Health Appraisal Questionnaire _____

Thank-you for contacting our office and we look forward to meeting you on:

Appointment Date: _____ Time: _____

CLIENT HEALTH HISTORY

Dear Client,

In order to get a clear understanding of your present state of health it is important that you fill out the following questionnaire as thoughtfully and accurately as you can. As with any questionnaire there may be questions that do not pertain to you (just leave these blank) or you may feel that there is important information that you would like to share that has not been requested. Please feel free to include all of the information that you feel is relevant to your current state of health. Your doctor is the only person who will review these forms and your confidentiality will be strictly maintained. Any further questions, concerns and/or clarifications regarding your health status will occur during your initial consult. Thank-you in advance for taking the time to carefully complete these forms and we look forward to helping you optimize your health.

Client Information

Name: _____ Date: _____

Address: _____

City/Town: _____ Postal Code: _____

Home Phone: (____) _____ Work Phone: (____) _____ Ext: _____

Cell Phone: (____)_____ E-Mail: _____

Birth Date: _____ Sex: _____ Height: _____ Weight: _____

Occupation: _____ Employer: _____

Medical Doctor: _____ Marital Status: _____

Referred by: _____ Blood Type: _____

Present Health Concerns

What is the primary reason you are requesting care at our clinic?

Are there any secondary reasons for seeking our care?

Please indicate whether there was a significant event (e.g. trauma, stress, travel etc.) that may have contributed to your current health concerns.

How long have you had these health concerns?

Is your primary health concern: a) getting better b) staying the same c) getting worse

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Please indicate the type and the severity of any pain or discomfort you are experiencing:

Symptom:	Minimal	1	2	3	4	5	6	7	8	9	10	Extreme
Symptom:	Minimal	1	2	3	4	5	6	7	8	9	10	Extreme
Symptom:	Minimal	1	2	3	4	5	6	7	8	9	10	Extreme
Symptom:	Minimal	1	2	3	4	5	6	7	8	9	10	Extreme
Symptom:	Minimal	1	2	3	4	5	6	7	8	9	10	Extreme

Does anything aggravate or make your present signs and symptoms worse?

Does anything relieve or make your present signs and symptoms better?

What therapeutic interventions/treatments have you tried (e.g. acupuncture, chiropractic, massage, naturopath, medical doctor, medications etc.)?

What steps have you personally taken to improve your health?

Do you feel that there are any significant stressors that are still effecting your well-being (e.g. trauma, addictions, change of job, relationship conflict, loss of loved one, work environment, history of abuse)?

Are you presently being cared for by another health care professional other than your family doctor (e.g. medical specialist, chiropractor, massage therapist, counselor, psychotherapist, acupuncturist etc.)?

Health History

Please list all of the surgical operations you have had and the approximate dates.

Please list **ALL** of the medications you presently use.

Please circle all of the following conditions that you have had:

Acne	Cataracts	Gout	Lupus	SADS
AIDS	Chronic Fatigue Syndrome	Hay Fever	Menopause	Sinusitis
Anemia	Cold Sores	Hepatitis	Migraines	Stroke
Angina	Crohn's	Herpes	Multiple Sclerosis	Ulcers
Anxiety	Depression	High Blood Pressure	Osteoarthritis	Ulcerative Colitis
Asthma	Diabetes	High Cholesterol/Heart Disease	Osteoporosis	Yeast Infections
ADD/ADHD	Ear Infections	Hives	Parasites	Hiatus Hernia
Bladder infections	Eczema	Hypoglycemia	PMS	
Bronchitis	Endometriosis	Hypothyroidism	Pneumonia	
Cancer	Fibromyalgia	Insomnia	Prostate Enlargement	
Candidiasis	Food Allergies	Irritable Bowel Syndrome	Psoriasis	
Canker Sores	Gallstones	Kidney Stones	Rheumatoid Arthritis	

Other: _____

Please circle all of the conditions present in your family's history.

Alcoholism	Eczema/Psoriasis	Hypothyroidism
Asthma	Emotional Disorders	Migraines
Autoimmune (M.S., Lupus, R.A.)	Food Allergies	Osteoarthritis
Cancer	Hay Fever	Osteoporosis
Depression	Heart Disease	Prostate Enlargement
Diabetes	High Blood Pressure	Stroke
Drug Abuse	High Cholesterol	Yeast Infections

Other: _____

Please list any medical testing which you have had done over the past number of years.
(e.g. x-rays, bone mineral density, mammograms, CAT scan, MRI, colonoscopy etc.)

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Digestion/Elimination Assessment

When do you first become "physically" hungry?
____ immediately after waking
____ 1 - 2 hours after waking
____ lunch time
____ never, I eat because it is time to eat

After eating do you experience any of the following?
____ burping or reflux
____ heartburn
____ gas
____ stomach pain
____ bloating
____ abdominal pain
____ cramping or loose stools

Do you experience any symptoms if you miss a meal?

Do you crave any foods (e.g. sweet, sour, salty etc. or bread, chocolate etc.)?

Do you have any food allergies? Y N If so, please list. _____

Do you suspect you have any food sensitivities? If so, please list. _____

How often do your bowels move: a day: _____ ; a week: _____ (on average)

Do you ever use laxatives? Y N

If so how often: daily _____ ; weekly _____; what type: _____

Do you ever have trouble initiating your bowel movement or does abdominal cramping/discomfort ever accompany your bowel movements?

Use these codes to answer the following questions: 1 - never, 2- infrequent, 3 - frequently, 4 - constantly

Stool size/consistency:
____ large (e.g. 3 fingers wide, 6" long)
____ medium (e.g. 2 fingers wide, 4-6" long)
____ small (e.g. 1-2 fingers wide, less than 4" long)
____ soft and well-formed
____ hard and difficult to pass
____ thin, long, narrow
____ loose but not watery
____ diarrhea
____ alternates between diarrhea and constipation
____ often float
____ often sink

Stool odour:
____ offensive consistently
____ offensive occasionally
____ little odour

Stool colour:
____ medium brown
____ dark brown
____ very dark or black
____ yellow, light brown, clay coloured
____ greenish colour
____ greasy, shiny appearance
____ blood is visible
____ mucus is visible
____ undigested food is visible

Intestinal gas:
____ daily
____ occasionally
____ excessive with pain
____ foul smelling

Urination Patterns:
____ difficulty starting or stopping when urinating
____ feels as if bladder doesn't completely empty
____ get up at night to urinate, if so how often _____
____ urgent and/or frequent urination
____ burning or irritation during or after urination
____ strong odour to the urine

Immune System Assessment

Was your mother healthy throughout her pregnancy?

Were there any complications during the birth process or in the first 6 months after birth?

Were you breast fed during the first 6 months of life? What other foods were introduced during this time?

Were you a colicky baby (e.g. sleep challenges, bowel challenges, gassy etc.)?
Until what age?

Did you require any medical attention, surgeries, medication as an infant/child? If so please give details.

As a child did you ever have parasite/worm infection?

Did you have any immunizations? If so did you have any adverse reactions?

As a child did you suffer from any recurrent infections (ear, bladder, sinus, tonsil etc.)?
If so, estimate how many courses of antibiotics you would have received per year.

How many colds/flus do you get a year? Do you get over them quickly? If not, please explain.

In the last 10 years have you experienced any of the following for which you would have received medications:

____ acne
____ bronchitis/pneumonia
____ ear infection
____ prostatitis
____ sinusitis
____ strep throat
____ toe/finger nail infection
____ tonsilitis
____ vaginitis
____ other

Lifestyle Assessment

Sleep Patterns

On average, what time to you go to bed? _____

What time do you usually rise? _____

How many hours do you usually sleep? _____

Do you feel refreshed/rested on waking? _____

Do you nap throughout the day? _____ If so, for how long? _____

Do you have trouble falling asleep? Y N If so, how long does it usually take you? _____

Do you have trouble staying asleep? Y N If so, how often do you wake a night? _____

If you wake at night, approximately what time does that occur? _____

If you wake at night, how long does it take you to fall back to sleep? _____

On a scale of 1 -10 (10 being excellent) rate your quality of sleep. _____

Exercise

Do you exercise regularly? Y N If so, indicate the frequency. ____ daily ____ weekly ____ monthly

Please indicate the nature of the exercise (e.g. yoga, walking etc. or cardio, strength, stretching) and the duration of the exercise.

Do you monitor your pulse during exercise? Y N What is your resting pulse rate? _____

Do you perspire with exercise? ____ lightly ____ moderately _____ heavily

Does your perspiration have a strong odour to it? Y N

Do you experience any symptoms during or after exercising (shortness of breath, joint/muscle pain, increased fatigue following exercise etc.)? If so, please explain.

Natural Light and Fresh Air

At your place of work (office, home etc.) do you have a specialized air filtration system? Y N

Do you open the windows? Y N

Do you come into contact (at home, work, hobbies etc.) with any toxic substances/fumes (paints, plastics, glues, gases etc.)? If so, please list.

Do you smoke? Y N

If you smoked in the past please indicate: how many a day, the length of time and the date you quit.

Are you exposed to second hand smoke? Y N

On average, how many minutes/hours do you spend outside in a day?

When you are outside do you always wear sunglasses, glasses, or contact lenses? Y N

Other Lifestyle Issues

Do you try and drink 8 -10 glasses of purified or bottled water a day? Y N

Do you drink alcohol? Y N What type do you drink?

How much; a day _____; a week _____

Do you use any recreational drugs? Y N What type?
Frequency of use:
Do you wear a medical bracelet or tag? Y N If so, for what condition?_____

Do you have any self-destructive lifestyle habits? If so, please list.

Are you aware of any allergies to medications, topical compounds, inhalants etc.? If so please list.

Stress Management

Please rate your current level of stress. Minimal 1 2 3 4 5 6 7 8 9 10 Extreme

Do you feel that you handle stress well? Y N

If not, do you feel that stress is having an impact on your current health challenges? Please describe.

Do you regularly practice any stress management techniques (deep breathing, meditation, visualization etc.)? If so, please indicate the type and duration.

What areas of your lifestyle would you like to improve? Prioritize them 1,2,3 etc.

____ my stress management skills
____ my exercise program
____ my diet and nutrition program
____ my supplement program
____ my sleep patterns
____ my time spent outdoors in nature
____ my level of anxiety
____ my creative expression

How confident are you that you will follow through on the healthy lifestyle changes (e.g. nutrition, exercise, sleep, stress management etc.) that it will take to achieve your health goals? (Rate from 1 “not at all” to 10 “100% certain.)

Thank-you once again for taking the time to thoughtfully complete the above questionnaire. Your responses go a long way towards helping us understand your most significant healthcare needs.

Signature: _____ Date: _____

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MEDICATION AND SUPPLEMENT HISTORY

Please list any medication which you are currently taking or which you have taken in the past. Also please record any vitamin/mineral/herbal/homeopathic supplement which you are currently taking or which you used in the past and found particularly helpful.

Medication/Supplement	State Date/Stop Date	Reason for It and Results

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Statement of Acknowledgement and Consent to Treatment

THIS FORM MUST BE SIGNED BEFORE ANY TREATMENT WILL BE RENDERED

Naturopathic medicine uses non-invasive methods of assessing the bodily functions and the use of natural therapeutics for correction. In order to clarify my position as your health care practitioner, and our mutual responsibility in your health care, I ask for your cooperation in signing this statement. In doing so, you acknowledge:

1. That you understand that I am a naturopathic doctor and not a conventional medical doctor; that I use non-invasive, natural methods of assessment and treatment of body dysfunctions; that any treatment you receive is not mutually exclusive from any treatment or advice you may now be receiving or may receive in the future from another licensed health care provider;

2. That you understand that the methods I may use have proven clinical foundation, yet may not be accepted by standard (allopathic) medicine;

3. That you understand that treatment and/or referral to other health practitioners is based on the assessment of your health revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation, including electromagnetic evaluation. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario;

4. That you understand I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be provided;

5. That you are not an agent of any private or government agency attempting to gather information without so stating your intentions;

6. That while changes in dietary habits are not an absolute pre-requisite for treatment, you understand that failure to follow sound nutritional, exercise and lifestyle programs could undermine the expected results;

7. That you are accepting or rejecting this care of your own free will;

8. That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this;

9. That I reserve the right to discontinue my services where it is apparent that your expectations and what I can provide are not in agreement;

I, _____ attest that I have read and understand the above statements, and with my signature I acknowledge said statements.

Signature: _____ Date:_____

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Office Policies and Procedures

In an ongoing effort to serve our clients more effectively, we have established the following office policies and procedures. If you have any questions or concerns please feel free to talk with your healthcare practitioner and or any of the office staff.

1. Naturopathic health care is **not** covered by OHIP. If you have extended healthcare insurance your policy may cover naturopathic consultations. Please check your policy.

2. If you need to cancel an appointment please call 24 hours in advance. This will allow us to schedule another client into that time slot.

3. Our office hours are designed to accommodate most people's schedules. If for some reason you can not find a suitable time for one of your appointments, we are open to arranging an appointment to accommodate your special needs.

4. At times it will be appropriate to schedule a phone consultation (e.g. due to distance, acute condition etc.). The fee for a phone consultation will be based on the amount of time required to review your case file and conduct the consultation.

5. Fees for service/product are due the day that service/product has been provided.

6. While our goal is to run on time, we ask for your understanding when circumstances make this difficult to accomplish. In the field of healthcare, there are situations that arise which demand more time and attention than have been scheduled for. In these situations we appreciate your patience and know that the length of your appointment will not be affected in any way.

7. Our goal is to provide exceptional healthcare and quality service. If at any time you feel that your needs have not been heard or that you have not been attended to with consideration and efficiency, please give us your constructive feedback.

I, _____ attest that I have read and understood the above statements, and agree to fulfil my responsibilities as a client as stated herein.

Signature: _____ Date: _____

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Fee Schedule

The number and length of appointments, treatments and lab assessments will vary depending on the severity of your condition and the nature of your health goals. Initially it is recommended that clients engage in naturopathic visit 1 and 2 after which the frequency of visits/treatments will be determined.

1) Naturopathic Visit 1 - review of case history and intake forms
- length: 60 minutes

2) Naturopathic Visit 2 - initial lab work/physical exam/proposed treatment plan
- length: 60 minutes

3) Naturopathic Visit 3 (and so on...) - re-assessment of labs/physical exam/treatment protocol
- length: 30 - 45 minutes

4) Naturopathic Phone Consult - At times it will be appropriate to schedule a phone consultation (e.g. due to distance, poor weather, acute condition etc.). The fee will be based on the amount of time needed to review the case file and conduct the consultation.

Naturopathic Visits:

1) 60 minutes	$175.00
2) 45 minutes	$ 130.00
3) 30 minutes	$ 80.00
4) Phone Consult	- varies depending on length

All supplements are subject to HST.

OHIP does not cover any naturopathic services. If you have additional healthcare coverage please check your insurance policy to see whether you have coverage for naturopathic services.

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PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of the Union Wellness Centre, while providing you with quality Naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In the Union Wellness Centre, Dr. Catharine Hildebrand acts as the Privacy Information Officer.

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 trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic 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 protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

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

This clinic 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 send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with trained assistants and other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners Act*

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- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

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 as outlined above.

Patient Consent

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

I agree that the Union Wellness Centre can collect, use and disclose personal information

about _____ as set out above in the information about
(patient name)

the Union Wellness Centre's privacy policies.

_____ _____
Signature print name

_____ _____
date signature of witness