Lakeside Natural Health
CENTRE

Adult Intake Form

Today's date: ___________________________

Name:_________________________________ Age:________ Birth date:_____________________ M F

Address: ______________________________City: ______________________ Postal: _________________

Home Phone #:(______)__________________________Work #: (_____)________________________________

E-mail: ___________________________________ Preferred method of contact: Home # Work # Email

Emergency Contact name, phone #, and relationship to you:____

Occupation:____

Names of other Healthcare providers:

1.________________________________ Phone #: (____)________________________________

2.________________________________ Phone #: (____)________________________________

How did you hear about this clinic? ____

What are your chief concerns? (Please list them in order of importance to you)

1. ____
2. ____
3. ____

Previous Treatments and results? ____

Your Medical History

How would you describe your general state of health?

Excellent Good Fair Poor

Please check the following that apply to you:

Cancer	Diabetes	Surgeries	Depression
High blood pressure	Seizures	Other major illness	Asthma
Heart disease	Hepatitis	Venereal disease	Allergies
Rheumatic fever	Thyroid Disease	Arthritis	Alcoholism
Significant trauma (auto accidents, falls, other)		HIV	Other

Family Medical History (please write the family member beside checked category, eg/ "mother")

Cancer ________________________	High Blood pressure _____________________
Asthma ________________________	Depression ____________________________
Diabetes ______________________	Heart Disease __________________________
Allergies ______________________	Thyroid disease _________________________
Seizures _______________________	Stroke ________________________________
Alcoholism _____________________	Kidney disease __________________________
Arthritis	Other _________________________________

7 Elmwood Avenue North
Port Credit, Ontario L5G 3J8
905.274.4375
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Medical and Lifestyle Information

Date of last physical exam:__________________ Weight ______ Height______Weight 1 year ago _______

Date of last dental check up: _________ Do you have any mercury fillings? Y N If yes, how many? ____

Energy level (1-10, 10 being the best energy you've ever experienced) _________________________________

Do you wake up feeling refreshed? Y N How many hours of sleep do you get a night? ____________

Do you wake during the night? Y N If so, at what time(s)? ________________

Reason for waking during the night? ____________ Do you drink coffee? Y N #cups/day___________

Have you/do you use recreational drugs? Y N Do you drink alcohol? Y N #drinks/week________

Do you smoke? Y N #cigarettes/day______________How long have you smoked?___________________

Do you drink pop? Y N How much/day? _____________ Do you use artificial sweeteners? Y N

Describe your weekly exercise (# of times/week and description of exercise): ___________________________

____

What do you value in your life? ____

Please circle the number that Indicates your level of stress

(0= no stress, 5= moderate stress, 10= extremely stressful)

Financial	0	1	2	3	4	5	6	7	8	9	10
Job Related	0	1	2	3	4	5	6	7	8	9	10
Relationship	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10
Family Members	0	1	2	3	4	5	6	7	8	9	10
Spiritual	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

List all your current prescription medications

____

____

How many times have you been treated with antibiotics in the last 5 years? ____________________________

List all your over-the-counter medications that you take (for example: aspirin, Tums, Tylenol) and include dose and frequency:

____

List all vitamins, minerals, herbs, Asian medicines, or homeopathic supplements you are taking and include dosage: ____

____

Do you have any known allergies (environmental, medicines)? Y N If yes, what are they?

____

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Are you on a restricted diet? Y N Have you ever been on a restricted diet? Y N
If yes to either question please describe the type of diet.

____

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

____

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

Check off any of the following if they are a CURRENT or RECURRING symptom.

General

Change in appetite	Night sweats	Weight gain
Poor sleep	Sweat easily	Weight loss
Fatigue	Sudden decrease in energy	Peculiar tastes or smells
Chills	Cravings	Bleed or bruise easily
Fevers	Strong thirst	

Skin and Hair

Rashes	Change in hair or skin texture	
Eczema	Loss of hair	Dryness
Itching	Dandruff	Ulcerations
Pimples	Recent moles	Skin Cancer

Head, Eyes, Ears, Nose, and Throat (HEENT)

Headaches	Color blindness	Nose bleeds
Head or neck problems	Blurry vision	Teeth problems
Concussions	Cataracts	Jaw clicks
Eye strain	Earaches	Gums bleed easily
Glasses	Poor hearing	Facial pain
Night blindness	Ringing in ears	Recurrent sore throats
Eye pain	Sinus problems	Sores on lips, tongue or mouth

Respiratory

Difficulty breathing	Asthma	Coughing blood
Cough	Pain with a deep breath	Pneumonia
Bronchitis	Production of mucus	Other

Cardiovascular

High blood pressure	Fainting	Cold hands or feet
Low blood pressure	Chest pain	Swelling of hands
Irregular Heartbeat	Varicose veins	Swelling of ankles/feet
Dizziness	Blood clots	

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Gastrointestinal

Indigestion	Abdominal pain or cramps	Rectal pain
Gas	Nausea	Hemorrhoids
Bad breath	Vomiting	Blood in stool
Constipation	Laxative use	Diarrhea

Genito-urinary

Frequent urination	Unable to hold urine	Impotency
Urgency to urinate	Decrease in flow	Sores on genitals
Pain on urination	Blood in urine	Frequent urinary tract infections
Wake at night to urinate	Kidney stones	Other

Gynecology and Pregnancy

Are you pregnant? Y N What is the first day of your last period? ____________________________

Age of first period_________________________________How long does your period last?______________

Date of last PAP__________________ Normal cells Abnormal cells

Regular periods — Live pregnancies #_________

Irregular periods — Miscarriage #____________________

Painful periods — Abortion #________________

Vaginal discharge — Birth control used. If yes, what type?________________________

Vaginal sores — How many years have you been on the birth control pill? ________

Clots

Changes in body or emotions prior to menstruation. Please describe. __________________________

Heavy flow — Light flow

Musculoskeletal

Neck pain	Knee Pain	Muscle pain
Back pain	Foot / ankle pain	Muscle weakness
Hand/wrist pain	Hip Pain	
Shoulder pain	Other joint or bone problems?	

Neuropsychological

Loss of balance	Depression	Concussion
Quick temper	Susceptible to stress	Seizures
Poor memory	Dizziness	Areas of numbness
Anxiety	Lack of coordination	

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INFORMED CONSENT

I would like to take this opportunity to welcome you to Lakeside Natural Health Clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. If you are working with a naturopathic doctor a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

As a patient of this clinic I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. As Lakeside Natural Health Centre is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I understand that my treatment will be based in naturopathic medicine, which has a proven clinical foundation, yet may not be accepted practice by standard allopathic medicine. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture.
I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

I, ___________________________________ have read, understood and acknowledge the above statements.

Date: ____________________________ Signature: ____________________________

Witness (if present): ___________________________________

Lakeside Natural Health
CENTRE

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

Privacy of your personal information is an important part of providing you with quality naturopathic care. We understand the importance of protecting your personal information and 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.

The privacy policy outlines what the centre 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 THIS CENTRE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

This centre understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how we are using and disclosing your information.

The centre 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 other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- 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*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this centre to comply with all regulatory requirements
- To comply generally with the law

PATIENT CONSENT

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.

I have reviewed the above information that explains how your centre will use my personal information, and the steps your Clinic is taking to protect my information.

I agree that the Naturopathic Doctors at Lakeside Natural Health Centre can collect, use and disclose personal information about

______________________________ (patient name) as set out above in the centre's privacy policy.

______________________________ Signature

______________________________ Print name

______________________________ Date

______________________________ Signature of Witness

Jessica Liu, ND, Kate Morrison, ND
Naturopathic Doctor
Lakeside Natural Health Centre
7 Elmwood Avenue North
Mississiauga, ON L5G 3J8
Tel: 905-274-4375 Fax: 905-274-6209

AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL TO LAKESIDE HEALTH CENTRE

(Please send a copy of this form back with records)

Section 1:
(Patient to complete Section 1 and 3 of this form)

To: Dr.(MD): ______________________________
(please print)
Fax No#: ______________________________

Address: ______________________________

____

____

Telephone: ______________________________

From: Patient: ______________________________
(please print)
Date of Birth: ______________________________

Address: ______________________________

____

____

Telephone: ______________________________

Section 2:

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records ______________________________

Laboratory Results __*most recent complete blood work up______________

Imaging Results ______________________________

Other ______________________________

Section 3:

I ______________________________ give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.

Signature of patient: ______________________________

Date: ______________________________

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FEE SCHEDULE, CANCELLATION POLICY & PAYMENT OPTIONS

PATIENT COPY

Fee Schedule

Visit Type	Adult	Child/Senior
Initial Consultation	170.00	145.00
Follow up Consult – 15 min	40.00	35.00
30 min	65.00	55.00
45 min	90.00	80.00
60 min	120.00	110.00
75 min	140.00	125.00
90 min	160.00	140.00
120 min	200.00	185.00

Telephone Consults	Charged according to above rates
Email Consults	Charged according to above rates for any new concerns (emails regarding treatment plans already prescribed are free of charge)

* All fees are subject to 13% H.S.T.
* Child/Seniors Rates: Children under 12, Seniors over 65
* Any Prescribed supplements/botanicals/homeopathics and /or appliances are not included in the above fees

Cancellation Policy

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours advance notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with this clinic policy.

Payment Options

At Lakeside we are pleased to be able to accept the following method of payments for your convenience:

Cash, Cheque, Debit, *Visa and *MasterCard

Patient Confirmation

By signing this form you have agreed to the conditions of our cancellation policy and acknowledge our fee schedule and payment options.

I ______________________________ have reviewed the above information and understand that if I do not provide 48 hours notice to cancel my appointments I will be sent an invoice by mail that will be due 15 days from invoiced date.

Signature ____ Date _________________________

Lakeside Natural Health
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Your Natural Health Solution

CANCELLATION POLICY & PAYMENT OPTIONS

CLINIC COPY

Cancellation Policy

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours advance notice are subjected to a 100% charge for the appointment. We appreciate your cooperation with this clinic policy.

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Patient Confirmation

By signing this form you have agreed to the conditions of our cancellation policy and acknowledge our fee schedule and payment options.

I ______________________________ have reviewed the above information and understand that if I do not provide 48 hours notice to cancel my appointments I will be sent an invoice by mail that will be due 15 days from invoiced date. A 1.5% interest charge will be applied to overdue invoices.

Signature ____ Date _________________________