STONETREE
NATUROPATHIC CLINIC

Welcome to StoneTree, and to the first steps on your way to feeling better! Thank you for choosing us as a part of your health care team.

Your Forms and Health History
Your new patient intake forms are attached to this letter. They may be more extensive then what you're used to – that's because naturopathic doctors are trying to look at you as a whole person in an effort to get to the root of what is causing your health issues. The more information we have to do this job, the better, and as a result, we ask a lot of questions!

Your First Appointment
Feel free to bring any other information you feel is relevant to your first appointment. If you like, you should also feel comfortable bringing a friend or family member with you, too. You can find directions to the clinic on our website at www.stonetreeclinic.com.

How You Found Us
If you'd care to share how you found your way to our clinic, we'd love to know.

☐ I was referred by a health professional

Who? _____.

Do we have your permission to discuss your case with this professional?
☐ YES ☐ NO

☐ I was referred by a friend or family member

We are so grateful to the people who refer to us. Please help us thank them by letting us know who sent you here:

_____

☐ I read an article. Where? _____

☐ I saw an advertisement. Where? _____

☐ Other (internet, etc) _____

We look so forward to seeing you at your first visit! **If you have any questions, don't hesitate to call us at (705)444-5331.**

Yours in good health,

The StoneTree Team

27 Third Street Collingwood ON L9Y 1K4
(705) 444-5331 feelbetter@stonetreeclinic.com

Phone: (705)444-5331 Fax: (705)446-1777 - 27 Third Street, Collingwood, ON L9Y 1K4

ADULT INTAKE

First name:_____ Initial:_____ Last name: _____ M ____ F ____

Address:_____ City: _____ Postal Code: _____

Please list only the numbers at which we may contact you.

Web site:_____ E-Mail: _____

Home phone: _____ Bus phone: _____ Ext: ____

Cell Phone: _____ Fax: _____

Date of birth: _____ Occupation: _____

Marital Status: _____ Name of Spouse: _____ # Dependents: ____

Emergency contact: _____ Phone: _____

Other health care providers:

Name: _____ Name: _____ Name:_____

Designation: _____ Designation: _____ Designation: _____

Phone: _____ Phone: _____ Phone:_____

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHOURIZED US IN WRITING TO DO SO. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

What health concerns problems brought you to this office today?_____

_____

_____

If this is a chronic illness, how long have you had this condition?_____

Who diagnosed your illness? _____ When was the diagnosis made?_____

What specialists have you seen? (Indicate the year of consultation) _____

_____

If you are a female are you currently pregnant? YES NO

CURRENT MEDICATIONS

List all CURRENT prescribed medications:

Drug name:_____ Dosage:_____ Length taken:_____
Drug name:_____ Dosage:_____ Length taken:_____
Drug name:_____ Dosage:_____ Length taken:_____
Drug name:_____ Dosage:_____ Length taken:_____

List all CURRENT non-prescription medication used:

List all CURRENT vitamins, minerals, herbs, that you take more than occasionally:

List all PAST prescribed medications that you've taken for longer than 3 months:

List any prescribed medication you've had an adverse reaction to in the past. Indicate the drug name, when you took it and the reaction you had:

Drug name:_____ When taken:_____ Reaction:_____
Drug name:_____ When taken:_____ Reaction:_____
Drug name:_____ When taken:_____ Reaction:_____

List all known allergies:

How many times have you been treated with antibiotics in the past 5 years?_____

Family Medical History

	Age	Health problems	If deceased, cause	Age at death
Father				
Mother				
Siblings				
Children				
Grandparents				

MEDICAL HISTORY

Please check only those that pertain to you personally

☐Alcohol abuse
☐Allergies
☐Anaemia
☐Asthma
☐Arthritis
☐Back, Muscle, Joint pain
☐Bladder/Urinary problems
☐Candida
☐Epilepsy
☐Diabetes
☐Rheumatic fever
☐Lung problems
☐Mononucleosis
☐Influenza
☐Rheumatism
☐Malaria
☐Female Gynaecological problems
☐Gallstones
☐Gum/Teeth problems
☐Heart attack
☐Heart problems
☐High blood pressure
☐Kidney problems
☐Measles
☐Depression
☐Overweight
☐Psychological problems
☐Pneumonia
☐Eczema
☐Hay fever
☐Pleurisy
☐Chronic swollen glands
☐Skin problems
☐Stroke
☐Suicide
☐Thyroid problems
☐Tuberculosis
☐Ulcers
☐Venereal disease
☐Chronic fatigue
☐Liver problems
☐Chronic sinusitis
☐Cancer
☐Gout
☐Bowel disease
☐Constipation
☐Hives
☐Hypoglycaemia

Blood type: _____

Date of last physical exam: _____ For what reason? _____

Do you get regular SCREENING TESTS done by another doctor? (Pap, blood test, etc.) YES NO

PERSONAL HEALTH HABITS

Height:_____ Current weight:_____ Weight 1 year ago:_____ Max weight:_____Year:_____

Smoker? YES NO Amount/day?_____Years smoked?_____Year stopped?_____

Are you exposed to smoking at home? YES NO Are you exposed to smoking at work? YES NO

Alcohol use? YES NO Type:_____Frequency: _____

Recreational drug use? YES NO Type:_____Frequency:_____

Caffeine use ? YES NO Type:_____Frequency:_____

Are there any food groups that you avoid? YES NO
What? _____Why? _____
_____ _____
_____ _____

Are you frequently exposed to animals? YES NO What type?_____

Are you regularly exposed to toxins or other hazards? YES NO

What kind? _____

Do you exercise regularly? YES NO Type:_____Frequency:_____

How many hours do you sleep per night?_____ Do you wake rested: YES NO

How many hours do you work each day?_____ Do you do shift work? YES NO

What level of personal stress are you experiencing right now?

☐Minimal ☐Average ☐Considerable ☐Unbearable

The main stressor is:

☐Financial ☐Job related ☐Marriage ☐Health
☐Interpersonal ☐Unfulfilled expectations ☐Family ☐Spiritual

What do you do to deal with stress? _____

When was your last vacation?_____Where did you go?_____

What are your hobbies?_____

CHRONOLOGICAL HEALTH HISTORY

This sort of health history helps to establish trends in a person's health that may be relevant to present conditions. Indicate below any accidents, broken bones, falls, illnesses, hospitalization, surgeries, and any emotional traumas such as deaths, loss of jobs, divorces, etc.

Year 1-5 _____
Year 6-10 _____
Year 10-15 _____
Year 16-20 _____
Year 21-25 _____
Year 26-30 _____
Year 31-35 _____
Year 36-40 _____
Year 41-45 _____
Year 46-50 _____
Year 51-55 _____
Year 55-60 _____
Year 61-65 _____
Year 66-70 _____
Year 71-75 _____
Year 76-80 _____
Year 81-90 _____

Mothers state of health during her pregnancy with you, if you know?

_____

How was your birth? Any complications?

_____

SYMPTOMS REVIEW

Please check (√) Y if you have the symptom now, and P if the symptom is in the past.

SKIN	Y	P
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

HEAD	Y	P
Tension headaches		
Migraine headaches		
Head injury		
Dizziness		
Other		

EYE	Y	P
Impaired vision		
Use of contact lenses		
Eye pain		
Tearing		
Dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Light sensitive		
Itching		
Redness		
Discharge		
Blind spot		
Other		

EARS	Y	P
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

NOSE & SINUSES	Y	P
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

MOUTH & THROAT	Y	P
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Other		

NECK	Y	P
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

RESPIRATORY	Y	P
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Difficulty breathing		
Pain on breathing		
Shortness of breath		
Shortness of breath at night		
Shortness of breath when lying		
Positive tuberculin test		
Last TB test		
Last chest X-ray		
Other		

CARDIOVASCULAR	Y	P
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitation, fluttering		
Last ECG		
Other		

BREASTS	Y	P
Do you do breast self exam?		
Lumps		
Pain (or tenderness)		
Nipple discharge		
Last mammogram		
Other		

GASTROINTESTINAL	Y	P
Trouble swallowing		
Heartburn		
Change in appetite		
Nausea		
Vomiting		
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stool		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Last colonoscopy		
Other		

BLOOD/LYMPHATIC	Y	P
Anaemia		
Easy bleeding/bruising		
Past transfusions		
Lymph node swelling		
Other		

URINARY	Y	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

MALE REPRODUCTIVE	Y	P
Hernia		
Testicular masses		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease		
Discharge of sores		
Sexually active		
Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		
Last prostate exam		
Last PSA level		
Other		

FEMALE REPRODUCTIVE	Y	P
Age of first menses		
Last menstrual period		
Number of days of menses		
Length of cycle		
Bleeding between periods		
Irregular cycles		
Pain during intercourse		
Painful menses		
Excessive flow		
PMS		
Number of pregnancies		
Number of life births		
Number of miscarriages		
Number of abortions		
Difficulty conceiving		
Sexual difficulties		
Vaginal discharge		
Vaginal itching		
Sexually active		

FEMALE REPRODUCTIVE	Y	P
Check sexual preference:		
Heterosexual		
Homosexual		
Bisexual		
Menopause		
Age of onset		
Hormone therapy		
Last gynaecological exam		
Last pap smear		
Other		

MUSCULOSKELETAL	Y	P
Broken bones		
Muscle spasms/cramps		
Weakness		
Joint swelling		
Backache		
Other		

PEREPHERAL VASCULAR	Y	P
Deep leg pain		
Cold hands/feet		
Varicose veins		
Thrombophlebitis		
Leg cramps		
Extremity numbness		
Extremity coldness		
Extremity swelling		
Extremity ulcers		
Other		

NEUROLOGIC	Y	P
Fainting		
Seizure/Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of balance		
Speech problems		
Other		

ENDOCRINE	Y	P
Heat or cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive urination		
Excessive sweating		
Diabetes		
Hypoglycemia		
Hormone therapy		
Other		

EMOTIONAL	Y	P
Depression		
Angry		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual difficulties		
Drug abuse		
Psychiatric care		
Psychological counselling		
Other		

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WITH YOUR PERMISSION….

It is really important to the regulated health professionals at StoneTree Clinic that you understand what you are getting into. Informed consent is not just about signing a piece of paper, it is about really understanding and having the ability to ask questions and get clarity. If you have any questions at any time during your care at StoneTree Clinic, we are committed to answering them.

Here is what you can expect from the StoneTree Clinic team:

We believe in the healing power of nature. That means we are always trying to support your body to do what it should be doing to be healthy. The tools we use to do this are largely natural remedies – diet and nutritional supplementation, herbal medicine, acupuncture, physical manipulations and life style counseling.

We want to get to the root of the problem. That means we want to figure out WHY you are having the symptoms. As a result we sometimes do different assessments than what you might be used to, or look at your current lab tests in a different way. Lab tests ordered by your ND are NOT covered by OHIP. Any charges for lab tests will be discussed with you BEFORE they are ordered.

We like to look at our patients as "whole" people and treat them individually. Not all people with headaches have headaches for the same reason. As a result, we might ask you questions that have seemingly nothing to do with your headaches. Also, you might get a different treatment plan than your friend Betty who came in for the same problem. The reason, you are both different people and the CAUSE of your headaches might be different.

We are REALLY committed to the idea of "Doctor as Teacher" and prevention as the best form of healthcare. As a result you are going to be given lots of information. We do weekly blog-posts and monthly newsletters. We like to communicate with our patients via email with info and links to help you on your journey to wellness.

Want to reach us by email? No problem. We use email a lot to check in, clarify treatment plans and give further information as needed. Here is what we can't do via email - assess and treat you for a new complaint. That, we have to do in person.

We work as part of a TEAM. There are Naturopathic Doctors, Medical Doctors and Registered Nurses on the StoneTree Clinic team. All of these individuals work together to deliver your care safely and effectively. Don't worry – you will have one doctor who is primarily responsible for your care, but that doctor, and you, has access to the whole team when managing your case. The team meets weekly to ensure best care. We cover each others holiday to ensure there is always someone around who can care for you when you need it. When you become a patient of StoneTree Clinic you are a patient of the whole team. Want to know who is presently on the team and their credentials? Let us know and we will give you a list.

Although this should go without saying, the StoneTree Clinic team is absolutely committed to keeping your health information completely confidential.

We believe you should be "driving your own healthcare bus", the StoneTree Clinic team are your navigators. We will never instruct you to refrain from seeking the advice or treatment from another regulated health care provider. We want to be a valued and trusted part of your health care team.

DECLARATION AND CONSENT TO TREAT

I understand that:

I may be assessed and treated in a way different than what is usually offered by a MD

If I am pregnant or lactating I will make sure the StoneTree Clinic team know about it.

I accept the inherent risks of treatment at StoneTree Clinic. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting due to stress or needle fears.
- Puncturing of an organ with acupuncture needles
- Accidental burning of skin from the use of moxa.
- Muscle strains and sprains, disc injuries from spinal manipulation

I agree to be a patient of the entire StoneTree Clinic team of licensed and regulated Health Professionals – Including ND's, MD's and RN's. **Initial:** _____

I am at liberty to seek or continue medical care from a medical doctor or other care providers licensed to practice in Ontario.

I understand that results are NOT guaranteed. **Initial:** _____

I understand care at StoneTree Clinic is not covered by OHIP. I agree to pay my full account at the time of each visit. **Initial:** _____

I understand that advice given via email will be only for clarification or information.

I understand that a 24-hour cancellation policy is in effect. Full fees are applied without 24-hour notice. **Initial:** _____

I will be given a full and complete verbal explanation of the present and future treatments and/or services that I will receive.

I am not only free to, but am enthusiastically encouraged, to ask as many questions as I need to feel confident about any assessment and treatment I am to receive at StoneTree Clinic.

I can withdraw my consent at any time.

I understand that StoneTree Clinic adheres to the Personal Health Information Protection Act 2004. The Clinic's Health Information Custodian is Tara Gignac ND.

Name of Patient/Representative: _____

Signature of Patient/Representative: _____ Date:_____

Witness:_____ Date:_____