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

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

DECLARATION AND CONSENT TO TREAT

This is to acknowledge that I (or Parent/Legal Guardian) have been informed and understand that:

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental emotional and spiritual aspects of the individual. A number of different approaches are used: Diet and nutritional supplements, botanical medicine, homeopathy, Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counseling.

A StoneTree Clinic naturopath will take a thorough case history, do a screening physical exam and if your case requires, do more specific physical examinations including breast exams, gynecological exams and genital exams. Certain laboratory assessments may also be required on a case specific basis.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those on multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform your naturopathic doctor of any disease process that you are suffering from or if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise your naturopathic doctor immediately.

There is some slight health risks to treatment by Naturopathic Medicine. 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 or 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

As a patient of StoneTree Clinic, I am at liberty to seek or continue medical care from a medical doctor or other care providers licensed to practice in Ontario. No employee, agent, board member, student, instructor or anyone else under the direction or control of StoneTree Clinic, has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

The Treatment and therapies rendered or recommended at StoneTree Clinic may be different that those usually offered by a medical doctor or other licensed health care providers.

As a patient of StoneTree Clinic, I understand that results are not guaranteed.

I agree to pay my full account at the time of each visit or treatment, including fee for services, cost of supplements and remedies, cost of laboratory tests and other fees unless otherwise discussed. Payment can be made in cash, personal cheque, Debit Card, Visa or Mastercard.

I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during intake of my case.

I understand that a 24-hour cancellation policy is in effect. To avoid a visit charge I will notify the office 24-hours before a scheduled appointment. ___________(intial)

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

OVER……

Privacy of your personal information is an important part of our practice, 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. For more detailed information ask the Privacy Information Officer for a copy of our privacy policy.

In this office Tara Gignac, ND acts as the Privacy Information Officer.

This consent form is intended to cover the entire course of treatments in this office. I understand that I

am free to withdraw my consent and to discontinue participation in these procedures at any time.

Dated this ________________________________ day of ______________________________

Patient's Printed Name ____

Patient's Signature ____

Legal Guardian (if applicable) ____