Dr. Marc Conteduca, ND
Dr. Sarina Gandhi, ND Patient Intake Forms

Name:_____ Date:_____

Health History Summary

Name _____ Age _____ Date of Birth (y/m/d) _____

Address: _____ City:_____ Postal Code:_____

E-mail Address: _____ Phone: _____(H) _____ (W)

In case of emergency contact _____ Phone: _____ (1) _____(2)

How did you hear about our clinic? _____

Your Current Health Concerns
What is your main reason for coming in today? _____

List, in order of importance other health problems that are troubling you:

1) _____ How long? _____
2) _____ How long? _____
3) _____ How long? _____

What kind of conventional treatment have you received? _____

Please circle all of the following complementary healthcare practitioners you have seen:
Naturopathic Doctor Chiropractor Acupuncturist Massage Therapist Osteopath Other

Last Physician or Health Practitioner seen _____ When _____
When was your last physical exam? _____ Were blood tests done? **Y/N** Blood Type_____

Family Doctor (Name and Clinic Name and Location)_____

Your Health History
What is the general state of your health? Excellent Good Average Fair Poor

What is your current approximate Weight? _____ Height? _____
Do you have any allergies to any drugs, herbs, foods, animals or other? **Y/N** *If yes, please specify* _____
_____

Have you had any major injuries? **Y/N** *If yes, what happened and when?* _____
_____

Previous surgeries and hospitalizations (include dates) _____
_____

Health Centre of Milton
420 Main St. E Unit 102-103
Milton, Ontario L9T 1P7
905.878.8131

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Name:_____ Date:_____

Please list your current medications: (name, dose, and amount of time on the medication.)

_____

_____

_____

Please list your current supplements/herbal rememdies: (name, dose, and amount of time on the supplements.)

_____

_____

_____

Please indicate which of the following conditions you have had and indicate “now” () or “past” (P)

	N	P		N	P		N	P		N	P
Allergies			Weight Problems			Anemia			Measles		
Asthma			Gallstones			HighBlood Pressur			Mumps		
Hayfever			Gout			Stroke			Chicken Pox		
Sinusitis			Thyroid Problems			Cancer			Whooping Cough		
Ear Infections			Speech Problems			Jaundice			Shingles		
Strep Throat			Tooth/Gum Problems			Alcoholism			Diphtheria		
Tonsillitis			Ringing in Ears			Hepatitis			Scarlet Fever		
Mono			Visual Problems			Gas/Bloating			Polio		
Eczema			Fainting			Diarrhea			Rheumatic Fever		
Psoriasis			Poor Memory			Constipation			Small Pox		
Acne			Balance Problems			Hemorrhoids			Malaria		
Warts			Broken Bones			Rectal Bleeding			Pneumonia		
Varicose Veins			Numbness/Tingling			Parasite			Tuberculosis		
Canker Sores			Cold Hands/Feet			Herpes			Physical Trauma		
Headaches			Arthritis			STD			Emotional Trauma		
Migraines			Epilepsy			Gonorrhea			Sexually Transmitted Disease		
Depression			Diabetes								

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Other? _____

Are there any ailments from which you feel you have never been well since? _____

Which of the following do you currently use? (Please indicate how much, how often and how long.)

Alcohol _____ Tobacco _____

Coffee _____ Tea _____

Recreational Drugs _____

Family History

	Mother	Father	Sibling	Grandparent		Mother	Father	Sibling	Grandparent
Cancer					Kidney Disease				
Tuberculosis					Diabetes				
Heart Disease					Asthma				
Stroke					Depression				
High Blood Pressure					Other _____				

General Information

Marital Status? **Single Married Divorced Separated Widow Other** _____ Number of Children ____

Who do you currently live with? **Spouse Partner Parents Children Friends Alone**

Are you currently in a happy and supportive relationship? **Very Mostly Somewhat No**

What is your weakest organ system and why? (ex: digestive, immune, etc) _____

Do you exercise? **Y/N** *If yes, what do you do and how often?* _____

Occupation _____ Employer _____

Anything Else I should know about you?_____

_____

_____

_____

_____

_____

Thank you for taking your time to fill out this lengthy questionnaire

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Patient Consent Form

Congratulations for making a commitment to your health by coming in for a naturopathic assessment at the Health Centre of Milton. We hope that you enjoy your experience as we work together to help you achieve your full health potential.

Naturopathic Medicine is a unique and comprehensive approach to improving health and treating illness. As primary health care practitioners, our goal is to provide safe and effective health care to each patient in a compassionate and efficient manner. In order to assess your individual condition, your Naturopathic Doctor will take a thorough case history, perform a screening physical exam, and laboratory tests. Therapeutics include clinical nutrition and supplementation, botanical medicine, acupuncture, and Traditional Chinese Medicine, homeopathy and lifestyle counselling. Further detailed information on the treatments used by Naturopathic Doctors can be provided on request (either through verbal or written explanation provided by the Naturopathic Doctor).

Each Person must sign this document prior to the initial visit.
My signature acknowledges that I have been informed and understand that:

1) I am encouraged to create a comprehensive health care team working towards my best interests and continue to seek medical care from other qualified health practitioners (physician, chiropractor, dentist, etc.) as required.
2) I understand that Naturopathic Doctors are required by their licensing boards to perform a screening physical exam on each new patient. This will be adhered to unless the referring practitioner sends a full report to the N.D.
3) I am aware of the slight health risks concerning some treatments, which may include, but are not limited to; aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, fainting, bruising or injury from acupuncture or venipuncture. I have received a full and complete explanation of the treatment or services that I may receive at this office and hereby **authorize consent to treatment.**
4) I understand that working with a Naturopathic Doctor involves a team-like approach and while appropriate individualized advice regarding obtaining my treatment goals will be provided, I also commit to being responsible for my own health. If I am having difficulty following a treatment plan, I will contact my ND so that we can make the necessary modifications to ensure that I am able to continue to work towards my health and wellness goals.
5) I am aware that I can purchase the products recommended by my Naturopathic Doctor at the location of my choice. I am under no obligation to purchase products from the Health Centre of Milton. However, if I do purchase products at the clinic, I am aware that they cannot be returned for refund, as they will not be resold. Just as a pharmacy cannot accept returns on pharmaceutical products, we cannot accept returns on nutraceutical products so that we can guarantee that all of our products have been stored in appropriate conditions until they are dispensed.
6) I understand that a record will be kept of health services provided to me. This record will be kept confidential and will not be released to anyone outside this office unless so directed by myself or unless it is required by law.
7) I understand that I may look at my medical record at anytime and that copy of my file will be provided to me, for a fee, upon request. I have reviewed my treating naturopath's privacy policy and I understand how it applies to me. I agree to the collecting, using and disclosing personal information about me as set out in this policy.
8) I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provicinal 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.
(print name)

_____ _____
(signature of patient) (date)

_____ _____
(signature of N.D) (date)

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FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The privacy of your personal information is an important part of your ND's naturopathic practice. Your naturopath and the clinic staff 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.
As your naturopathic doctor, 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

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 The College of Naturopaths of Ontario (2015)

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 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 complete claims for insurance purposes
· to invoice for goods and services
· to process credit card payments
· 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.
· to allow us to efficiently follow-up for treatment, care and billing
· to comply with legal and regulatory requirements of our regulatory body, the College of Naturopaths of Ontario acting under the authority of the Regulated Health Practitioners Act

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

Patient Consent

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

I _____ agree that Dr. _____can collect use and disclose personal information
(print name of patient or power of attorney)
as set out above in the information for _____
(patient name)

_____ _____ _____
signature of patient/power of attorney Date Witness

I, _____, hereby agree and consent that Dr._____may
(print name of guardian)
communicate and disclose medical information with the following people, through in-house visits, email and phone:

_____ _____ _____
name of person authorized signature of patient date

_____ _____ _____
name of person authorized signature of patient date

_____ _____ _____
name of person authorized signature of patient date

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