NORFOLK CHIROPRACTIC WELLNESS CENTRE

☐ **Dr. Katie Thomson Aitken BAS, ND**
☐ **Dr. Alaina Gair, B.Sc., ND**

86 Norfolk St., Guelph 519-827-0040

Naturopathic & Acupuncture Intake Form (Age 14+)

Contact Information

Name: _____ Gender: ____ Age: _____ Birth Date (dd/mm/yy): _____

Address: _____ City: _____ Postal Code: _____

Phone – Home: ( ) _____ Work: ( ) _____ Ext.: _____ Cell: ( ) _____

Okay to leave a message? No / Yes (which number) Email: _____

May we email you regarding appointments and information that may be useful to you? Y / N

Occupation: _____ Employer: _____

How did you find us? _____

Emergency contact: _____ Relationship: _____ Phone: ( ) _____

Family Physician: _____ Phone: ( ) _____ Fax: ( ) _____

Address: _____ Date of last visit: _____ Blood work done?_____

Findings of concern? _____

Do you receive an annual physical exam? N / Y, from? _____

Specialist Physician(s) and city: _____

Health History

What is your MAIN reason for coming in today?

1. _____
   _____
   _____ Date of Onset: _____

Please list in order of importance any other health concerns that are troubling you:

2. _____ Date of Onset: _____
   _____
3. _____ Date of Onset: _____
   _____
4. _____ Date of Onset: _____
   _____
5. _____ Date of Onset: _____
   _____

Medical History

What is your current level of energy from 1 to 10 (10 being the best you have ever felt)? _____

Your height: _____ Weight (approx.): _____

Hospitalizations; surgeries; major injuries (please include dates): _____
_____
_____
_____
_____

Are you working or have you worked with a professional counselor, psychologist, social worker, energy healer, pastor or other therapist? N / Y, with: _____

Which over the counter, prescription and/or natural health products do you use?

Taking CURRENTLY:	**Dose:**	**Reason for Use:**	**Dates of Use:**

Family History

Relative:	**Age if Living:**	**Health Conditions:**	**Age at Death:**	**Cause of Death:**
Mother				
Father				
Sister(s)				
Brother(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

Other blood relatives with notable health history (e.g. cancer, heart disease, stroke, mental illness, etc.)				
Relative:	**Age if Living:**	**Health Conditions:**	**Age at Death:**	**Cause of Death:**

Please indicate which of the following conditions you have NOW or have had in the PAST:

Condition	**Now**	**Past**	**Condition**	**Now**	**Past**	**Condition**	**Now**	**Past**	**Condition**	**Now**	**Past**
Allergies			Strep Throat			Tonsillitis			Poor Memory		
Anemia			Measles			Whooping Cough			Ringing in ears		
Asthma			Mumps			Canker sores			Balance problems		
Arthritis			Rubella			Herpes			Speech problems		
Eczema			Chicken Pox			Gout			Hepatitis		
Ear Infections			Diphtheria			Gall Stones			Jaundice		
Psoriasis			Scarlet Fever			Kidney Stones			Epilepsy		
Hay fever			Rheumatic Fever			Fainting			Diabetes		
Sinusitis			Small Pox			Addiction			Alcoholism		
Acne			Polio			Thyroid problem			High blood pressure		
Pneumonia			Yeast infections			Cancer			Stroke		
Bronchitis			Gas/bloating			Migraine			Heart disease		
Tuberculosis			Hemorrhoids			Headaches			Heart attack		
Malaria			Rectal bleeding			Infertility			Varicose veins		
Mono			Parasites			Venereal disease			Gonorrhea		
Warts			Broken bones			Numbness/ tingling			Syphilis		
Miscarriage			Blackouts			Visual problems			Cold hands/feet		
Depression			Anxiety			Physical abuse			Emotional abuse		
Child abuse			Sexual abuse			Rape			Other:		

Is there any condition or event in your life from which you feel you have been never well since? _____
_____
_____

Marital Status: _____ Number of children: _____

Any other questions or concerns you would like me to be aware of? _____
_____
_____
_____

Thank you,

Dr. Katie Thomson Aitken BAS, ND
Dr. Alaina Gair B.Sc., ND

NORFOLK CHIROPRACTIC
WELLNESS CENTRE

INFORMED CONSENT TO TREATMENT

Please note that this form must be signed in our office PRIOR to the rendering of any treatment or service. At any time during the course of your naturopathic care you may discuss with your Naturopathic Doctor (ND) any questions or concerns that you may have regarding your treatment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors are regulated primary care providers who assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. The gentlest and most non-invasive techniques available are generally used in order to stimulate the body's inherent healing capacity and achieve health care goals.

Your practitioner will take a thorough case history, perform a relevant physical examination and may order blood or urine testing. If required, the physical exam may include more specific examinations such as gynecological, breast, rectal or genital exam.

It is very important to inform your Naturopathic Doctor immediately of any illness from which you or your child are/is suffering and any medications or over-the-counter drugs that you or your child are/is taking. As a patient, or parent of your child who is a patient, you will receive information about diagnosis and/or treatment, alternative courses of action, expected benefits, risks, side effects, costs and the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short and temporary.

Some individuals may experience allergic reactions to supplements and herbs. Please advise your ND of any known or suspected allergies.

Acupuncture treatment may be associated with pain, bruising around the insertion site; fainting; or puncturing of an organ with acupuncture needles. Your ND is trained to handle emergencies should the need arise.

I, (print name) _____ confirm that I have read, understood and agree:

- That treatment results cannot be guaranteed
- That I am free to withdraw my consent in full or in part, and to discontinue treatment at any time.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- That I have read and understood the Fee Schedule and Cancellation Policy and I agree to take responsibility for the fees incurred in treatment.

_____ _____

Patient Signature Date

NORFOLK CHIROPRACTIC
WELLNESS CENTRE

PRIVACY POLICY

Privacy of personal information is important at Norfolk Chiropractic Wellness Centre (hereafter: "the clinic"). In providing you with quality Naturopathic Care, we are committed to the responsible collection, use and disclosure of your personal information in accordance with current regulations *(Personal Health Information Protection act (PHIPA), Ontario 2004).*

Your personal information will be collected and used 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 healthcare providers
- ✓ To allow us to efficiently follow-up for treatment, care and billing
- ✓ To complete claims for insurance purposes
- ✓ To invoice for goods and services
- ✓ To process credit card payments
- ✓ To collect unpaid accounts
- ✓ Disclosure: to comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others
- ✓ To use for educational and research purposes (this includes case summaries, photographs, lab results and other pertinent medical information)

Your identity will be protected at all times and, where required, identifying information will be altered to protect your privacy in all the above instances. In the event that your file with us becomes inactive, your personal information will be retained securely for a period of 10 years after your last visit, at which time it will be destroyed.

By signing this Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

CONSENT TO COLLECTION AND USE OF PERSONAL INFORMATION:

I, (print name) _____, have reviewed the above information and agree that my practitioner and the clinic can collect, use and disclose my personal information for the purposes outlined in this privacy policy, as described above.

_____ _____

Patient Signature Date