Welcome to Naturopathic Care

Dear New Client,

Congratulations on taking this important step in making your health a priority and committing to Naturopathic Medicine as a part of your health care plan. Naturopathic Medicine is an extensive healing system that can help you achieve your health and wellness goals. The Benefits of optimal health will be proportional to the effort and dedication you put into your daily choices. You have the option to feel better, live healthier, longer, look and feel younger. It is found that lasting improvement in one's health takes place in the presence of heightened focus, dedication and education.

Naturopathic Doctors are trained as primary health care providers. The main difference between a Naturopathic Doctor and your conventional family doctor is the philosophy of care and the treatment options that are available to you. We acknowledge that every sign and symptom your body exhibits has significance and directs the doctor's attention to causative underlying issues that need correcting. Naturopathic Doctors strive to identify and reverse the unique **underlying causes** of your health concerns using gentle, safe therapies that restore your natural ability to heal and support your journey toward lifelong optimal health. We are committed to maintaining the highest professional ethics, competence and personal integrity.

Your **careful consideration** of each of the enclosed questionnaires will enhance our efficiency, improve our accuracy and will provide more effective use of your scheduled consultation time.

Please read and complete each form to the best of your ability. **Note, you will have to get started on the diet survey promptly** as this requires time and careful attention. Many find that completion of these forms a valuable process in itself.

Important: please bring any **supplements & medications** you are currently taking with you to your appointment. Also, please bring with you any lab work (blood work, imaging reports etc.) that may be relevant.

Thank you for your time. We look forward to helping you achieve your health goals.

What to do when you arrive?

When you arrive at the clinic please check in with the main Reception desk as you enter the clinic, or proceed to our Naturopathic reception area. Our Naturopathic Receptionist will come greet you and give you an office tour. She will then bring you to the Naturopathic reception area in preparation to your appointment.

At subsequent appointments please make your way to the Naturopathic Reception to check-in and let us know you have arrived. Please make yourself comfortable in either reception area and enjoy a hot cup of herbal tea or coffee.

It is always our aim to be on time with your appointments. However, complications and emergencies do arise and in these circumstances we appreciate your patience and understanding. You also will receive the devoted time and care of your Naturopathic Doctor.

What to expect at visits

Your first appointment will last 1 1/2 hours. We will discuss your chief concerns and review your history and completed health forms. We will discuss relevant aspects of your lifestyle, beliefs and philosophy about health and healing, and any other issues that impact your wellness. We will also do a relevant physical exam and Naturopathic functional assessment. The Assessment may include but is not limited to EAV testing, Muscle Reflex Testing and Energetic screening. This in-depth assessment allows your Naturopathic Doctor to develop a thorough understanding of your current state of health, energy systems and vital force which will guide a program which is safe and effective for you. Recommendations for relevant blood or lab work may take place. Your Naturopathic Doctor will outline to you how the many tools of Naturopathic Medicine can be used to help you reach your goals for health, recovery and wellness.

Your second visit will be approximately 30-45 minutes and will generally take place 3-4 weeks after your initial appointment. It will consist of relevant follow-up functional testing/evaluation and a discussion of findings in order to provide you with a diagnosis and appropriate treatment plan. Recommendations for any additional lab work may be made if necessary. If your healing needs require work with your energy systems or mental-emotional-spiritual focus, Quantum Energy Healing or Life Transformation Sessions may be suggested. See website under Services for details.

Most follow-up visits are 30 minutes and will be used to provide you with ongoing care, to monitor your progress and address any other concerns that may arise.

In the event that you require care for an acute concern between scheduled visits (ie. treatment for a cold or flu, checking a child's ear for infection, blood pressure check), we will make every effort to accommodate a same-day appointment for existing patients. Do not hesitate to call the clinic with questions or concerns at 519-273-0777.

Office Policies

To facilitate the efficiency of our office and to ensure that you and other clients will derive maximum benefit from the care offered, we have established the following office policies:

1. Full payment is to be made at the time of your visit. We accept cash, cheque, Debit, Visa or MasterCard.
2. We respectfully request ***a minimum of 2 business days' notice*** in the event that you cannot keep your appointment so that someone else on our waiting list could be accommodated. Otherwise ***we will have to invoice you for 50% of you missed appointment fee***. This time has been especially reserved for you and we ask that you advise us if a change in your schedule is needed. We understand that there are unforeseen events and circumstances, and these will of course be taken into consideration. Our answering machine is available outside of business hours to take messages.
3. With the number of clients we thoroughly interview, assess and treat, timing is crucial. For the respect and convenience of our clients and for the efficient operation of the clinic, we endeavor to keep scheduled appointments on time. However, complications and emergencies do arise and in these circumstances, we appreciate your patience and understanding. You also will receive the devoted time and care of your doctor. ***Please note that when you arrive late for your appointment, only the remaining balance of the time that was booked for you can be used.***
4. We reserve the right to discharge any case where the naturopath feels that the case is beyond the scope of practice of this clinic or the client refuses to co-operate with the recommendations mutually agreed upon.
5. We are required by our licensing board to perform a physical examination on each new client. This will be adhered to unless a full report is send by the referring practitioner and it is acceptable by this office.
6. Telephone, Skype, and e-mail consultations provide a professional service and as such will be subject to a fee on the discretion of the attending Naturopathic Doctor. See the enclosed fee schedule.

Adult Patient Intake Form

Date: Name:

Age: Date of Birth:

Address:

City: Postal Code:

Home Phone: Cell Phone:

Work Phone: E-mail Address:

Height: Weight: Occupation:

Referred by:

Emergency contact: Phone:

Doctor's name: Phone:

Main Concern:

Describe carefully any factors that you suspect may have played a role in its onset and perpetuation:

What are the most significant measures which you have taken to-date, to improve your state of health?

Is your health currently: ◯Getting better ◯Getting worse ◯Staying the same

What seems to make it better?

What seems to make it worse?

Secondary concern(s):

Have you consulted a medical doctor regarding the aforementioned condition(s)? Please explain his/her diagnosis, therapy and results:

Have you attended a Doctor of Naturopathic Medicine before?

◯Yes ◯No Who? _____

Have you attended any other Doctor or alternative practitioner before?

◯Yes ◯No Who? _____

Have you seen a professional counsellor in the past?

◯Yes ◯No

If you have been counselled in the past, please explain:

_____

_____

_____

_____

Please list the three most stressful events in your life (past or present):

_____

_____

_____

_____

Please list any allergies, the age and date when they began, and the symptoms they cause:

Drug(s):

What:	When:	Symptoms
What:	When:	Symptoms
What:	When:	Symptoms

Food(s):

What:	When:	Symptoms
What:	When:	Symptoms
What:	When:	Symptoms

Environmental:

What:	When:	Symptoms
What:	When:	Symptoms
What:	When:	Symptoms

Explain any treatments you have received for any of the aforementioned allergies:

_____

_____

_____

Family History: please indicate if there is any history of the following conditions in your family:

◯ heart disease ◯ diabetes ◯ asthma ◯ osteoarthritis ◯ kidney disease

◯ multiple sclerosis ◯ alcoholism ◯ drug abuse ◯ allergies ◯ psoriasis

◯ eczema ◯ mental illness ◯ rheumatoid arthritis ◯ ankylosing spondylitis

◯ other autoimmune disorders – type:_____

◯ cancer – what type(s):_____

Other conditions in your family: _____

_____

_____

Lifestyle Factors

How many hours of sleep do you get a night?_____ Is it restful?_____

What keeps you from getting a good nights sleep?_____

_____

Do you snore	Y	N	
Do you use medications or alcohol to sleep?	Y	N	
Do you take a multivitamin-mineral daily?	Y	N	If yes, please put details on medication history form
Do you consume 6-8 glasses of water daily?	Y	N	
If yes, is it purified water?	Y	N	What type of filtration?
Do you eat red meat?	Y	N	If yes, how many times per week?
Do you fry or BBQ meat more than 3x/week?	Y	N	
Do you consume processed/preserved meats?	Y	N	If yes, how often?
Do you eat vegetables every day?	Y	N	If yes, how many servings daily?
Do you consume artificial sweeteners?	Y	N	What sources do you consume?
Have you ever conducted a detox program?	Y	N	If yes, what type?

Do you fast for medical or religious reasons?	Y	N	If yes, what types?
Have you ever smoked?	Y	N	If yes, how long?
Do you presently smoke?	Y	N	If yes, how much?
Do you drink alcohol?	Y	N	If yes, how often and how much?
Have you ever been an alcoholic?	Y	N	How long?

What exercise or physical activities do you take part in?

Do you know your BMI (body mass index) number? A BMI number above 25 increases your risk of cardiovascular disease and diabetes. Google and calculate it. My BMI number is: _____

Occupational Factors

Please list any current or past jobs/hobbies that may involve exposures to toxic compounds like: solvents, disinfectants, antiseptics, chemicals, pesticides, herbicides, heavy metals, paints, polyvinyl chlorides etc.

Household Factors

Do you have wireless technology in your home?	Y	N	
If yes, do you have EMF protective devices installed?	Y	N	What types?
Do you use a cell phone, portable phone or Handheld wireless device?	Y	N	
Do you use conventional cleaning products & detergents?	Y	N	
Do you use organic cleaning products & detergents?	Y	N	
Do you have vinyl shower curtains in your bathroom?	Y	N	
Do you have wall to wall carpeting in your house?	Y	N	

What is the age of your home? _____Years old

If your home was built before 1973, has it been checked?

for lead & asbestos?	Y	N	
Do you have a moist/wet basement?	Y	N	
Do you live within ¼ miles of hydroelectric power?			
transformers or wires?	Y	N	Now or in the past?_____
Do you live within ¼ mile of a garbage dump?	Y	N	Now or in your past?_____
Do you have an air purification system in your house?	Y	N	If yes, what type?_____

Dental Factors

Do you have any implants?	Y	N	
Do you have any root canals?	Y	N	If yes, how many?_____
Do you have any crowns?	Y	N	If yes, how many?_____
Do you have any bridge work?	Y	N	
Do you have any mercury amalgams (silver fillings)?	Y	N	
Do you have any composite fillings (plastics)?	Y	N	
Have you had old mercury fillings removed or replaced?	Y	N	O By a conventional dentist
			O By a biological dentist
Do you presently have any teeth or gum infections?	Y	N	If yes, describe_____
Do you or have you ever been diagnosed with gum disease?	Y	N	
Do you or have you ever been diagnosed with oral thrush?	Y	N	
Do you have any dental issues you would like to discuss?	Y	N	If yes, describe_____
Do you use fluoride toothpaste?	Y	N	
Do you regularly floss your teeth daily?	Y	N	

Review Symptoms

Mark the applicable with: **C** = currently | **F** = frequently | **O** = occasionally | **S** = seldom | **P** = past | **N** = never

ALLERGIES/INFECTION

___asthma

___cough (frequent acute)

___cough (chronic)

___wheezing

___sinusitis

___seasonal allergies

___year round allergies

___frequent colds

___ear infections (acute)

___ear infections (chronic)

___hearing loss

___bronchitis (acute)

___bronchitis (chronic)

___pneumonia

___chronic fatigue

___fatigue spells

___nosebleeds

___sore throats

___high fevers

___tonsillitis

___runny nose

___itchy eyes

___rings under eyes

___red/dry cheeks

___post nasal drip

Med. Alert tag Y N

For what?_____

Other: _____

URINARY

___incontinence

___kidney stones

___bladder infections

___kidney infections

___kidney malformations

___bed wetting

Other:_____

DIGESTION

___canker sores

___diarrhea

___constipation

___stomach aches

___vomiting spells

___food allergies

___gas

___bloating

___abdominal cramps

___colic

___hernia

Other:_____

SKIN

___dry

___chronic rash

___eczema

___psoriasis

___hives

___skin tags

___acne

___bumps on back of arms

Other:_____

DYSIOSIS

___jock itch

___thrush

___candida

___vaginal irritation or discharge

___colic/gas

___athletes foot

___craves sugar

Other:_____

SKETETAL

___arthritis

___flat feet

___broken bones

___spinal disorders

___back pain

___sciatica

___neck pain

___herniated discs

Other:_____

MIND & DISPOSITION

___dyslexia

___attention deficit

___hyperactive

___quick learner

___mentally challenged

___slow learner

___insomnia

___nervous/anxious

___timid

___fearful

___phobias

___fearless

___aggressive

___angry, irritable

___violent

___calm, relaxed

___sad/depressed

___happy

___sociable

___anti-sociable

Other:_____

CARDIC

___heart condition

___heart murmur

___hypertension

Other:_____

OTHER

___vision problems

___headaches

___eating disorders

Explain:_____

_____

_____

_____

___vehicle accident(s)

How many?_____
When?_____
_____

Other:_____

GASTROINTESTINAL

___food allergies

___heart burn/GERD

___hernia

___nausea

___vomiting

___excessive belching

___excessive passing of gas

___bloating

___jaundice

___liver disease

___gallbladder disease

___gallstones

___ulcer

___indigestion

___Number of bowel movements/day

___loose stools

___diarrhea

___hard stools

___mucous in stool

___blood in stool

___black, tarry stool

___yellow/pale stool

___irritable bowel syndrome

___colitis

___Crohn's Disease

___rectal bleeding

___hemorrhoids

___anal fissures

___anal prolapse

___abdominal pain

___stomach pain

___pancreas disease

___bowel polyps

Other:_____

BLOOD/LYMPHATIC

___anemia

___easy bruising

___easy bleeding

___past transfusions

___lymph node swelling

___lymphatic disease

___blood diseases

Other:_____

EMOTIONAL

___depression

___anxiety

___mood swings

___nervousness

___panic attacks

___phobias

___irritable

___angry

___insomnia

___worrier

___S.A.D.

MALES ONLY

___prostate problems

____prostate surgery

__hernia

___testicular masses

___testicular pain

___discharge or sores

___venereal disease

___sexual difficulties

Other:_____

FEMALES ONLY

Have your periods ceased?
Y N

Hysterectomy Y N
Why?_____

Birth control Y N
Type:_____

Age of menses___years old

Average length of cycle____

Number of days of menstruation____

___irregular cycles

___bleeding between periods

___PMS

Symptoms:_____
_____

___painful menses

___excessive flow

___fibroids

___ovarian cysts

___cervical dysplasia

___cervical/uterine cancer

___ovarian cancer

___vaginal discharge

___vaginal dryness

___pain on intercourse

___hot flashes

___night sweats

___estrogen replacement

Type:_____

# of pregnancies_____

# of miscarriages_____

# of abortions_____

___difficulty conceiving

___breast lumps

___breast tenderness

___mastitis

___breast implants

___nipple discharge

___sexual difficulties

Last PAP:_____

Results:_____

STDs:_____

Other:_____

LIFESTYLE

# of coffees/day_____

# of teas/day_____

Herbal/Regular

# of colas/day_____

___relaxation exercises

___recreational drugs

Type:_____

Frequency:_____

Medication History

Please record from the most recent to the most distant (past). Also, please indicate those that you are on presently, when you started them and how long you were on various medications in the past.

Medications	Start Date	Stop Date	Reason for Medication and its Results	Present	Past
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
Natural Supplements				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯
				◯	◯

** Please bring in all medications & supplements to your first visit with your Naturopathic Doctor.

Personal Medical History

Blood type: A B AB O

List hospitalizations & surgeries (date & why):_____
_____
_____
_____

List X-rays, CAT scans, EKOs, MRIs, etc. (date & why):_____
_____
_____
_____

List any past traumas or accidents with the date of occurrence:_____
_____
_____
_____

Childhood History

Were you breastfed? Y N For how long?_____

Were you bottle feed? Y N For how long?_____

Are you immunized? Y N If yes, any reactions?_____

◯travel vaccines ◯flu shots ◯non-mandated vaccines

Was your birth process natural? Y N

Did you experience ◯forceps ◯C-section ◯epidural anesthesia

Were you a colicky baby? Y N Until what age?_____

Which childhood illnesses did you have?

◯Polio ◯Chicken pox ◯German measles ◯Mumps ◯Scarlet fever

◯Rashes ◯Red measles ◯Rheumatic fever ◯Worms ◯Ear infections

◯Allergies ◯Whooping cough ◯Frequent colds ◯Eczema ◯Diphtheria

◯Croup ◯Bronchitis/pneumonia Other:_____

Other History

Have you ever had a tick bite or suspect Lyme disease? Y N

Have you ever suspected or have had parasites? Y N

Have you ever had Mono (Epstein Barr syndrome)? Y N

Have you ever been diagnosed with:

◯Heart troubles ◯Diabetes ◯Thyroid disease ◯Circulation problems

◯Arthritis ◯Cancer ◯AIDS ◯Auto immune disease

What do you feel is your weakest organ system and why?_____

_____

_____

How many times per year do you have a cold, sinusitis, sore throat, bronchitis, or flu? _____

How long do they usually last?_____

Do you take any medication for the above? Y N

If yes, what do you take? _____

Other Questions

If you could break any rule without consequences, what rule would you break?_____

_____

Are you in a romantic relationship? If so, are you happy?_____

Are you in touch with your life purpose?_____

Are you financially stressed?_____

If your health condition had a message, what would it tell you?_____

_____

_____

What does your body need in order to heal?_____

_____

_____

Do you have a mystery symptom you would rather not talk about? Y N

This information is strictly confidential between you and the Doctor and your accurate responses are vital to effective health care at this office. Please consider your responses and their accuracy. Thank you!

Neurobehavioral Symptom Checklist

From time to time, everyone feels out of sorts, not themselves, nervous, depressed, irritable, or anxious. These questions are designed to assist your doctor in identifying patterns of behaviour, chemical or hormonal imbalances, and feelings that tend to affect the quality of your relationships with family and friends, performance at work, and your overall sense of well-being.

Directions:

Please check the boxes that best describe your feelings and ability to function most of the time. When answering each question, consider the degree to which your daily life is affected.

1. Over the last year, I have experienced:

- ❒ Becoming forgetful
- ❒ Lapses in memory
- ❒ Becoming less attractive
- ❒ Less interest in normal activities
- ❒ Feeling less sharp
- ❒ Difficulty remembering people's names
- ❒ Difficulty making decisions
- ❒ Problems finding the right words to communicate
- ❒ Difficulty solving routine problems
- ❒ Difficulty learning new things
- ❒ Problems writing, reading, or organizing thoughts
- ❒ Difficulty following instructions

2. I experience:

- ❒ Lack of interest in normal activities
- ❒ Loss of energy
- ❒ Oversleeping or sleepiness
- ❒ Sense of sadness for no apparent reason
- ❒ Increased appetite, especially for carbohydrates
- ❒ Fatigue
- ❒ Symptoms that usually get worse in the winter
- ❒ Weight gain or weight loss
- ❒ Difficulty concentrating and processing information, especially in the afternoon
- ❒ Diminished sexual desire

3. I frequently:

- ❒ Feel tense and have trouble relaxing
- ❒ Have headaches and other aches and pains
- ❒ Get crabby or grouchy
- ❒ Have trouble falling asleep or staying asleep
- ❒ Sweat and have hot flashes in anticipation of events
- ❒ Feel irritable or short tempered
- ❒ Have trouble letting things go
- ❒ Get angry for no apparent reason
- ❒ Women only: Get worse symptoms prior to getting my period

4. I often:

- ❒ Feel overly active and compelled to do things, like being driven by a motor
- ❒ Have difficulty relaxing and unwinding when I have time to myself
- ❒ Misplace and have difficulty finding things
- ❒ Crave caffeine and stimulants to keep me going
- ❒ Delay getting started when I have a task or work that requires a lot of thought
- ❒ Get easily distracted by activity or noise around me
- ❒ Have difficulty keeping my attention when doing boring and repetitive work
- ❒ Fidget or squirm with my hands and feet when I have to sit down for a long time
- ❒ Leave my seat in meetings or other situations in which I am expected to remain seated
- ❒ Have problems remembering appointments or obligations
- ❒ Have difficulty concentrating on what people say to me, even when they are speaking to me directly

5. I experience:

- ❒ Waking up frequently during the night with difficulty returning to sleep
- ❒ Looking forward to catching up on my sleep on the weekends
- ❒ Taking more than 30 minutes to fall asleep at night
- ❒ Stomach problems or nausea
- ❒ Waking up repeatedly throughout the night
- ❒ Waking up groggy and not well rested
- ❒ Preferring to go to sleep later than midnight and waking up late, after 10:00 am
- ❒ Preferring an early bedtime—going to sleep between 7 pm and 9 pm and waking up early, around 5:00 am
- ❒ Jet lag
- ❒ Difficulty turning off my thoughts when I lay down to sleep

Dysbiosis Questionnaire

HISTORY **POINT SCORE**

To answer "yes" to a question, circle the point score on the right.

1. Have you taken tetracycline or other antibiotics for skin, acne, or anything else for 1 month or longer?.....25
2. Have you, at any time in your life, taken other broad spectrum antibiotics for respiratory, urinary or other infections 4 or more times in a 1 year period?.....20
3. Have you taken a broad spectrum antibiotic drug – even a single course?.....6
4. Have you at any time in your life been bothered by recurrent or persistent prostatitis, vaginitis or other problems affecting your reproductive organs?.....25
5. Have you taken birth control pills…
    a. For more than 5 years……..25
    b. For more than 2 years……15
    c. For 6 months to 2 years……8
6. Have you been pregnant
    a. 2 or more times……5
    b. 1 time……..3
7. Have you taken prednisone, decadron or other cortisone type drugs…
    a. For more than 6 months……..25
    b. For more than 2 weeks……..15
    c. For 2 weeks or less……..6
8. Does exposure to perfumes, insecticides, clothing or hardware stores and other chemicals provoke…
    a. Moderate to severe symptoms……20
    b. Mild symptoms……..5
    c. List symptoms:_____
9. Are your symptoms worse on damp muggy days or in mouldy places?.....20
10. Have you had athletes foot, ring worm, "jock itch" or other chronic fungus infections of the skin or nails? Have such infections been…
    a. Severe or persistent……...20
    b. Mild to moderate……10
11. Have you ever had parasitic infection, dysentery or unexplained episode of prolonged diarrhea, & intestinal distress?.....15
12. Do you have or have you ever had an ulcer, colitis, Crohn's disease or diverticulitis?.....35

TOTAL SCORE:_____

Diet & Activity Report

Name:_____

Please take time to complete the following survey carefully and accurately. List in detail the quantity and the exact nature of all foods and beverages consumed (ie. frozen, canned, etc.). Please mention if the foods were raw or cooked. Be sure to list any condiments used (ie. mayonnaise, ketchup, margarine, relish, etc.).

MEAL	DAY ONE	DAY TWO	DAY THREE
Morning meal & time			
Snack			
Noon meal & time			
Snack			
Evening meal & time			
Snack			
Condiments (salt, sugar, herbs, spices, etc.)			
Fats/Oils used			
Water (cups per day)			
Other beverages			
Type of exercise			

MEAL	DAY FOUR	DAY FIVE	DAY SIX
Morning meal & time			
Snack			
Noon meal & time			
Snack			
Evening meal & time			
Snack			
Condiments (salt, sugar, herbs, spices, etc.)			
Fats/Oils used			
Water (cups per day)			
Other beverages			
Type of exercise			

Fee schedule - Dr. Cormier, HBSc, ND

Naturopathic Care

Initial Consultation – 90 minutes.....$260

Naturopathic Consultation – 30 minutes.....$110

Extended Naturopathic Consultation – 60 minutes.....$150

Naturopathic Review – 15 minutes.....$55

Initial Cranial Sacral Therapy.....$125

Cranial Sacral Therapy $100

Tapping.....$60

Acupuncture.....$60

Extended Acupuncture.....$75

Initial Darkfield Lab Analysis.....$150

Darkfield Lab Recheck.....$110

Quantum Reiki/Qigong Healing.....$110

Meridian/Chakra Balancing.....$110

Facial Rejuvenation – 60 minutes.....$250

Ear Wax Removal.....$30

Phone or E-mail Consults (per15 min.).....$25

Forms or Comprehensive reports.....$15-120

Prices vary according to service provided and treatment length.

ADDITIONAL LAB SERVICES AVAILABLE: Hair Analysis, Glucose, Cholesterol, Urinary Indican, Urinary Chemstrip, Blood Type, Allergy Testing, Saliva Hormone Testing, Digestive Stool Analysis, Urinary Neurotransmitters, Various Conventional OHIP Blood Panels. **Note that there is a lab processing fee of $25 on all lab requisitions.**

EAV Analysis (Electro Acupuncture according to Dr. Voll) will be used during some visits. It is an elite form of Bio-Energetic Testing which uses the body's meridian system to help determine the health, function & balance of the organs involved. The combi-2 unit complies with NE regulations.

Services are not currently subsidized by OHIP, and are HST exempt. Check with your independent insurance company for coverage. Fees for health services are due when services are rendered and may be paid in Cash or Cheque, Visa, MasterCard or Debit.

I have read and fully understand the above description of the fee system and agree to honor it.

_____ _____

Client or Guardian signature **Date**

Code of Ethics

- This practitioner recognizes that the primary obligation is toward the client and at all times I will practice my skills to the best of my ability for benefit to the client. The comfort, safety and welfare of the client always has priority.

- Consultation, assessment and treatments will be carried out with the full consent of the client or guardian/parent in the case of minors.

- Any knowledge or information gained during consultation, assessment or treatment will be confidential in accordance with the guidelines set out by my governing board of Naturopathic Medicine and will not be divulged to anyone without the client's consent, except as required by law.

- I will share professional information with other professional practitioners upon request of the client with written consent upon.

- I expect that this is a mutual partnership towards health & wellness, and it is the client's responsibility to covey any changes in medical conditions and medications, supplementation, lifestyle changes, other treatments or services and relevant information to me in order for me to be sufficiently updated and provide proper care.

- I will not deliberately mislead or misdirect, for my own gain, a client seeking advice and professional assistance.

- All reasonable care will be taken to ensure adequate hygiene, quality of materials, supplements, and safety of equipment used.

- I will not attempt to treat conditions that are above my level of understanding, expertise or training and will refer clients to appropriate practitioners should this be required.

- I reserve the right to cancel any client treatments or discontinue care at any time as I see fit to do so.

- I will post any fee changes one month in advance of the time of change.

- I will not share your email or phone data with any outside groups, they are collected strictly for client communication within this office and for educational purposes related to professional care.

Dawn Cormier, HBsc., ND, Qigong & Energy Practitioner

Declaration and Informed Consent to Treatment

This is to acknowledge that I have been informed and I understand that:

Any treatment or advice provided to me as a client of Dr. Dawn Cormier, Naturopathic Doctor, is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider. I am at the liberty to seek or continue medical care from physicians or other health care providers who are qualified to practice. Dr. Cormier, ND has not suggested to me to refrain from seeking or following the advice of another licensed health care provider.

Although Naturopathic Medicine uses very gentle therapies, even these may induce complications in certain physiological conditions such as pregnancy, lactation, very young children and in certain conditions including but not limited to diabetes, liver, heart, kidney, cancer or autoimmune diseases. It is therefore IMPORTANT to inform Dr. Cormier, ND of any illnesses you may suffer from and all medications and supplements you may be taking. Failure to disclose this information may put you at risk. If you are female and are pregnant, suspect you may be pregnant or are nursing it is your responsibility to advise Dr. Cormier ND.

I understand that slight health risks of some Naturopathic treatments may include but are not limited to: aggravation of a pre-existing condition or symptoms, herxheimer reactions, changes in digestive function, allergic reactions, detoxification rashes, pain and inflammation after some physical therapies, very rarely with acupuncture pain, fainting, bruising or injury. I will inform Dr. Cormier via phone or email if I suspect a reaction of concern. Because each individual may respond differently to treatment protocols, Dr. Cormier, ND may not be able to anticipate and explain ALL risks and possible complications to treatments, but will do her best to ensure your safety.

The potential benefits and limitations of Naturopathic treatment and expected outcomes of treatments have been explained to me.

I understand that Dr. Cormier, ND will answer any questions I have to the best of her ability. I understand that the results are no guaranteed and may vary with each client.

This consent form is intended to cover the entire course of treatments throughout the duration of care with Dr. Cormier, ND. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic/therapeutic procedures and have discussed to my satisfaction this and any requests or concerns for related information with Dr. Dawn Cormier, ND.

I agree to pay the full amount for each visit and supplement purchase.

_____	_____	_____
Patient Name (print)	**Patient or Guardian Signature**	**Date**
_____	_____	_____
Doctor's Signature	**Witness's Signature**	**Date**

Patient Consent Form - For collection, use and disclosure of personal information

Privacy of your personal information is an important part of our Clinic operations. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly.

In this Health & Wellness Centre, office reception 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 of your information as per the Personal Health and Information Protection Act, 2004.

Our privacy policy outlines what our Clinic is doing to ensure that:

- only necessary information is collected about you
- we only share your information to other healthcare professionals with your consent
- storage, retention and destruction of your personal information complies with existing legislation and privacy protection
- our privacy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopaths

How our Clinic Collects, uses and discloses patient's personal information

The clinic will collect, use and disclose information about you for the following purposes:

- to access your health concerns and provide health care
- to advise you of treatment options
- to invoice for goods & services & process credit card payments
- to collect unpaid accounts
- to remind you of upcoming appointments and establish and maintain contact with you
- to communicate with other treating health-care providers
- to educate via clinic newsletters
- to allow efficiently follow-up of treatment, care and billing
- to comply generally with the privacy laws and regulatory requirements
- to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the 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 as above.

I agree that Dr. Cormier's Quantum Naturopathic Health & Wellness Clinic can collect, use and disclose my personal information as set out above in the clinic privacy policies.

Please be advised that emails are not deemed 100% protected when sharing medical information. _____ By initialling this paragraph, you are consenting to share appropriate medical information when requested by either party necessary for convenience and documentation for your ongoing medical care.

Signature_____ Print name_____

Date_____ Witness_____