Naturopathic Health & Wellness Centre

# 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.

# Patient Intake Form

Date: Name:

Mother's Name: Father's Name:

Age: Grade: Date of Birth:

Sibling name(s) & age(s):

Address:

City: Postal Code:

Home Phone: Cell Phone:

Work Phone: E-mail Address:

Child's Doctor: Phone:

Child's Specialist: 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 child's state of health?

Is his/her health currently: ◯Getting better ◯Getting worse ◯Staying the same

Secondary concern(s):

# Pregnancy & Infancy

Birth Weight: Born: ◯ on time ◯ early ◯late

If born early or late, by how many weeks?

Was the birth natural (ie. Without medical intervention such as forceps, epidural, C-section…)? Please explain in detail:

Complications of mother and/or infant:

During Pregnancy:

During labour/delivery:

After birth:

Developmental landmarks: ◯Delayed ◯Slower ◯Average ◯Faster ◯Accelerated

Additional comments and explanations:

# Nutrition

Breastfed ◯Yes ◯No How many months?

Formula fed ◯Yes ◯No How many months?

Colicky baby ◯Yes ◯No Until what age?

First foods: 1. at months

2. at months

3. at months

# Vaccinations

◯Yes ◯No Any illness associated with them?

# Allergy Shots

◯Yes ◯No For what?

Have you ever suspected or has your child ever had worms or parasites? ◯Yes ◯No

Does your child have any allergies to foods, drugs, inhalants? ◯Yes ◯No

If yes, please explain to what and how he/she reacts:

## Present Medications/Supplements

1: Dosage: For what:

2: Dosage: For what:

3: Dosage: For what:

4: Dosage: For what:

## Dental Factors

Does your child have any mercury fillings (silver)? Y N If yes, how many?

Does your child have any composite fillings (plastic)? Y N If yes, how many?

Did your child have mercury fillings in his/her baby teeth that have fallen out? Y N

Does or has your child ever been diagnosed with oral thrush? Y N

Has your child had an abscessed tooth? Y N

Are there any dental issues to be aware of in your child? Y N

If yes, describe:

## Household Factors

Does mom or dad work in what you would consider a toxic work environment? Y N

If yes, please describe:

Are there any smokers in the home? Y N

If yes, do they smoke inside the home or car? Y N

Do you have wireless technology in your home? Y N

If yes, do you have EMF protective devices installed? Y N What types?

Does your child use a cell phone, or handheld wireless device? Y N

If yes, does it have an EMF protective device on it? Y N

Does your child use wireless gaming devices? Y N

Does the school you child attends have wireless technology? Y N

Do you use conventional cleaning products & detergents? Y N

Do you use organic cleaning products and 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

If yes, is it less than 2 years old? 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

Is there mold in your basement, bathroom, kitchen etc? Y N

Do you live within ¼ mile of hydroelectric power transformers or wires? Y N Now or in your past?

Do you live within ¼ mile of a garbage dump? Y N

Do you have an air purification system in your house? Y N

# Lifestyle Factors

Does your child consume 4-6 glasses of water daily? Y N

Is the water municipal water with fluoride? Y N

Does your child use fluoridated toothpaste? Y N

Is the water your child consumes filtered? Y N What type of filtration?

Does your child consume water from plastic bottles? Y N

Does your child consume:

◯Pop ◯Sugar-added drinks ◯Energy drinks ◯Fruit cocktails ◯Chocolate milk

Does your child participate in regular exercise or sports? Y N

If yes, please describe:

# 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
____ diaper rash
____ acne
____ bumps on back of arms

Other:_____

**DYSBIOSIS**

____ thrush
____ diaper rash
____ vaginal irritation
____ colic/gas

Other:_____

**SKELETAL**

____ arthritis
____ flat feet
____ broken bones
____ spinal disorders
____ back pain
____ sciatica
____ neck pain

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-social

Other:_____

**CHILDHOOD INFECTIONS**

____ chicken pox
____ red measles
____ German measles
____ croup
____ diphtheria
____ mumps
____ scarlet fever
____ rheumatic fever
____ whooping cough

Other:_____

**BOWELS**

____ constipation
____ diarrhea
____ regular (1-2 b.m./day)

____ mucous

____ blood

____ green/yellow

Other: _____

**BLOOD/LYMPHATIC**

____ anemia

____ easy bruising

____ easy bleeding

____ past transfusions

____ lymph node swelling

____ lymphatic disease

____ blood diseases

Other: _____

**OTHER**

____ heart condition

____ heart murmur

____ vision problems

____ headaches

____ head injuries

____ car accidents

Other: _____

# 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.

| Drug | Start Date | Stop Date | Reason for Medication and its Results | Present | Past |
|---|---|---|---|---|---|
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
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| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| Natural Supplements | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |
| | | | | ○ | ○ |

** Please being all medications & supplements with you to your first visit with the Naturopathic Doctor.

# 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_____