



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.

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

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

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	<u>What types?</u>
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 By a conventional dentist
 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

<p>ALLERGIES/INFECTION</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> cough (frequent acute)</p> <p><input type="checkbox"/> cough (chronic)</p> <p><input type="checkbox"/> wheezing</p> <p><input type="checkbox"/> sinusitis</p> <p><input type="checkbox"/> seasonal allergies</p> <p><input type="checkbox"/> year round allergies</p> <p><input type="checkbox"/> frequent colds</p> <p><input type="checkbox"/> ear infections (acute)</p> <p><input type="checkbox"/> ear infections (chronic)</p> <p><input type="checkbox"/> hearing loss</p> <p><input type="checkbox"/> bronchitis (acute)</p> <p><input type="checkbox"/> bronchitis (chronic)</p> <p><input type="checkbox"/> pneumonia</p> <p><input type="checkbox"/> chronic fatigue</p> <p><input type="checkbox"/> fatigue spells</p> <p><input type="checkbox"/> nosebleeds</p> <p><input type="checkbox"/> sore throats</p> <p><input type="checkbox"/> high fevers</p> <p><input type="checkbox"/> tonsillitis</p> <p><input type="checkbox"/> runny nose</p> <p><input type="checkbox"/> itchy eyes</p> <p><input type="checkbox"/> rings under eyes</p> <p><input type="checkbox"/> red/dry cheeks</p> <p><input type="checkbox"/> post nasal drip</p> <p>Med. Alert tag Y N</p> <p>For what? _____</p> <p>Other: _____</p>	<p>URINARY</p> <p><input type="checkbox"/> incontinence</p> <p><input type="checkbox"/> kidney stones</p> <p><input type="checkbox"/> bladder infections</p> <p><input type="checkbox"/> kidney infections</p> <p><input type="checkbox"/> kidney malformations</p> <p><input type="checkbox"/> bed wetting</p> <p>Other: _____</p> <p>DIGESTION</p> <p><input type="checkbox"/> canker sores</p> <p><input type="checkbox"/> diarrhea</p> <p><input type="checkbox"/> constipation</p> <p><input type="checkbox"/> stomach aches</p> <p><input type="checkbox"/> vomiting spells</p> <p><input type="checkbox"/> food allergies</p> <p><input type="checkbox"/> gas</p> <p><input type="checkbox"/> bloating</p> <p><input type="checkbox"/> abdominal cramps</p> <p><input type="checkbox"/> colic</p> <p><input type="checkbox"/> hernia</p> <p>Other: _____</p> <p>SKIN</p> <p><input type="checkbox"/> dry</p> <p><input type="checkbox"/> chronic rash</p> <p><input type="checkbox"/> eczema</p> <p><input type="checkbox"/> psoriasis</p> <p><input type="checkbox"/> hives</p> <p><input type="checkbox"/> skin tags</p> <p><input type="checkbox"/> acne</p>	<p><input type="checkbox"/> bumps on back of arms</p> <p>Other: _____</p> <p>DYSIOSIS</p> <p><input type="checkbox"/> jock itch</p> <p><input type="checkbox"/> thrush</p> <p><input type="checkbox"/> candida</p> <p><input type="checkbox"/> vaginal irritation or discharge</p> <p><input type="checkbox"/> colic/gas</p> <p><input type="checkbox"/> athletes foot</p> <p><input type="checkbox"/> craves sugar</p> <p>Other: _____</p> <p>SKETETAL</p> <p><input type="checkbox"/> arthritis</p> <p><input type="checkbox"/> flat feet</p> <p><input type="checkbox"/> broken bones</p> <p><input type="checkbox"/> spinal disorders</p> <p><input type="checkbox"/> back pain</p> <p><input type="checkbox"/> sciatica</p> <p><input type="checkbox"/> neck pain</p> <p><input type="checkbox"/> herniated discs</p> <p>Other: _____</p> <p>MIND & DISPOSITION</p> <p><input type="checkbox"/> dyslexia</p> <p><input type="checkbox"/> attention deficit</p> <p><input type="checkbox"/> hyperactive</p> <p><input type="checkbox"/> quick learner</p> <p><input type="checkbox"/> mentally challenged</p> <p><input type="checkbox"/> slow learner</p>	<p><input type="checkbox"/> insomnia</p> <p><input type="checkbox"/> nervous/anxious</p> <p><input type="checkbox"/> timid</p> <p><input type="checkbox"/> fearful</p> <p><input type="checkbox"/> phobias</p> <p><input type="checkbox"/> fearless</p> <p><input type="checkbox"/> aggressive</p> <p><input type="checkbox"/> angry, irritable</p> <p><input type="checkbox"/> violent</p> <p><input type="checkbox"/> calm, relaxed</p> <p><input type="checkbox"/> sad/depressed</p> <p><input type="checkbox"/> happy</p> <p><input type="checkbox"/> sociable</p> <p><input type="checkbox"/> anti-sociable</p> <p>Other: _____</p> <p>CARDIC</p> <p><input type="checkbox"/> heart condition</p> <p><input type="checkbox"/> heart murmur</p> <p><input type="checkbox"/> hypertension</p> <p>Other: _____</p> <p>OTHER</p> <p><input type="checkbox"/> vision problems</p> <p><input type="checkbox"/> headaches</p> <p><input type="checkbox"/> eating disorders</p> <p>Explain: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p>___ vehicle accident(s) How many? _____ When? _____ _____ Other: _____</p> <p>GASTROINTESTINAL</p> <p>___ 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</p>	<p>___ rectal bleeding ___ hemorrhoids ___ anal fissures ___ anal prolapse ___ abdominal pain ___ stomach pain ___ pancreas disease ___ bowel polyps Other: _____</p> <p>BLOOD/LYMPHATIC</p> <p>___ anemia ___ easy bruising ___ easy bleeding ___ past transfusions ___ lymph node swelling ___ lymphatic disease ___ blood diseases Other: _____</p> <p>EMOTIONAL</p> <p>___ depression ___ anxiety ___ mood swings ___ nervousness ___ panic attacks ___ phobias ___ irritable ___ angry ___ insomnia ___ worrier ___ S.A.D.</p> <p>MALES ONLY</p> <p>___ prostate problems</p>	<p>___ prostate surgery ___ hernia ___ testicular masses ___ testicular pain ___ discharge or sores ___ venereal disease ___ sexual difficulties Other: _____</p> <p>FEMALES ONLY</p> <p>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</p>	<p>___ 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: _____</p> <p>LIFESTYLE</p> <p># of coffees/day _____ # of teas/day _____ Herbal/Regular # of colas/day _____ ___ relaxation exercises ___ recreational drugs Type: _____ Frequency: _____</p>
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Personal Medical History

Blood type: A B AB O

List hospitalizations & surgeries (date & why): _____

List X-rays, CAT scans, EKO's, 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.
- I expect that this is a mutual partnership towards health & wellness, and it is the client's responsibility to convey 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

Acupuncture Meridian Assessment-“New” Medicine Based on Ancient Principles

Acupuncture, originating in China several thousand years ago, is known for alleviating pain and promoting healing. Acupuncture is based on the belief that the balance of the energy flow (Chi) through the *meridians* of the body is the essence of all living organisms for harmony and optimal health.

Meridians are “pathways” of energy flow through the body. Each meridian follows a very specific pathway that includes specific organs, tissues, muscles, and bones. There are hundreds of meridians throughout the body. Acupuncture uses very specific points on a meridian to influence the Chi, the health and vitality, of all the body elements on that meridian. When the chi, the energy flow, is blocked, the body is said to have an imbalance and will, sooner or later, suffer some sort of illness.

There are over 500 acupuncture points that have been established as having specific relationships with internal organs according to Traditional Chinese Medicine. A skilled physician can, in a short time, measure about 50 major Acupuncture points. He/she may discover not only which organs have problems but also the intricate relationships of causes and effects of internal and external disturbances. For example, dental infection might be the cause or effect of an arthritic pain and heart problem; wheat intolerance might be the cause of eczema or an intestinal problem.

So, what exactly is Acupuncture Meridian Assessment (AMA)? AMA simply uses an electronic device placed on acupuncture points to assess energy flow through the meridians of the body. AMA is called by various names such as EDS (Electrodermal Screening), Electro-acupuncture Biofeedback, and EAV (Electro-acupuncture according to Dr. Voll).

Dr. Reinhold Voll, MD, Internist and acupuncturist in Germany in the 1940’s, noticed changes in electrical conductivity at each of the body’s acupuncture points. He discovered that higher or lower readings than “normal” at the particular acupuncture point indicate degeneration or low energy flow. These imbalances can indicate the root causes of illnesses that are unexplainable by modern biochemistry-based medicine. Based on Dr. Voll’s work, a new field of energy medicine was developed in Europe.

Acupuncture Meridian Assessment can help physicians gather more data about the patient to better understand the patient’s health and body, and monitor the patient’s energy level and balance during treatment, as they return to the desired level. It assists in determining the right remedies at the right timing, level and sequence.

Today, EAV devices are widely used in Europe and Asia. In the North America, EAV is still unknown to most medical practitioners and the public. I have been using Acupuncture Meridian Assessment for over 25 years in my practice. I cannot imagine fully understanding my patient’s needs without an EAV device. To me, not using an EAV device as a guiding tool would be like navigating an airplane without radar equipment.

Acupuncture and Energy Medicine are evolving very rapidly. Acupuncture Meridian Assessment is leading the way into the future of medicine. When we can integrate all the above knowledge of ancient wisdom with modern science, there will be a quantum jump in the understanding of the causes of many unexplainable, chronic illnesses from chronic fatigue to environmentally induced illness.

Dr. Dawn Cormier
Naturopathic Doctor

The purpose of this Disclaimer is to explain to you what Dr. Dawn Cormier, Naturopathic Doctor can do for you and what you can expect. Naturopathic Doctors (NDs) in the province of Ontario are considered primary care physicians and as such have the ability to legally diagnose medical conditions. My practice is aligned with a model of integrative natural and energy healing, which is very different from a conventional disease care model. My approach addresses all aspects of your health and wellbeing. This includes physiological, chemical, metabolic, bioenergetics, mental, emotional and spiritual aspects of your whole system. My philosophy is that you are your own healer and that healing comes from within you. Your innate intelligence and Vital Force will direct your healing at the right level, system, and timing for your needs. This often happens in stages in the capacity to which the body can heal and rebalance function back to homeostasis. I can assist and direct your healing process by evaluating your system via various conventional and alternative functional tests and procedures. Natural therapies and treatments will be advised to support you on your restoration of health and wellbeing specific to your needs, bringing balance and healing to the degree you are able. For a list of services and detailed information on Naturopathic Medicine and what to expect, please visit the website or talk to Dr. Dawn Cormier, ND in your visit.

The natural alternative therapeutics, assessments, evaluations, products and services provided at this office are not intended to diagnose, treat, cure or prevent any disease or medical condition. Rather, the natural therapeutics, and services are meant to address any physical, metabolic, chemical, emotional and bioenergetics imbalances, stressors or blockages that may have an impact on wellness facilitating the body's natural ability to bring itself to homeostasis, which may have an impact on health and well-being. Individual improvement may vary and is dependent on the current state of a person's overall health and an individual's commitment to their personal goals.

Informed Consent for Electro Acupuncture according to Voll (EAV) and Acupuncture Meridian Assessment

I have specifically sought out the services and perspective of Dr. Cormier for the way she practices Alternative Medicine. As part of that service, I understand that she commonly uses an EAV device as part of her evaluation. Dr. Cormier has explained to me and I fully understand the following:

- a) The EAV device is classed as a Class II Medical Device by health Canada.
- b) The FDA has not approved EAVs for the treatment of any disease or conditions. The EAV device is only approved as a biofeedback device and Ohm meter by the FDA and is not a diagnostic device.
- c) The basic principle of EAVs has been explained in the article "Acupuncture Meridian Assessment-New Medicine Based on Ancient Principles". I have received, read and understood this article.
- d) The procedure is totally non-invasive and uses a probe to measure the skin resistivity at the acupuncture points located on the hands and feet for over 50 meridians, testing minute electro physical signals.
- e) This device is being used for investigational purposes only and is not being interpreted for a diagnosis.
- f) Dr. Cormier will design a treatment plan based on the EAVs data, physical exam, medical history, standard lab and functional tests.
- g) This device is one of many tools Dr. Cormier uses for evaluations. There are no guarantees of a successful outcome. Dr. Cormier believes that a patient's active and consistent participation in following recommended therapies results in greater and more consistent changes toward health.
- h) I can terminate the EAV evaluation at any time. It was my independent choice whether to see Dr. Cormier and it is always my choice whether to continue with her.

I have fully read and understand the above information, the elements of my informed consent, my rights and responsibilities, and hereby give consent to the use of EAV device.

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

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.

Print name _____ **Signature** _____

Date _____ **Witness** _____