PINEWOOD NATURAL HEALTH CENTRE

220 Duncan Mill Road, Unit 110
Toronto, Ontario M3B 3J5
(416) 656-8100

1295 Wharf Street, Unit 11
Pickering, Ontario L1W 1A2
(905) 427-0057

Date _____

Name _____ Age ___ Date of Birth _____
yyyy / mm / dd

Address _____ City _____ Postal Code _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Email _____

Occupation _____ Employer _____

Emergency Contact _____ Telephone _____

Marital Status (circle one) S M D W Sep Number of Children _____

Found out about clinic by _____

☐ Yes, I would like to receive "Pinewood Paradigm" newsletter and specials by email.

PLEASE LIST YOUR MAJOR COMPLAINTS IN ORDER OF IMPORTANCE

COMPLAINT	SINCE	POSSIBLE CAUSE(S)

What medications are you currently taking?

MEDICATION	SINCE	ADVERSE EFFECTS

What other treatments are you currently following? (i.e., chiropractic, physiotherapy, etc.)

_____

_____

Please list all of your known allergies. (food, environmental or drug)

_____

_____

_____

Please list your supplements/vitamins with dosages.

_____

_____

_____

Which of the following conditions have you had?

☐	Abscesses	☐	Depression	☐	Heart Disease	☐	Mononucleosis	☐	Rubella	☐	Tonsillitis
☐	Alcoholism	☐	Diabetes	☐	Hepatitis	☐	Mumps	☐	Scarlet Fever	☐	Tuberculosis
☐	Allergies	☐	Emphysema	☐	Herpes Genitalia	☐	Parasites	☐	Sexual Abuse	☐	Typhoid
☐	Amnesia	☐	Epilepsy	☐	Influenza	☐	Pelvic Inflammatory Disease	☐	Skin Disease	☐	Venereal Disease
☐	Arthritis	☐	Gall Stones	☐	Kidney Disease	☐	Peritonitis	☐	Strep Throat	☐	Warts
☐	Asthma	☐	Goiter	☐	Leukemia	☐	Pleurisy	☐	Sinusitis	☐	Whooping Cough
☐	Cancer	☐	Gonorrhea	☐	Malaria	☐	Pneumonia	☐	Sunstroke	☐	Worms
☐	Chicken Pox	☐	Gout	☐	Measles	☐	Prostatitis	☐	Stroke	☐	Yellow Fever
☐	Cold Sores	☐	Hay Fever	☐	Miscarriage	☐	Rheumatic Fever	☐	Syphilis		

Other, please list: _____

_____

For the above conditions, is there any where you have never been totally well again or any that have been severer than usual? Which ones? _____

_____

_____

Do you have any of the following? (Circle)

Amalgam (silver) fillings ○ YES NO ◉
Root canal ◉ YES NO ○
Periodontal disease ○ YES NO ◉

Dental implants? ○ YES NO ◉
Orthodontics? ○ YES NO ◉

What, if any, operations have you had?

OPERATION	WHEN	COMPLICATIONS?

What major injuries have you had?

INJURY	WHEN	LONG TERM EFFECTS?

WOMEN ONLY

Age of first menses _____
Last Menstrual Period (date) _____ Number of Pregnancies _____
Last Breast Exam (date) _____ Last Pap Test (date) _____
Last Bone Density Test (date) _____ Were these tests normal? YES◯ NO◉

MEN ONLY

Do you have difficulty with maintaining or achieving an erection? YES◯ NO◉
Last prostate exam _____ PSA (blood test done) YES◯ NO◉

What vaccinations have you had? _____
Any adverse effects from them? _____

Have you lost any weight lately? YES◯ NO◉ If yes, how many pounds? _____

How much of the following substances are you using?

Tobacco: _____ Alcohol: _____ Coffee: _____
Soda Pop: _____ Recreational Drugs: _____

Which of the following ailments listed, or any others, have affected your family?
(Check as many as apply)

☐Alcoholism ☐Allergies ☐Arthritis ☐Asthma ☐Cancer ☐Depression
☐Diabetes ☐Epilepsy ☐Gonorrhea ☐Gout ☐Hay Fever ☐Heart Disease
☐Tuberculosis ☐Paralysis ☐Pneumonia ☐Skin Dz. ☐Syphilis ☐Mental Illness
Other: _____

How often do you participate in physical activities/exercises?

____Daily ____2-3 times / week ____ once a week ____less than once a week

What type of activities? _____

On average, how many hours of sleep do you get per night? _____
Do you have interrupted sleep? YES◯ NO◉
Do you wake rested? YES◯ NO◉

Any dietary restrictions? (Religious or otherwise) _____
_____

How many glasses of water per day? _____

DIGESTION AND ELIMINATION

Digestion (circle or fill in the answer)

Do you have any problems with gas, bloating or fullness after eating? YES NO
Any heartburn? YES NO How often? _____
How often do you have gas, fullness or bloating after eating?
____ often ____ sometimes ____never
How severe is it? ____mild ____moderate ____severe
Do you have gas in the upper or lower part of the abdomen or is it both areas? _____
How long have you had this problem? _____
How often do you have bowel movements? _____
Do you ever have any blood, mucus, undigested food or black stools (movements)? _____
Do you have rectal itching? YES NO Do your stools tend to be formed or loose? _____
How often do you have diarrhea? _____
Do you ever have alternating constipation and diarrhea? YES NO
How often do you have thin, long and narrow stools? Often Sometimes Never
Do you ever have small and hard stools? Often Sometimes Never
Do your stools have a strong disagreeable odor? Often Sometimes Never
Have you ever fasted? YES / NO Juice or Water? How long did you fast? _____
How did you feel while you were fasting? _____
Have you traveled outside of Canada in the last 5 years? YES NO
Camping in the past 5 years? YES NO

Kidneys and Bladder:

Have you had recurrent bladder infections? YES NO
How were they treated? _____
How many bladder infections have you had in the last 3 years? _____
Do you have any burning sensation during or after urination? YES NO
In the past ____ or present ____
Is your urine dark yellow, bright yellow, cloudy, pale or clear? Circle one.
Does your urine have a strong odor to it? YES NO
Do you have difficulty starting or stopping when urinating? YES NO
Do you have difficulty perspiring? YES NO
Do you perspire when you exercise? Slightly Moderately Heavily
Do you perspire at other times, other than when exercising? YES NO
If yes, when: _____
Does your perspiration have a strong smell? YES NO
Does your temperature tend to run low ____ high ____ or average ____ compared to others?

Occupational/Household:

How long have you lived at your present address? _____
Where have you lived previously? _____
Please describe location, if old or new building, i.e., new construction, older construction, damp or moldy, etc. _____
Do you have specialized air filtration at home? YES○ NO⊙
Do you live in a city? YES○ NO⊙
Do you work in an office building? YES⊙ NO○ Do the windows open? YES○ NO⊙
Do you work in the presence of toxic fumes or chemicals? YES○ NO⊙
Do any of your hobbies involve toxic materials? YES○ NO⊙
Are you exposed to second hand smoke currently? YES○ NO⊙
What do you use for drinking water? Bottled ____ Filtered ____ Tap Water ____
Do you have anything else you would like to comment on? _____
_____
_____

Do you have any limitations on time or finances? YES○ NO⊙

Do you have a private health care plan? YES○ NO⊙ Limit? $ _____

Have you ever seen a Naturopathic Doctor before? YES○ NO⊙

If yes, for what ailment(s)? _____

Are any other members of your family patients of our clinic? YES○ NO⊙

STATEMENT OF ACKNOWLEDGEMENT AND CONSENT TO EXAMINATION AND TREATMENT

N.B. This form must be signed before any treatment will be rendered.

Naturopathic medicine uses non-invasive methods of assessing the bodily functions and the use of natural therapeutics for correction. The methods used at this clinic include the use of FUNCTIONAL BIOMETRY, such as German electro-acupuncture feedback techniques and aid in assessment with structural, nutritional, electromagnetic and lifestyle techniques as therapeutic methods.

The current health care system in Ontario is under scrutiny. In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your cooperation in signing this statement of acknowledgement, in so doing:

1. That you understand that I am a Naturopathic Doctor, and not a conventional medical doctor; that I use non-invasive, natural methods of assessment and treatment of body dysfunctions. That any treatment you receive is not mutually exclusive from any treatment or advise you may now be receiving or may receive in the future from another licensed health care provider.

2. That you understand that methods that I may use have a proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.

3. That you understand that I am required by my licensing board to perform a physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is deemed acceptable.

4. That you understand that treatment and/or referral to other health practitioners is based on the assessment of your health, revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation, including electromagnetic evaluation. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

5. That you understand I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended.

6. That you are not an agent of any private or government agency attempting to gather information without so stating your intentions.

7. That while changes in dietary habits are not an absolute prerequisite for treatment, that you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.

8. That you are accepting or rejecting this care of your own free will.

9. That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectations and what I can provide are not in agreement.

10. That you understand that all fees, for services and supplements are payable at the time of the appointment by the patient or the guardian. **That there is a fee for completing insurance forms, letter writing and telephone consultations of greater than 10 minutes. Notice of 24 hours is required for appointment cancellation, otherwise you will be charged an administrative fee of $35.00.** Any special financial arrangements may be made clear in advance.

I, _____ have read and understood and acknowledge the above statements.

_____ Date: _____

Signature of patient or guardian.

☐ This consent was discussed and any questions or concerns have been addressed. _____

Primary ND's Signature

Privacy Information Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, the Privacy Information Officer is:

Michael Rahman N.D.

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 all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing to ensure that:

- only necessary information is collected about you;
- we only share your information with your consent;
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses and Discloses patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services
- To communicate with other treating health-care providers, including specialists and referring doctors
- To allow us to maintain communication and contact with you to distribute healthcare information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- To comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the practice.

- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To prepare materials for the Health Professions Appeal and Review Board (HPARB).
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirement
- To comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

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

I know that your office has a Privacy Code, and I can ask to see the code at any time.

I agree that Pinewood Natural Health Centre can collect, use and disclose personal information about

_____ as set out above in the information about the office's privacy policies.
(Patient's Name)

Signature _____

Print Name _____

Date _____ Witness _____

☐ This consent was discussed and any questions or concerns have been addressed. _____
Primary ND's Signature

Privacy Information Sheet

How to Access the Privacy Process in Our Office

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your information.

Our privacy information officer can be reached at:

Pinewood Natural Health Centre
220 Duncan Mill Road, Unit 110
Toronto, ON
M3B 3J5
416 656-8100 (tel)
416 656-8107 (fax)
email: pinewood@rogers.com

Our privacy information officer will attempt to answer any questions or concerns that may arise. If you have a concern and/or wish to make a complaint to us about our privacy practices, including asking questions about the contents of your charts or records, you must make your request in writing. Please send it to our office's Privacy Information Officer by surface mail, fax, or email.

Our Privacy Information Officer will promptly acknowledge receipt of your complaint in writing, and will ensure that it is investigated thoroughly. You will be provided with a formal decision in writing, and the reason for the decision. If you are dissatisfied with the decision, you may seek further information from the Privacy Commissioner of Canada. We have included all the necessary contact information listed below.

Postal Address:
Privacy Commissioner of Canada
112 Kent Street
Ottawa, ON K1A 1H3

General Inquiries:
Phone: 613-995-8210
Toll Free: 1-800-282-1376
Fax: 613-947-6850

Our privacy policies and procedures comply with federal legislation called the Personal Information Protection and Electronic Documents Act (PIPEDA). This very complex law does provide some exceptions to the privacy principles that are too detailed to outline here. Our privacy code sets out this office's commitment to protecting your private health and personal information. It is available on request by asking any of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

INFORMED CONSENT TO NATUROPATHIC DIAGNOSTIC PROCEDURES

Patient Name_____
Address_____ Phone No._____
City/Town_____ Attending N.D._____
Province_____ Assistant_____

Recommended Diagnostic Procedure(s):

(including those by referral to another Pinewood practitioner)

During initial visit:

- Physical examination
- Electrodermal Testing

Subsequent visits, if recommended

- BTA(Biological Terrain Assessment) and/or
- Microscopy and/or
- Thermography and/or
- Hair Analysis and/or
- Blood Testing and/or
- Heart Rate Variability

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic procedure(s) and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the diagnostic procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily consent/my informed consent for the recommended diagnostic procedure(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

_____ _____
Patient or Lawful Representative Signature Date Signed

_____ _____
Witness Signature* Witness Relation to Patient

Address_____ _____
City/Town_____ Phone No.
Province_____ _____
Postal Code_____ Attending N.D./Assistant

*Witness signature is advised but not necessary

☐ This consent was discussed and any questions or concerns have been addressed. _____
Primary ND's Signature

INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

Patient Name_____
Address_____ Phone No._____
City/Town_____ Attending N.D._____
Province_____ Assistant_____

Recommended Therapeutic Procedure(s) / Plan:

(including those by referral to another Pinewood practitioner)

During initial visit: Subsequent visits, if recommended

- Nutritional/Botanical/Homeopathic supplementation and/or
- Diet and Lifestyle modification

Subsequent visits, if recommended:

- Ion cleanse, Sauna, Presso Therapy, Magnetic Field Therapy, Ionized Oxygen Therapy, Pulsation Therapy, Accupuncture.

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/plan and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily consent/my informed consent for the recommended therapeutic procedure(s)/plan as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

_____ _____
Patient or Lawful Representative Signature Date Signed

_____ _____
Witness Signature* Witness Relation to Patient

Address_____ _____
City/Town_____ Phone No.
Province_____ _____
Postal Code_____ Attending N.D./Assistant

*Witness signature is advised but not necessary

☐ This consent was discussed and any questions or concerns have been addressed. _____
Primary ND's Signature