



Pinewood Natural Health Centre

Inspiring your journey to change.

Welcome!

We are here to support you in your goal to raise a healthy, active child from birth through to 16 years of age.

You may have heard about Pinewood Natural Health Centre from a family member, friend or colleague; the majority of individuals and families are referred to us by our amazing patients! In fact, patients who have been with Pinewood for many years have become part of our extended family. Like you, they value health and vitality and are reaching out to help us build healthier families and communities. We invite you to join our mission, *“To educate, support and inspire our patients on their journey to superior health and vitality so they can live their best life.”*

Or, perhaps you found us online. If so, you have likely explored our website to learn about our services, you have read about our dedicated health care team, and you really have the commitment to improve your child’s health. That’s why you’re perfect for Pinewood. We love working with parents like you who want to improve your child’s health with naturopathic medicine, because a healthy, active child who develops to their full potential is every parent’s wish!

What to Expect?

Your child’s first appointment is typically much longer than you may have experienced with a conventional Medical Doctor. Your Naturopathic Doctor will spend the majority of the first visit listening to you as together you review your child’s health concerns, health history, lifestyle habits, stress level, school and social life, depending on their age. You will also discuss any previous treatments, therapies, medications and supplements and how they worked for your child. Your Naturopathic Doctor will then conduct a physical exam. Treatment recommendations will begin at this first visit.

This first important visit helps define the starting point on your child’s health journey through to age 16. Follow-up visits are scheduled based on individual needs to allow for treatment modifications as your child’s health continues to improve or to address new health challenges that arise. It is important to realize that it takes time to feel better using naturopathic medicine, isn’t it? You may notice changes in your child early on or it may take a while depending on the complexity of their health. We ask you to be patient! As a team, with consistent effort from you and your child combined with recommendations from your Naturopathic Doctor, you can rest easy knowing you are investing in your child’s good health and vitality so they can reach their full potential.

Now, let’s get started!

To begin we need to know about the pregnancy, birth, developmental progress, your child’s health history and the home environment. Please take some time to thoroughly complete the following Naturopathic Pediatric Intake Form. Bring the completed forms to the first appointment. For security reasons, please do not email the completed form to us; we want to protect your privacy. It is also helpful to bring any recent (in last 6 months) blood or diagnostic results and the actual bottles of any medications or supplements your child is currently taking. We know you’re eager to get started, so you might like to visit our website and read some of the many informative posts in our Pinewood Blog.

We look forward to meeting your child and you!

Your team of Naturopathic Doctors



Pinewood Natural Health Centre

220 Duncan Mill Road, Unit 110, Toronto ON M3B 3J5 **416.656.8100**

1295 Wharf Street, Unit 11, Pickering ON L1W 1A2 **905.427.0057**

Naturopathic Pediatric Intake Form

To be completed by Parent or Guardian

Date _____

Name _____ Age ____ Date of Birth _____
First Last dd / mm / yyyy

Address _____ City _____ Postal Code _____

Phone: (Home) _____ Gender Male Female

Name of parent /guardian _____
First Last

Address _____ City _____ Postal Code _____
(if different from child)

Phone: (Home) _____ (Work) _____ (Cell) _____

Email _____

Medical doctor or referral _____

Found out about clinic by: family friend/coworker internet practitioner other

MAJOR COMPLAINT(S) List in order of importance:

Please relate any relevant history to the major complaint(s):

PAST HISTORY

Family History (check the appropriate boxes if present in family):

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> allergies | <input type="checkbox"/> mental illness | <input type="checkbox"/> rheumatism |
| <input type="checkbox"/> cancer | <input type="checkbox"/> birth defects | <input type="checkbox"/> goiter |
| <input type="checkbox"/> hypertension | <input type="checkbox"/> heart disease | <input type="checkbox"/> Alzheimer's disease |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> kidney disease |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> syphilis | <input type="checkbox"/> stomach or gastro-intestinal disorders |

A. Please fill in the following family table:

Family Member	Living (L) or Dead (D)	Age at Death	Cause of Death
Grandmother (maternal)			
Grandfather (maternal)			
Grandmother (paternal)			
Grandfather (paternal)			
Father			
Mother			
Brother 1			
Brother 2			
Sister 1			
Sister 2			

Does mother or father have a chronic disease? If so, please fill in details below:

<u>Mother</u>	<u>Father</u>
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B. Ante-natal History (before birth period)

Age of mother at child's birth: _____

Mother's health at conception: Poor Fair Good Excellent

Father's health at conception: Poor Fair Good Excellent

If poor, why: _____

Was pregnancy planned? Yes No

Birth order of child (e.g. eldest or youngest): _____

Number of pregnancies: _____

Number of live births: _____

Mother's health during pregnancy (please check appropriate box):

- bleeding
- hypertension
- diabetes
- cigarette/alcohol/drug consumption. If so, quantity per day _____
- illnesses
- thyroid problems
- physical or emotional trauma
- medications (prescribed AND over the counter) _____

How was the diet over pregnancy? Poor Fair Good Excellent

Supplements taken during pregnancy: _____

C. Birth History:

Term: Full Premature Late Number of weeks of pregnancy _____

Weight at birth: _____ kg _____ lb

Length of labour _____ hours

Please check: vaginal birth Cesarean birth (reason) _____

Complications: _____ Resolved? Yes No

Was the mother ill at labor with other disease?

- genital herpes
- diabetes
- hypertension
- other sexually transmitted disease (specify) _____
- other disease (specify) _____

Were there any significant findings at birth?

- congenital disease. What? _____ birth injuries. Specify _____
- blue baby syndrome jaundice/icterus
- physical malformations or birth defects What? _____
- low birth weight _____ kg/lb Others (specify) _____

How was your overall feeling about the whole pregnancy and childbirth experience?

- poor fair good excellent

Why? _____

E. Diet of Child

Post-natal diet for first year:

- breast fed How long? _____ months
- formula Specify type _____
- cow's milk
- soy milk
- nut milk Specify type _____

First liquid introduced (besides water) when weaned from breast feeding: _____

Age began solid foods _____

List the foods and age when solids were introduced into the child's diet within the first 12 months of life:

Solid food	Month introduced	Allergic reaction?

Please write out the child's diet in a typical present day. Include all snacks and fluids:

Breakfast	Lunch	Dinner	Vitamins/Medications

Food allergies/intolerances? Yes No If yes, name the food allergen and how it was diagnosed.

Food allergen	Age discovered and year discovered	Test used to diagnose

F. Environment of Child

Was your child's **physical** development:

- slower than average
- average
- faster than average

Was your child's **mental** development:\

- slower than average
- average
- faster than average

How is the child's behaviour and performance in school/home?

Child's natural parents:

- married
- divorced
- common law
- remarried
- separated

What is the emotional climate of the child's home presently?

- very stable
- stable
- stressful
- very stressful

Does child sleep by him/herself? Yes No

What was the child's sleep patterns like?

Does any member in the house take the following recreational drugs? Check ones that apply:

- smoking
- alcohol
- marijuana
- other, specify _____

Do you live near any high tension electrical wires: Yes No

If yes, please indicate the distance these wires are from your house: _____ meters/feet

What form of heating do you use?

- oil electricity gas

Do you have any of the following inside the house? Check where present:

- air conditioner wood stove electric stove central heating
 gas stove air purifier humidifier fireplace

Do you live near any of the following?

- industrial plant Specify _____
 commercial business (e.g. nurseries, labs) Specify _____
 dump sites Specify _____
 non-residential property (e.g. highways, hospitals) Specify _____

Have you acquired or done the following chores in your house? Check where applicable:

- | | |
|---|--|
| <input type="checkbox"/> new furniture | <input type="checkbox"/> new car |
| <input type="checkbox"/> new carpet | <input type="checkbox"/> house deodorant spray |
| <input type="checkbox"/> refinished furniture | <input type="checkbox"/> colognes or perfumes |
| <input type="checkbox"/> remodeling your home | <input type="checkbox"/> potpourri |
| <input type="checkbox"/> weatherizing the home | <input type="checkbox"/> plants |
| <input type="checkbox"/> pesticides and herbicide use on garden,
home and pets | <input type="checkbox"/> flowers |

How old is the house? _____

Describe the general area of your house. For example, rural and near the water/stream, etc

General activities/hobby of child during day. Include all activities:

Activity	Time	Location

Source of drinking water _____

Please list the products/brand that you use on the child:

1. soap _____
2. shampoo _____
3. bubble bath _____
4. body lotion _____
5. talcum powder _____
6. diapers _____
7. clothing _____
8. hair products _____
9. others. Specify _____

Temperature of child's bath water _____

Is the child chilly, medium or hot all the time? _____

What kind of toys does the child play with? List the main ones:

Toy	Description	Share with others?	Age of toy

If there is anything that is missed by this intake form and that you think is relevant to the case of the child, please fill in this space:

Thank you for filling out this intake form. The information you provided will help us greatly in the recommendation of holistic treatment of the child.



STATEMENT OF ACKNOWLEDGEMENT AND CONSENT TO EXAMINATION AND TREATMENT

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

Patient Name: _____ Date of Birth: _____
First Name Last Name dd / mm / yyyy

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Phone: _____

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. Note that you may be requested to see other Naturopathic Doctors at Pinewood to provide diagnostic and treatment strategies as deemed necessary or appropriate by your primary Naturopathic Doctor. 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 the supplements/products sold to you through our dispensary are for your personal use only and are to be taken according to the instructions outlined on the Prescription/Recommendation Form I provide to you at your consultations.

The supplements/products are available through our dispensary as a convenience to you. You may choose to purchase the supplements/products elsewhere being diligent to purchase the correct formula/dose that I have prescribed/recommended.

10. 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.
11. That you understand, if you are a patient of Dr. Michael Rahman, ND, there is a \$25.00 fee for non-urgent email and phone inquiries and a \$45.00 fee for prescription repeat requests from your pharmacy when you are overdue for a follow-up consultation.
12. That you understand that all fees for services and supplements/products are payable at the time of the appointment/purchase by the patient or the guardian. If you arrange to have Pinewood mail your supplements/products to you (in Canada only) you will be billed for the postage/shipping fees and acknowledge you are financially responsible for this cost. **That there is a fee for completing insurance forms, letter writing and telephone consultations. Notice of 24 hours is required for appointment cancellations, otherwise you will be charged an administrative fee of \$35.00.** Any special financial arrangements may be made clear in advance and documented in your chart.

I, _____ have read and understood and acknowledge the above statements.
(print first and last name)

Signature of patient or Guardian or Lawful Representative

Date: _____

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

Primary ND's Signature or Intake ND's Signature



Patient Rights

As a naturopathic patient of Pinewood you have the right to:

Know what your Naturopathic Doctor is recommending, including:

- the nature and purpose of the treatment;
- the intended outcome and possible side effects;
- the risks and anticipated benefits; and
- reasonable alternatives.

At any time, ask a question.

Refuse or stop treatment at any time.

Consent, or withdraw your consent, to all assessments including physical examinations or laboratory tests.

Ensure that your personal health information remains confidential and that your privacy is respected.

Obtain a second opinion from another health professional.

Be listened to.

Express concerns about care/service and be informed of the process for doing so.

Know the names and roles of the members of your health care team.

To voice concerns with the College of Naturopaths of Ontario, the regulatory body for naturopaths in our province.

Be free of mental, physical, sexual and financial abuse.

Professional care free from bias.

A clear explanation of the services you will receive and who will provide them.

Access a copy of your personal health record.



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 – please print)

 Signature of patient or Guardian or Lawful Representative. Date: _____

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

 Primary ND's Signature or Intake 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: toronto@pinewoodhealth.ca

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: _____ Date of Birth: _____
 First Name Last Name dd / mm / yyyy

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Phone: _____

Name of Primary ND or Intake ND: _____

Recommended Diagnostic Procedure(s)

- During initial and subsequent visits:
- Physical examination, including vitals testing
- Electrodermal testing
- Urinary analysis

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 confirm 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 Guardian or Lawful Representative Signature Date Signed (dd / mm / yyyy)

Address: _____ City/Town: _____
Province: _____ Postal Code: _____ Phone: _____

Witness Signature* *Witness signature is advised but not necessary Witness Relation to Patient

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

Signature of Naturopathic Doctor / Clinical Assistant performing the diagnostic procedure(s)



INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

Patient Name: _____ Date of Birth: _____
First Name Last Name dd / mm / yyyy

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Phone: _____

Name of Primary ND or Intake ND: _____

Recommended Therapeutic Procedure(s) / Plan:
(including those by referral to another Pinewood practitioner)

During initial visit and subsequent visits:

- Nutritional/Botanical/Homeopathic supplementation
- Diet and Lifestyle modification
- Medical education

During subsequent visits:

- Presso therapy
- Ionized Oxygen therapy
- Acupuncture

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 Guardian or Lawful Representative Signature

Date Signed (dd / mm / yyyy)

Address: _____

City/Town: _____

Province: _____ Postal Code: _____

Phone: _____

Witness Signature* *Witness signature is advised but not necessary

Witness Relation to Patient

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

Signature of Naturopathic Doctor / Clinical Assistant performing the diagnostic procedure(s)