Pinewood Natural Health Centre
Inspiring your journey to change.

Dr. Sheleena Jinnah, D.C.
110 – 220 Duncan Mill Road, Toronto, ON M3B 3J5
416-656-8100 toronto@pinewoodhealth.ca

DOCTOR SUPERVISED CHIROTHIN WEIGHT LOSS PROGRAM

Weight Loss Intake Form

Date _____ Referred by: _____

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

Address _____ City _____ Postal Code _____

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

Email _____ Occupation _____

Gender ❑ Male ❑Female Marital Status (circle one) S M D W Sep Number of Children _____

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

Have you ever seen a chiropractor before: ❑ Yes ❑ No When was your last visit? _____

1. What are your reasons for wanting to lose weight? _____

   _____

2. How much weight would you like to lose? _____ lbs

3. Describe how will you **feel** when you accomplish this goal? *(example: more confident, "light", more motivated, happy)*

   _____

4. How will accomplishing this goal improve your life? *(example: better intimacy, easier to exercise, travel and plan with your kids/grandkids, etc.)*

   _____

5. What does it **feel** like in your body now? *(example: fatigued, easily winded, feel like a blob, don't want to go out, hate the scale/clothes/mirror, etc.)*

   _____

6. What does your current weight prevent you from enjoying in life? _____

   _____

7. Please list in order of preference (1 – 4) with 1 being most important, what you value most in a weight loss program.
   _____ Rapid and noticeable loss of weight and inches
   _____ Feeling supported by a knowledgeable team
   _____ Developing a long term trusted relationship with our health care team for life-long related
   _____ Learning proven methods for weight loss and long term age management.

8. If you have ever tried to lose weight before, please describe what you have done and the results you achieved.

   _____

   _____

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8. Are you currently pregnant, breast feeding, have active cancer, or cholecystitis? ❑ yes ❑ no

9. Do you experience any of the following conditions even if they are minor and go away on their own?

❑ High blood pressure	❑ Diabetes	❑ Headaches	❑ Hypoglycemia
❑ Cancer	❑ Neck pain	❑ Upper/Low back pain	❑ Thyroid problems
❑ Heart disease	❑ Digestive problems	❑ Arthritis	❑ Chronic fatigue
❑ Fibromyalgia	❑ Numbness	❑ Stress/irritability	❑ Sinus/allergy
❑ Hip/knee pain	❑ Osteoporosis	❑ Chronic inflammation	❑ Other

10. Family History – Please indicate any of your relatives who have had any of the following conditions:
(parent, sibling, grandparent, etc)

❑ Alcoholism _____	❑ Anemia _____	❑ Arthritis _____	❑ Cancer _____
❑ Diabetes _____	❑ Emphysemia _____	❑ Epilepsy _____	❑ Glaucoma _____
❑ High BP _____	❑ Stroke _____	❑ Heart Disease _____	❑ Osteoporosis _____
❑ Mental illness _____	❑ Other _____		

11. Please list any medications you are taking & what they are treating.

Please list any vitamins and natural supplements you are taking.

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

12. Please use this area to describe any significant emotional trauma, injuries/accidents & approximate age they occurred.

1. _____ Age _____
2. _____ Age _____
3. _____ Age _____
4. _____ Age _____
5. _____ Age _____
6. _____ Age _____

Other: _____

13. Do you have any other health challenges that you feel are important for us to know about?

_____

_____

continued on next page

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Weight Loss Intake Form

ChiroTHIN Consent

I understand that I will not use or consume any of the ChiroTHIN products if I am pregnant or think I might be pregnant. I understand that, as a dietary supplement, ChiroTHIN has been approved by Health Canada. I additionally understand that The ChiroTHIN Weight Loss Program is not meant to diagnose, treat or cure any disease or medical condition and that I am to undergo participation in the ChiroTHIN Weight Loss Program only under doctor supervision. I also understand that I should consult with my doctor prior to starting ANY exercise or nutritional supplement program. I hereby consent to, and assume the risks associated with the use and consumption of ChiroTHIN product and agree to follow the recommendations and instructions of my supervising chiropractor.

Questions or Concerns

You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care.

Inform your chiropractor immediately of any changes in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

_____
Name (please print)

_____ Date: _____
Signature of Patient (or legal guardian) (dd/mm/yyyy)

_____ Date: _____
Signature of Chiropractor (dd/mm/yyyy)

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(416) 656-8100

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

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, BSc, ND

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 of Patient or Guardian : _____ Date: _____

Name of Patient or Guardian (please print): _____

Witness: _____

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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.