Pinewood Natural Health Centre
Inspiring your journey to change.

Marsha Fenwick, CNP, RNCP
110 – 220 Duncan Mill Road, Toronto, ON M3B 3J5
416-656-8100 toronto@pinewoodhealth.ca

Lifestyle Assessment Form

Date _____ Referred by: _____

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

Address _____ City _____ Postal Code _____

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

Email _____

Emergency contact _____ Relationship _____ Phone _____

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

What are your main health concerns in order of importance to you:

1. _____

2. _____

3. _____

How are you feeling overall?_____

What do you feel might be the underlying factors contributing to your present health concerns?

_____

Height: _____ Weight: _____

Do you wish to: ❑ gain weight ❑ lose weight How Much? _____

MEDICAL HISTORY

How is your blood pressure? _____

How is your cholesterol? _____ When was your last physical? _____

Are you currently taking any medication? _____

_____

Supplements you are currently taking and the amounts/dosage: _____

_____

_____

_____

Have you received any vaccinations including the flu shot in the last few years? _____

_____

Have you taken antibiotics in the last few years? _____

Do you have any allergies/food sensitivities? _____

_____

_____

How is your menstrual cycle? _____

❑ cramps ❑ bloating ❑ back pain ❑ irritability ❑ headaches ❑ skin breakouts

Do you ever get yeast/bladder infections? _____

Have you ever been diagnosed with an illness? Explain: _____

_____

_____

Any heartburn? _____

Any bloating? _____

How often do you have a bowel movement? _____

Do you strain to have a bowel movement? ❑ Yes ❑ No ❑ Sometimes

Do you experience (check all that apply):

❑ loose stools ❑ blood ❑ mucus ❑ undigested food ❑ smelly stools

Describe: colour? _____ shape? _____ Do stools: ❑ float ❑ sink

Do you experience frequent colds/infections? _____

Do you ever have sinus pain/congestion? _____

Do you ever experience pain in the joints? _____

Do you ever experience headaches/migraines? _____

How is your skin? _____

How are your nails? _____

How are your teeth? # of amalgams_____ # of root canals/Implants_____ Mouth ulcers_____

FAMILY HISTORY

❑ Heart Disease ❑ Diabetes ❑ Allergies ❑ Anxiety ❑ Hypertension
❑ Arthritis ❑ Lactose Intolerance ❑ Obesity ❑ Cancer ❑ Osteoporosis
❑ Intestinal disease (Crohn's, colitis, IBS) ❑ Depression ❑ Autoimmune Disorder

Other:_____

What level of stress do you feel you are experiencing at this time in your life?

❑ Minimal ❑ Average ❑ Considerable ❑ Unbearable

What are the major causes of your stress?_____

What time do you go to bed? _____ wake up? _____ Avg. total = _____

Do you have trouble falling asleep? _____ Do you wake up during the night? _____

Do you wake feeling rested? ❑ yes ❑ no ❑ sometimes

Do you grind your teeth at night? _____

Describe energy level? _____

What type of work do you do? _____

How many hours a day do you work? _____

Do you enjoy your work? ❑ yes ❑ no ❑ sometimes

Do you smoke? ❑ yes ❑ no If yes, how much? _____

Have you ever smoked? _____

Are you often exposed to second-hand smoke? ❑ yes ❑ no

Describe what you do for exercise?_____

_____

DIETARY HABITS (food journal) State typical breakfast, lunch, dinner, snacks

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverage	Number of cups per day	Number of cups per week
Coffee (regular, decaf)		
Tea (black tea, green tea, caffeine free)		
Water (Tap, filtered, bottled)		
Soft drinks (diet, regular)		
Fruit juices (prepared, fresh squeezed)		
Vegetables juices (prepared-V8, freshly squeezed)		
Milk (skim, 1%, 2%)		
Rice or Soy Milk		
Beer, Wine, other alcoholic beverage		
Other (Please Specify):		

Do you use a microwave / plastic? ❑ yes ❑ no

Do you eat any of the following?

❑ fried foods ❑ fast foods ❑ candy ❑ artificial sweetener
❑ refined/processed foods ❑ luncheon meats ❑ margarine ❑ cooking oil: _____

Do you eat meat? _____

What foods do you crave, if any? _____

Do you experience any symptoms if meals are missed? Explain: _____

_____

Do you avoid certain foods? If so, what are they and why do you avoid them? _____

_____

_____

Do you experience any symptoms after meals? Explain: _____

_____

_____

What type of changes are you ready to make in your diet/lifestyle? _____

_____

_____

What are you looking for when we work together? _____

What have been your biggest challenges? _____

What has held you back from making changes before now? _____

Is there anything else about your health that you would like to share with me? _____

When we meet in person, we will review the following food categories. No need to fill out anything now!

Protein **Veggies** **Fruit** **Fat** **Grains** **Bread** **Liquid**

_____ _____

Patient signature Date (dd/mm.yyyy)

I look forward to working together to help you achieve your goals and optimize your health!

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416-656-8100 toronto@pinewoodhealth.ca

CLIENT CONSENT

Principles of care:

Marsha Fenwick is a Certified and Registered Holistic Nutritionist and is not a medical doctor. She is not legally permitted to diagnose diseases or conditions. For the diagnosis or treatment of any ailment or disease please consult a licensed physician. Marsha can however educate and advise you with respect to building and maintaining your wellness. She can provide guidance about giving your body the nutrients it needs to bring itself back into balance, regardless of what state it may be in. She is able and willing to work in collaboration with your doctor, naturopath or other specialized provider to ensure integrated care.

Informed Consent

I fully understand that Marsha Fenwick CNP is not a medical doctor and I am not here for medical diagnostic or treatment procedures. I am here to be educated and guided on nutrition and lifestyle issues.

I understand that the services performed by Marsha Fenwick are at all times restricted to consultation on the subject of nutritional matters intended for the maintenance of the best possible state of nutritional health, and do not involve the diagnosing, prognostication, or prescribing of remedies for the treatment of disease.

I acknowledge that it is my choice to participate in any program or service suggested by Marsha Fenwick. I also acknowledge that I have inquired about the nature of any activity, program, or service that I am not completely familiar with and I have been informed of any inherent risks. I understand that part of the risk involved in undertaking any activity is relative to my own state of fitness and health (physical, mental, and emotional) and the awareness, care and attention with which I conduct myself in that activity or program.

I confirm that I have disclosed all medical issues and any medications and supplements that I am taking.

I agree to be personally responsible for the fees that are charged by Marsha Fenwick in connection with the services provided to me. I will provide at least 36-hour notice if an appointment must be missed, otherwise will be billed 100% as a missed appt. Nutrition packages expire 6 months from date of purchase. Funds provided to Marsha Fenwick Nutrition shall not be refunded.

I am here on this and any subsequent visit, solely on my own behalf and not as an agent for any federal, provincial, municipal, or professional agency on a mission of entrapment or investigation.

I declare that I have read, understood, and agree to the contents of this consent agreement in its entirety.

Signature: _____

Name (Please Print): _____ Date: _____

In accordance with my commitment to the counseling profession, all consultations and communications are confidential and private. Your personal information is not shared with anyone.

Marsha Fenwick R.R.T. CNP, NNCP

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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

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.