



**905.465.4595**  
**2418 Lakeshore Road West**  
**Oakville, ON L6L 1H7**

**Naturopathic Medicine**

**Patient Information (please print clearly)**

Name: \_\_\_\_\_ Date of Birth: mm/dd/yyyy \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone: (H) \_\_\_\_\_ (B) \_\_\_\_\_ (M) \_\_\_\_\_  
 Email: \_\_\_\_\_ Would you like to receive our monthly newsletter?  Yes  No  
 Occupation: \_\_\_\_\_ Gender:  Male  Female  
 Where did you find our number? \_\_\_\_\_ If online, what site referred you?  Google  MSN  Yahoo  Other

**HEALTH CARE PROVIDERS**

Name of Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Are you currently under his/her care? Yes No Date of last physical exam: \_\_\_\_\_  
 Other Health Care Providers you are seeing

Name	Specialty	Telephone Number

**CURRENT HEALTH**

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please list all **CURRENT** medications (prescription, over-the-counter, vitamins, herbs). Please include BRAND & DOSE:

- |          |           |
|----------|-----------|
| 1) _____ | 6) _____  |
| 2) _____ | 7) _____  |
| 3) _____ | 8) _____  |
| 4) _____ | 9) _____  |
| 5) _____ | 10) _____ |

***Please turn over...***

Do you get any of the following screening tests regularly?

- Blood tests
- Bone density tests
- Mammograms
- PAP
- Prostate Exam
- Other: \_\_\_\_\_

Do you frequently use any of the following?

- Pain Relievers
- Laxatives
- Antacids
- Diet Pills
- Appetite suppressants
- Antibiotics
- Antidepressants
- Ulcer medication
- Sleep medication
- Birth Control: Pill / Injection / Implant / Patch

Alcohol: Amount / day or week: \_\_\_\_\_

Tobacco: Amount / day or week: \_\_\_\_\_

Caffeine: Amount / day or week: \_\_\_\_\_

Recreational drugs: Amount / day or week: \_\_\_\_\_

If you are female, are you currently pregnant?  Yes  No

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_ Maximum Weight: \_\_\_\_\_ When: \_\_\_\_\_

Forms of Exercise: \_\_\_\_\_ Amount per week: \_\_\_\_\_

**MEDICAL HISTORY**

Please indicate any serious conditions, illnesses, injuries, hospitalizations along with dates:

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Please list all **PAST** medications:

- 1) \_\_\_\_\_ 4) \_\_\_\_\_
- 2) \_\_\_\_\_ 5) \_\_\_\_\_
- 3) \_\_\_\_\_ 6) \_\_\_\_\_

Please indicate immunizations you have had:

- DPT (diphtheria, pertusis, tetanus)
- Haemophilis Influenza B
- Hepatitis A
- MMR (measles, mumps, rubella)
- "Flu"
- Hepatitis B
- Smallpox
- Polio
- Tetanus Booster When: \_\_\_\_\_
- Other: \_\_\_\_\_

Please describe any adverse reactions: \_\_\_\_\_

Do you have any allergies to the following? Please describe.

Drugs: \_\_\_\_\_

Foods: \_\_\_\_\_

Animals: \_\_\_\_\_

Other: \_\_\_\_\_

**DIET**

Do you have any dietary restrictions? (religious, vegetarian/vegan, health related etc.)

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**FAMILY HISTORY**

Please indicate if a close relative has/had any of the following:

	WHO?		WHO?
Allergies		Epilepsy	
Alzheimers		Heart Disease	
Anemia		High Blood Pressure	
Arthritis		Kidney Disease	
Asthma		Mental Illness	
Cancer		Multiple Sclerosis	
Depression		Parkinson's Disease	
Diabetes		Stroke	
Drug / Alcohol Abuse		Other	

I don't know my family medical history

**LIFESTYLE**

Please rate yourself in the area of life listed below in terms of satisfaction and stress. Lower numbers represent dissatisfaction and stress.

	1	2	3	4	5	6	7	8	9	10
Friends & Family										
Physical Environment										
Health										
Career										
Relationship / Romance										
Recreation										
Money										
Personal Growth / Spirituality										

Is there anything you feel that is important that has not been covered?

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**CONSENT TO TREATMENT & FEE POLICY**

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, including physical, mental and emotional aspects of the individual. Gentle techniques are used to stimulate the body's inherent healing capacity and correct any imbalances. Your visit may consist of a thorough case history and a screening physical examination, including breast examination for females. If your case requires, the physical examination may include more specific examinations such as rectal or genital exams. After collecting the necessary information, diagnosis, treatment and/or referral to other health care professional are made based upon the assessment of conditions revealed.

It is important that we are informed of any diseases that you are suffering from and if you are on any medication or over-the-counter drugs. If you are pregnant, suspect you are pregnant, or you are breastfeeding, please let us know.

There are some light health risks to treatment by naturopathic medicine. These include but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising or injury from acupuncture. Results are not guaranteed and not all risks and complications can be anticipated.

Payment is made at the time of visit:

- \$25 fee for NSF cheques
- Rescheduling fee of \$45.00 applies to any appointment changes with less than 24 hours notice.
- Supplements and products are individually priced. Patients are not required to purchase the recommended supplements in their treatment protocol from this office and are free to choose where they are purchased.

Your identity will be protected at all times and a record will be kept of the health services provided. Patients may look at their medical record at any time and can request a copy by paying the appropriate fee. The information from medical records may be analyzed for research purposes and all identities will be protected and kept confidential.

***Please turn over...***

**CONSENT REGARDING PERSONAL INFORMATION**

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

At this office, Samantha S. Ristimaki ND acts as the Privacy Information Officer. All staff members who come into 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 protection and appropriate use of your information.

Our privacy policy outlines what our clinic 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 the existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Drugless Therapy – Naturopathy.

**HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENTS PERSONAL INFORMATION**

To help you understand how we protect your personal information, we have outlines here how our clinic is using and disclosing your information:

- To assess your health concerns.
- To provide health care.
- To advise you of treatment options.
- To establish & maintain contact with you.
- To send newsletters and other information mailings.
- To remind you of upcoming appointments.
- To communicate with other treating health-care providers.
- To allow us to efficiently follow-up for treatment, care and billing.
- To complete claims for insurance purposes.
- To invoice for goods and services.
- To process credit card payments.
- To collect unpaid accounts.
- To comply with legal and regulatory requirements of our regulatory body, the Board of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners act*.
- To assist this clinic to comply with all regulatory requirements.
- To comply generally with the law.
- To allow potential purchasers, practice brokers or advisors to conduct and audit in preparation for practice sale.

By signing the consent section of this Patient Consent Form, you have agreed that you have given informed consent to the collection, use and/or disclosure of your personal information as outlined above.

**PATIENT CONSENT**

I \_\_\_\_\_, (patient name) agree that Samantha S. Ristimaki ND may collect use and disclose personal information as set out above regarding the clinic’s privacy policy. I also consent to diagnosis and therapeutic procedures for the entire course of treatment for my present condition(s), and understand that I am free to withdraw consent and to discontinue participation in theses procedures at any time. I have read, fully understood and agree to the outlined fees and policies, and understand that the fees may change without prior notice.

Signature\_\_\_\_\_ Date: \_\_\_\_\_

Guardian Signature (patients under age 16):\_\_\_\_\_

Witness Signature:\_\_\_\_\_

Thank you for taking time to complete this form.