INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
INNATEWELLNESS.CA

Personal Information

Today's Date	Name		Sex M F
Date of Birth	Age	Weight	Height
Address Email	Contact Information [h] [w] [c]		In case of emergency notify Contact number
Innate Wellness will email you confirmation of your upcoming appointments. If you wish to be contacted by phone, please list the best number to contact you.			
Occupation	Employer		
How did you learn about Innate Wellness?			

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General Health Questionnaire

Please take the time to fill out this questionnaire carefully to help us provide you with a complete evaluation. If you have further questions, concerns, or comments, please bring them to our attention.

Please list your additional Health Care Providers (i.e. Medical Doctor, Chiropractor, Medical Specialist, etc.)

Name Occupation Phone	Name Occupation Phone	Name Occupation Phone

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

Major concerns in order of importance:	Since	Cause
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list **all** prescribed and over-the-counter medications, vitamins, minerals, herbs, and homeopathic remedies, which you are **presently** using. Please include the dose, brand, and ingredients particularly for the natural

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Please list **all** prescribed and over-the-counter medications, vitamins, minerals, herbs, and homeopathic remedies, which you have used in the **past**. This includes antibiotics, vaccines, etc.

Medications – Past		Natural Supplements - Past	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you get regular screening tests by another doctor? Y / N Which tests?_____

_____

Medical History

Please check all illnesses or diagnosis you have had in the past along with the date.

Illness	**Date**	**Illness**	**Date**
☐ AIDS/Positive HIV	_____	☐ Infections	_____
☐ Allergies	_____	☐ Kidney/Bladder Disease	_____
☐ Anemia	_____	☐ Mental Illness	_____
☐ Arthritis	_____	☐ Migraine Headaches	_____
☐ Asthma	_____	☐ Mononucleosis	_____
☐ Colitis	_____	☐ Pap test, abnormal	_____
☐ Convulsions/Seizures	_____	☐ Polio	_____
☐ Depression	_____	☐ Prostate condition	_____
☐ Diabetes	_____	☐ Rheumatic Fever	_____
☐ Eating Disorder	_____	☐ STD	_____
☐ Endometriosis	_____	☐ Stomach/Duodenal Ulcer	_____
☐ Heart Disease	_____	☐ Thyroid Problems	_____
☐ Heart Murmur	_____	☐ Tuberculosis	_____
☐ Hepatitis	_____	☐ Urinary Tract Infections	_____
☐ High Blood Pressure	_____	☐ Vaginitis	_____

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Family Medical History

Health Concerns of:

Mother: _____

Father: _____

Please indicate any diseases which have occurred in your family, who had them and at what age. Specify which side of the family.

- ☐ Cancer_____
- ☐ Diabetes_____
- ☐ Heart Disease_____
- ☐ Mental Illness_____
- ☐ High Blood Pressure_____
- ☐ Stroke_____
- ☐ Thyroid Problems_____
- ☐ Autoimmune Disease_____
- ☐ Kidney Disease_____
- ☐ Arthritis _____
- ☐ Anemia_____
- ☐ Alcoholism_____
- ☐ Other _____
- ☐ Anything similar to your symptoms

_____

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Lifestyle

Do you participate in regular physical activities? What do you do and how often?

_____

Do you follow a particular diet or avoid any specific foods?

_____

Have you smoked in the past? If yes, for how many years? Are you now or have you been exposed to breathing in second hand smoke? If yes, for how long?

_____

Please indicate usage per day/week/month:

Cigarettes	_____ per day/wk/mth	Alcohol	_____ per day/wk/mth
Recreational Drugs	_____ per day/wk/mth	Chewing tobacco	_____ per day/wk/mth

Have you ever worked in a job or been in an environment that exposed you to excess chemicals, toxins, etc.? What did you do and for how long?

_____

What types of hobbies and activities do you do? _____

_____

How would you describe your home environment?

_____

_____

What are your regular sleeping hours? From _____ to _____
Do you wake refreshed? _____ What mood do you awaken in? _____

Are you regularly exposed to animals? If yes, please describe. _____

_____

How is your home heated? _____

Have you done any travelling recently? Where? _____

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Informed Consent

We would like you to understand the services we provide, the costs involved, and what we do with the personal information we obtain about you. If you have any questions about this, please ask. This informed consent begins today and is between the Naturopathic Doctor and the person named at the end of this document.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. The following outlines the therapies we may utilize.

- **Individual Diets and Nutritional Supplements** are recommended to address deficiencies, treat disease processes and to promote health.
- **Botanical Medicine** is a plant-based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations for the treatment of illness and disease.
- **Homeopathy** is a form of medicine based on the law of similars – that is the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal or mineral origin are used to stimulate the body's ability to heal itself.
- **Asian Medicine** includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, extracts or decoctions (strong teas) to be taken internally or used externally as a wash.
- **Physical Medicine** refers to the use of hands-on techniques such as soft tissue work and spinal manipulation.
- **Hydrotherapy** refers to the use of hot/cold water applications to improve circulation and stimulate the immune system.
- **Lifestyle Counseling** involves identifying risk factors and making recommendations to help optimize one's physical, mental and emotional environment.

During your initial visits, your N.D. will take a thorough case history, do a screening physical examination, and when indicated, take blood and urine samples.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. It is very important, therefore, that you inform your N.D. immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your N.D. immediately. Health risks associated with Naturopathic Medicine include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process;
- Allergic reactions to supplements, foods or herbs;
- Pain, bruising or injury from intramuscular injections or acupuncture;
- Fainting or puncturing of an organ with acupuncture needles;
- Muscle strains and sprains or disc injuries from spinal manipulation.

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Please check the box (☑) to indicate you have read and understand the following:

Disclaimer of Health Care Related Services

- ☐ I understand that the Naturopathic Doctor (N.D.) will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I will rely on her to exercise judgment during the course of the procedure which she feels at the time is in my best interests, based upon the facts then known.
- ☐ I understand that any treatment or advice provided to me by my N.D. is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from a physician, surgeon, or any other licensed health care provider.
- ☐ I understand that I am at liberty to seek or may continue to seek treatment or advice from a physician, surgeon or any other licensed health care provider and it has not been suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

Confidentiality

- ☐ I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
- ☐ I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy, by paying the appropriate fee.

Payments & Appointment Etiquette

- ☐ I understand the fee schedule as stated below and I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand Innate Wellness' lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and I am ready for my appointment.
- ☐ I understand that I may purchase any recommended medicines or supplements from the dispensary at Innate Wellness or a pharmacy or retail store of my choice.

Patient Name _____ Signature _____ Date _____
(please print)

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Fee Schedule

New Patient Initial Assessment

Naturopathic First Assessment (60-90min.)	200.00
Your N.D. may suggest further testing as part of the initial assessment	

Treatment Plan & Follow-up Appointments

Follow Up Visit (30-45min.)	125.00
Check In Visit (~15min.)	65.00

Supplements and Remedies

Supplements and remedies are available from the office dispensary or from a naturopathic pharmacy of your choice.

Missed Appointment Fee (less than 24 hours business days' notice) **Full price of the appointment**

Prices are subject to change.

We accept Cash, Visa, MasterCard, and Interac Debit.