Please complete the following information and give to the Receptionist upon your arrival at the office for your initial visit. This information will be used to set up your patient account in our database. The other forms are to be given to your Naturopathic Doctor and will be kept confidentially in your patient file. Thank you!

NAME : ____

____

(If patient is a child, please also provide name of parent(s).

ADDRESS : ____

____

EMAIL ADDRESS : ____

TELEPHONE # Home : ______________________

Cell : ______________________

Business : ____________________

DATE OF BIRTH : __________________________

THE GEORGETOWN
NATUROPATHIC WELLNESS CENTRE
(905) 873-2361

Child's Name: ______________________________________ Age: ________ Date of Birth: _____________________

Parent's Name: ____ Telephone #: ____________________

Address: ____ Postal Code: ______________________

E-Mail Address (optional –if you would like to receive newsletters, etc.): _______________________________________

How did you learn about this clinic? ____

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize me to do so.

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE	SINCE	CAUSE

WHAT TREATMENTS OR REGIMES IS YOUR CHILD FOLLOWING?	SINCE	RESULTS

WHICH OF THE FOLLOWING CONDITIONS HAS YOUR CHILD HAD?

Abcesses, allergies, amnesia, arthritis, asthma, cancer, chicken pox, cold sores, depression, diabetes, emphysema, epilepsy, gall stones, goitre, gonorrhea, gout, hay fever, heart disease, hepatitis, oral herpes, influenza, kidney disease, leukemia, malaria, german measles, red measles, mononucleosis, mumps, parasites, peritonitis, pleurisy, pneumonia, rheumatic fever, scarlet fever, sexual abuse, skin disease, strep throat, sinusitis, sunstroke, stroke, syphilis, tonsillitis, tuberculosis, typhoid fever, warts, whooping cough, worms

ANY OTHER MAJOR CONDITIONS? ____

____

ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH THE CHILD HAS NEVER BEEN TOTALLY WELL AGAIN, OR WHICH HAVE BEEN MORE SEVERE THAN USUAL? WHICH ONES?

____

____

WHAT OPERATIONS HAS YOUR CHILD HAD? WHEN? COMPLICATIONS, IF ANY?

_______________ _______ _______________

_______________ _______ _______________

WHAT MAJOR INJURIES HAS YOUR CHILD HAD? WHEN? LONG TERM EFFECTS?

_______________ _______ _______________

_______________ _______ _______________

ALLERGIES? ______________________________

Age at first menses? ________ Number of pregnancies ___________
What vaccinations has your child had? ______________________________
Any adverse affects from them? ______________________________
What exercise does your child do now and how much? ______________________________
How often does your child have a full and complete bowel movement? ______________________________
How often does your child get headaches? _________________ What triggers them? ______________________________

INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER AILMENTS, HAVE AFFECTED YOUR CHILD'S RELATIVES:

alcoholism	asthma	diabetes	gout	insanity	skin disease
allergies	cancer	epilepsy	hay fever	paralysis	syphilis
arthritis	depression	gonorrhea	heart disease	pneumonia	tuberculosis

RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS
Mother			
Father			
Sisters			
Brothers			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

IS YOUR CHILD CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN(S)?

PHYSICIAN	FOR WHAT CONDITIONS	TREATMENT

HAS YOUR CHILD BEEN TREATED WITH HOMEOPATHY BEFORE?

PHYSICIAN	FOR WHAT CONDITIONS	WHEN

Georgetown Naturopathic Wellness Centre

Informed Consent

Cathy Kuindersma, N.D.

This form provides information to help you understand the services we provide, the cost involved and what we do with the personal information we obtain about you. If you have any questions regarding this, please do not hesitate to ask.

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. The following outlines the therapies we may utilize:

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and 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 that uses minute doses of plant, animal, or mineral origins 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 disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally.

Physical medicine refers to the use of hands-on techniques such as soft tissue work and spinal manipulation.

Hydrotherapy refers to the use of alternating hot & cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental and emotional environment.

During your initial visit, your Naturopathic Doctor will take a thorough case history and perform a basic physical examination and, when indicated, may require blood and urine samples.

It is very important that you inform your Naturopathic Doctor of all disease processes 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 health care provider immediately.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. 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 or herbs.
- Pain, bruising or injury from venipuncture or acupuncture.
- Fainting or puncturing of an organ with acupuncture needles.
- Muscle strains and sprains or disc injuries from spinal manipulation.

______ Initials — 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. I have read and understand the privacy policy of the Georgetown Naturopathic Wellness Centre.

______ Initials — I understand that the Naturopathic Doctor 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 voluntarily consent to the diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

______ Initials — I understand that any treatment or advice provided to me by Cathy Kuindersma, N.D. is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from another licensed health care provider.

______ Initials — I understand that I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. Cathy Kuindersma, N.D. will not suggest or recommend that I refrain from seeking or following the advice of another licensed health care provider.

______ Initials — I understand that I may purchase any recommended medicines or supplements from the dispensary of the Georgetown Naturopathic Wellness Centre OR any pharmacy/retail store of my choice.

As the patient, you are responsible for the total charges incurred (visit fees plus any supplements or medicinal substances) for each visit. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): __________________________ Date: ______________________________

Signature of Patient (or Guardian): ____

Signature of Naturopathic Doctor: ____

Consent for Personal Information

I understand that to provide me with Naturopathic services, Cathy Kuindersma, N.D. will collect some personal information about me. For example; address, phone number and health history.

I have reviewed Cathy Kuindersma's, N.D. Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policy and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Cathy Kuindersma N.D. using and disclosing personal information about me as set out above and in the above Privacy Policy.

Signature: ______________________________ Date: __________________________

Printed Name: ____________________________