




Patient Name: \_\_\_\_\_

A 1095 1ST AVE. WEST, OWEN SOUND, ON N4K 4K7 W WWW.NATUREMED.CA  
T (519) 416-9355 F (519) 416-9356 E INFO@NATUREMED.CA

Dear Patient,

I would like to take this opportunity to welcome you to Nature Med Naturopathic Clinic. By investing in Naturopathic Medicine, you have taken a major step towards optimizing your health, for now and for the future. As your Doctor, I'm certain you will find your experience a positive and rewarding one, helping you set a new direction towards holistic health.

To prepare for your appointment there are few things you will need to do to get started. Please take the time to fill out the important patient intake form, either by downloading and printing it from the website, or, by filling in the secure online version. I know it is a long form, but the responses you provide will greatly assist me in understanding your health and health goals, so that we can formulate an individualized health care plan tailored to your needs. I am the only person who will review these forms and the information you share will be kept strictly confidential. Please remember to bring to your appointment:

-  Completed patient intake form
-  2 consent forms (see below)
-  Any available laboratory testing or medical results from the past 6 months

To have adequate time to explore your health and health history, your first appointment will generally last 60 – 90 minutes and may include a physical exam and relevant laboratory testing. Your treatment plan will be presented to you either on the 1<sup>st</sup> or 2<sup>nd</sup> visit, depending on the complexity of your health concerns. Follow-up appointments last for 30-60 minutes depending on individual health requirements.

Included in this package is a complete fee schedule of our services. Naturopathic care is not covered by OHIP. However, if you have extended medical insurance, please check with your plan to see if there is "Naturopathic Coverage", as many of the major insurance companies do offer this. The cost of supplements and laboratory testing is not included in the consultation fee. Our in-house dispensary carries only high quality professional product lines. However, any supplements prescribed at your visit may be purchased through a supplier of your choice. Please note that payment is due at the end of your visit. For your convenience, we accept cash, debit, cheque, Visa and MasterCard. If you are unable to make a scheduled appointment, please give 24 hours notice to avoid the late cancellation fee.

If you have any questions or concerns prior to your visit, please feel free to contact me by telephone at (519) 416-9355, or email at [drkara@naturemed.ca](mailto:drkara@naturemed.ca). Also, please refer to our website for more information, [www.naturemed.ca](http://www.naturemed.ca).

I look forward to working with you on your path to optimal health.

In Health,

**Kara Dionisio, B.Sc, M.Sc, ND**  
Doctor of Naturopathic Medicine  
Nature Med Naturopathic Clinic

## Fee Schedule

The following fees include your time spent with Dr. Dionisio and the time she requires to research your particular health needs. The fees do not include the cost of prescription items or laboratory testing, as these are determined on an individual basis. Initial consultations are 1 ¼ to 1 ½ hours, and a standard follow-up appointment is 30-45 minutes.

	<b>Approximate Time</b>	<b>Group</b>	<b>Fee</b>
<b>Initial Consultation</b>	75-90 minutes	Adults	\$150
		Students, Children, Seniors	\$135
<b>Follow-up Consultation (extended)</b>	60 minutes	Adults	\$100
		Students, Children, Seniors	\$85
<b>Follow-up Consultation (standard)</b>	30 – 45 minutes	Adults	\$75
		Students, Children, Seniors	\$65
<b>Acupuncture</b>	30 minutes	1 session	\$50
		Series of 5	\$200

\*Children= 16 and under

\*Students= full-time with valid student card

\*Seniors= 65+

### **Extended Health Insurance**

OHIP does not cover the fees of a Naturopathic Doctor, however, many extended healthcare providers do. Insured patients can check with their employer or insurance agent to see if they are covered. Naturopathic services are tax deductible.

### **Payment**

All office visits and lab test fees are payable in full at the time of your visit. GST applies to all services provided. Payments may be made by Visa, Mastercard, debit, cheque or cash.

### **Cancellation Policy**

There is no charge for cancellations with 24 hours notice. Appointments cancelled with less than 24 hours notice will incur a \$50 charge. A full office visit fee will be charged with failure to provide any notice of cancellation.

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## INFORMED CONSENT FOR NATUROPATHIC TREATMENT

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, and promote health by assisting the body's own healing mechanisms. Naturopathic doctors are highly educated primary health care providers who integrate standard medical diagnostics with a broad range of natural therapies, including botanicals (herbs), acupuncture, clinical nutrition, and lifestyle counseling. When required, we will work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

### Statement of Acknowledgement

I, \_\_\_\_\_ [print name], as a patient of Nature Med Naturopathic Clinic, understand that the form of medical care is based on naturopathic principles and practices. I will inform my naturopathic doctor of all my health concerns, allergies, medications, supplements, and medical interventions, because safe care requires that I truthfully and completely disclose this information.

I will inform my naturopathic doctor if I become pregnant and/or if I am breastfeeding. As a patient of the clinic I understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side-effects. I am entitled to know the consequences of *not* accepting treatment and of alternative courses of action. I am always at liberty to seek or continue care from another qualified healthcare provider. I understand that although naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to:

- ✔ Some patients experience allergic reactions to certain supplements and herbs
- ✔ Pain, bruising or injury from venipuncture (taking blood for tests) or acupuncture
- ✔ Fainting or puncturing of an organ with acupuncture needles

### I understand:

- ✔ The clinic does not guarantee treatment results
- ✔ That my naturopathic doctor will explain to me the exact nature of any treatment provided
- ✔ I am free to withdraw my consent and to discontinue treatment at any time
- ✔ I understand that Nature Med Naturopathic Clinic cancellation policy requires me to cancel a booked appointment 24 hours prior to that appointment. If I fail to do so, a cancellation fee of \$25 will be charged.

As the patient, you are responsible for the total charges incurred for each visit. If you have coverage for naturopathic medicine, you are responsible for billing your own insurance company- we will provide you with all of the information necessary to send your claim for reimbursement. Your Naturopathic Doctor may prescribe supplements that can be purchased from our in-house dispensary, or elsewhere. Most insurance companies do not cover the cost of supplements.

### PATIENT CONSENT

**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.**

\_\_\_\_\_  
*Signature of Patient (and/or Legal Guardian)*

\_\_\_\_\_  
*Patient Name (and name legal guardian if applicable)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Witness*

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## PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of this clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We 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 will handle your personal information.

### At Nature Med Naturopathic Clinic, our privacy policy ensures 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 protection protocols
- our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy- Naturopathy

### How our Clinic Collects, Uses and Discloses Patients Personal Information

Nature Med Naturopathic Clinic will collect, use and disclose information about you for the following purposes:

- to assess your health concerns and provide you with quality health care
- to advise you of treatment options
- to establish and maintain contact with you,
- to send you newsletters and other information mailings
- to remind you of upcoming appointments
- with your permission, to communicate with other treating health-care providers
- to allow us to efficiently follow-up for treatment, care and billing
- to comply with legal and regulatory requirements, and to comply generally with the law

### PATIENT CONSENT

**I have reviewed the above information that explains how Nature Med Naturopathic Clinic will use my personal information, and the steps Nature Med Naturopathic Clinic is taking to protect my information.**

I agree that **Nature Med Naturopathic Clinic** can collect, use and disclose personal information about \_\_\_\_\_ [print your name] as set out above in the information about the Clinic's privacy policies.

\_\_\_\_\_  
*Signature of Patient (and/or Legal Guardian)*

\_\_\_\_\_  
*Patient Name (and name legal guardian if applicable)*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Witness*

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## CONFIDENTIAL PATIENT INTAKE FORM

(Please Print)

*Your time, thoughtfulness and honesty in completing this overview will greatly aid us to assist your health needs.  
The following information is confidential, and will not be shared with anyone without your consent (see privacy agreement form).*

<b>Today's date (dd/mm/yyyy):</b> _____					
PATIENT INFORMATION					
Last Name:		First Name:		Initial:	
				<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.	
Birth date (dd/mm/yyyy) / /		Age:	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Address:		Apt #:	City:	Province:	Postal Code:
Home ☎ ( ) _____ - _____		Mobile ☎ ( ) _____ - _____		Work ☎ ( ) _____ - _____ Ext: Can we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
E-mail Address:				Occupation: _____	
Can we periodically send you clinic updates, newsletters, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Full Time <input type="checkbox"/> Part-time	
Other health care practitioners you are seeing: <i>(please note, we will not contact them without your consent)</i>					
Name: _____		Type: _____		Phone: _____	
Name: _____		Type: _____		Phone: _____	
Name: _____		Type: _____		Phone: _____	
Name: _____		Type: _____		Phone: _____	
Have you ever had previous Naturopathic Care? <input type="checkbox"/> Yes <input type="checkbox"/> No					
How did you hear about Nature Med?					
<b>Emergency Contact Information</b>		Name: _____		Relationship to you: _____	
Home ☎ ( ) _____ - _____		Mobile ☎ ( ) _____ - _____		Work ☎ ( ) _____ - _____ Ext:	

CURRENT STATE OF HEALTH					
<b>Please list your health concerns in order of importance. These will be discussed in detail on your initial visit.</b>					
1.					Onset:
2.					Onset:
3.					Onset:
4.					Onset:
5.					Onset:
Please briefly describe your health goals:					
Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No					
How would you describe your overall state of health? <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor					
Please rate your satisfaction with the following areas of your life (0 = no satisfaction, 4= great satisfaction)					
Health	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Diet	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
Family	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Work	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		
Social	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4	Significant other / Romance	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		

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**GENERAL MEDICAL HISTORY**

Height:	Weight:	Weight 1 year ago:	Maximum weight: When?
<b>Please indicate any serious conditions, traumas (including emotional), surgeries or hospitalizations:</b>			
1.			Year:
2.			Year:
3.			Year:
4.			Year:
5.			Year:
Please list any allergies, sensitivities, or adverse reactions you may have (e.g. to medications, chemicals, immunizations, environmental).			
Do you receive regular screening tests done by another doctor (Blood test, physical exams, pap tests, breast exams etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No Which ones? :			
<b>Do you use the following medications?</b> <input type="checkbox"/> Laxatives <input type="checkbox"/> Pain relievers <input type="checkbox"/> Antacids <input type="checkbox"/> Sleeping pills <input type="checkbox"/> Diet pills			
<b>Please list any prescription or over-the-counter medications you are <u>currently</u> taking:</b>			
1.	Reason: <i>(if known)</i>	Date Started:	Dose: Times per day:
2.	Reason: <i>(if known)</i>	Date Started:	Dose: Times per day:
3.	Reason: <i>(if known)</i>	Date Started:	Dose: Times per day:
4.	Reason: <i>(if known)</i>	Date Started:	Dose: Times per day:
5.	Reason: <i>(if known)</i>	Date Started:	Dose: Times per day:
<b>Please list any prescription or over-the-counter medications you have <u>taken</u> in the past:</b>			
1.	Reason: <i>(if known)</i>	Date Started:	Date Finished:
2.	Reason: <i>(if known)</i>	Date Started:	Date Finished:
3.	Reason: <i>(if known)</i>	Date Started:	Date Finished:
4.	Reason: <i>(if known)</i>	Date Started:	Date Finished:
5.	Reason: <i>(if known)</i>	Date Started:	Date Finished:
<b>Please list any nutritional supplements / natural health products/ herbal medicines you are you <u>currently</u> taking?</b>			
1.	Brand:		Dose:
2.	Brand:		Dose:
3.	Brand:		Dose:
4.	Brand:		Dose:
5.	Brand:		Dose:
6.	Brand:		Dose:

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### FAMILY MEDICAL HISTORY

*Please indicate whether the following health conditions pertain to your parents, grandparents, or siblings.*

Condition	Relative(s)	Age of Onset	Details
Heart problems (e.g. heart attack, atherosclerosis)			
High blood pressure			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			
Digestive problems (e.g. Chron's disease)			
Allergies			
Skin problems			
Diabetes			
Mental illness (e.g. depression, schizophrenia)			
Kidney disease			
Drug abuse (e.g. alcoholism)			
Cancer			
Other			
<input type="checkbox"/> I don't know my family medical history			

### LIFESYLTLE HABITS

**Please describe a typical day's diet:**

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

How much water do you drink per day? \_\_\_\_\_ How much coffee do you drink per day? \_\_\_\_\_

Other:

**Do you consume the following?**  Alcohol  Tobacco  Recreational drugs  Caffeine

**Are you regularly exposed to tobacco smoke (e.g. at work or home):**  Yes  No

**Are you regularly exposed to toxins or other hazards (e.g. at home, or as part of your job)?**  Yes  No

If yes, what?:

**Please list and food allergies or intolerances:**

**Do you have any dietary restrictions? (e.g. vegetarian, vegan, religious):**

**Please list your main interests and hobbies:**

**Do you exercise regularly?**  Yes  No **How many times per week?**

**Do you have any difficulty sleeping?**  Yes  No **Hours per night:** \_\_\_\_\_ **Do you wake rested?**  Yes  No

**Do you have children in your home?**  Yes  No **How many?** \_\_\_\_\_ **Ages:** \_\_\_\_\_

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### EMOTIONAL HEALTH

**Please rate the following from 0-4 (0 = low to nonexistent, 4 = high)**

Level of stress	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> n/a
Energy level	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> n/a

How would you describe the emotional climate of your home?

What is the biggest source of stress in your life?

How do you deal with stress?

Have you ever felt sad or depressed for two weeks or more at a time in the past year?  Yes  No

Comment:

**Is there anything else you feel is important that has not been covered on this form?**

Patient Name: \_\_\_\_\_

**REVIEW OF SYSTEMS**

For the following list of symptoms, please check (✓) "C" if you are Currently having the symptom, or "P" if you have had it in the Past. If you have never had the symptom, please leave it blank. You and your ND will review the information at the first visit.

Symptom	C	P	Symptom	C	P	Symptom	C	P
<b>SKIN</b>								
Rashes / Hives			Boils			Dry skin		
Acne			Lumps			Itching		
Eczema			Change in skin colour			Night sweats		
Psoriasis			Changes in moles			Other:		
<b>HEAD</b>								
Headaches			Head injury			TMJ / Jaw problems		
Migraine headaches			Dizziness			Other:		
<b>EYES</b>								
Impaired vision / blurring			Excessive tearing			Glaucoma		
Use of contact lenses / glasses			Floater / Blind spots			Cataracts		
Eye pain			Double vision			Last visit to eye doctor:		
Itching / Dryness / Redness			Light sensitivity			Other:		
<b>EARS</b>								
Impaired hearing / Hearing aids			Ringings			Excessive wax		
Earache / Ear pain			Discharge			Ruptured ear drum		
Dizziness			Infections			Other:		
<b>NOSE &amp; SINUSES</b>								
Frequent colds			Sinus problems			↑ or ↓ ability to smell		
Stuffiness			Nosebleeds			Trauma / Broken nose		
Hay fever			Infections			Other		
<b>MOUTH, THROAT &amp; NECK</b>								
Hoarse voice			Dry tongue or mouth			Pain / Stiffness in neck		
Dental problems / gum disease			Mouth sores / ulcers / HSV			Thyroid problems		
Difficulty swallowing			Frequent sore throats			Last visit to dentist:		
Loss of taste			Lumps / swollen gland in neck			Other:		
<b>RESPIRATORY</b>								
Cough			Bronchitis			Shortness of breath		
Sputum			Pneumonia			Difficulty breathing		
Spitting up blood			Pleurisy			Positive tuberculin (TB) test		
Wheezing			Emphysema			Last chest x-ray:		
Asthma			Pain on breathing			Other:		
<b>CARDIOVASCULAR</b>								
Heart disease			Swelling in ankles			Cyanosis (blue lips / nails)		
Chest pain / angina			Palpitations / fluttering			Last ECG:		
Murmur			High cholesterol			Other:		
<b>BLOOD / LYMPHATIC / PERIPHERAL VASCULAR</b>								
Anemia			Deep leg pain / Leg cramps			Extremity numbness		
Easy bleeding / bruising			Cold hands / feet			Extremity swelling (e.g. ankles)		
Blood transfusions			Varicose veins			Extremity ulcers		
Lymph node swelling			Painful veins (thrombophlebitis)			Other:		
<b>GASTROINTESTINAL</b>								
Nausea / vomiting			Food allergy			Hemorrhoids		
Heartburn / indigestion			Diarrhea			Liver disease		
Change in appetite / thirst			Constipation			Gallbladder disease		
Belching / passing gas			Blood in stools / rectal bleeding			Frequency of bowel movements per day: 1 2 3 4+		
Abdominal pain / bloating			Undigested food in stool					
Bad breath / bad taste in mouth			Hernia			Other:		

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A: 109  
T: 519

**MUSCULOSKELETAL**

Broken bones		Joint swelling		Osteoporosis	
Muscle spasms / cramps / weak		Back ache		Arthritis	
Weakness		Sciatica		Other:	

**NEUROLOGICAL**

Fainting		Muscle weakness		Involuntary movements	
Seizure / convulsions		Numbness or tingling		Loss of balance	
Paralysis		Loss of memory		Speech problems	

**ENDOCRINE**

Heat / cold intolerance		Excessive sweating		Hormone replacement therapy	
Thyroid problems		Diabetes		Excessive urination	
Excessive thirst		Low blood sugar		Fatigue	
Excessive hunger		Steroid therapy / use		Other:	

**URINARY**

Pain on urination		Inability to hold urine		Blood in urine	
Increased frequency of urination		Frequent urinary tract infections		Reduced urine flow / hesitancy	
Frequency at night		Kidney stones		Other:	

**MENTAL / EMOTIONAL**

Depression		Nervousness		Sexual difficulties	
Extreme anger		Tension		Drug abuse	
Mood swings		Anxiety		Insomnia	
Panic attacks		Thoughts of suicide		Other:	

**MALE & FEMALE SEXUAL HEALTH**

Are you sexually active? <b>Y N</b>	Type of contraception:		Chlamydia	
Are you happy with your sex life? <b>Y N</b>	Gonorrhea		Condyloma (Genital warts) / HPV	
Sexual orientation:	Syphilis		AIDS / HIV	
	Genital herpes (HSV)		Other:	

**MALE REPRODUCTIVE**

Hernia		Erectile dysfunction		Last prostate exam:	
Testicular mass		Prostate problems		Last PSA level:	
Testicular pain		Penile discharge		Other:	

**FEMALE REPRODUCTIVE**

Age of 1 <sup>st</sup> Menses / Period:	Menopause		Vaginal discharge	
Last menstrual period:	Date of final menstrual period:		Vaginal itching	
Number of days period lasts:	Hormone therapy		Pain during intercourse	
Length of cycle:	Hot flashes		Candida infections	
Bleeding between periods	Mood swings		Endometriosis	
Irregular cycles	Number of pregnancies		Ovarian cysts	
PMS	Number of live births		Fibroids	
Heavy flow	Number of miscarriages		Date of last PAP test & Gynecological exam	
Light flow	Number of abortions			
Painful menses	Difficulty conceiving		Other:	

**BREAST**

Nipple discharge / changes		Fibrocystic breasts		Date of last breast exam:	
Breast implants / surgery		Breast lumps		Date of last mammogram:	
Family history of breast cancer		Breast pain		Other:	