338 Norfolk Street South | Simcoe, ON N3Y 2W7
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DECLARATION AND CONSENT TO TREATMENT

Patients Name _____ Date _____

Address _____

City _____ Province _____ Postal Code _____

This is to acknowledge that I have been informed and I understand that:

- Any treatment or advice provided to me as a patient of the Clinic is not mutually exclusive from any treatment or advice that I may be receiving or may not be receiving or may in the future receive from another health care provider.
- I am at liberty to seek or continue medical care from a medical doctor or health care providers licensed to practice in Ontario.
- No employee, agent, board member, instructor or anyone else under the Clinic's direction or control has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.
- The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.
- I declare that I have received a full and complete explanation of the treatment and/or services that I will receive at the Clinic and hereby authorize and consent to treatment by the Clinic.

I acknowledge the following fee structure:

Visit Fee	$ 90.00 approximately half hour (minimum charge)
Review of Test Results	$170.00
Allergy Test	$190.00
Organ Testing	$170.00
Bio Identical Hormone	$270.00 approximately 1 hour (minimum charge)

Supplements, remedies, laboratory test and other services are charged separately and are not included in the visit fee. There will be no refunds or exchanges on visit fees, supplements, remedies, laboratory test and other services.

A 48-hour notice of cancellation must be given or the full visit fee will be charged. This will be strictly enforced!

I agree to pay my full account at the time of each visit or treatment.

Privacy of your personal information is an important part of our 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 handle your personal information.

In this Clinic, Dr. Lorenzo Diana acts as the Privacy Information Officer.

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 trained in the appropriate use and protection 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 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

Our Clinic understands the importance of protection your personal information. To help you understand how we are doing that, we have outlined here how our Clinic is using and disclosing your information:

- To access your health concerns
- To provide 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
- 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 comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy & Naturopathy acting under the authority of the Drugless Practitioners Act
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- 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 an audit in preparation for a practice sale

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 as outlined above.

Patient Consent

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

I agree that the Simcoe Natural Health Clinic And Education Centre can collect, use and disclose personal information about _____ as set out above in the information about the Clinic's privacy policy.

Dated this_____ Day of _____ 20 _____

Patient's Signature _____

Naturopathic Doctor's Signature_____

Patient Profile

First Name _____

Last Name _____

Birth Date _____ Age _____ Gender _____

Address _____

City _____ Province _____ Postal Code _____

Home Phone (_____)_____-_____ Work Phone (_____)_____-_____

Cell Phone (_____)_____-_____

Email Address:_____

Occupation _____

Employer (Name and Address) _____

Education_____

Are you : Married ___ Separated __ Divorced ___ Widowed ___ Common Law ___ Single ___ Other _____

Live with : Spouse ___ Parents ___ Relatives ___ Friends ___ Alone ___ Other____

Next of Kin _____

Relationship _____

Address_____

Home Phone (_____)_____-_____ Work Phone (_____)_____-_____

Cell Phone (_____)_____-_____

Email address _____

How did you hear about our clinic _____

What health concerns do you want to talk about today? List in order of importance

1) _____ 2) _____

3) _____ 4) _____

Past Medical History

What childhood illnesses have you had?

Rubella ___ Mumps ___ Measles ___ Chickenpox ___ Polio ___ Whooping Cough ___

Scarlet Fever ___ Asthma ___ Other _____

What immunizations have you had?

1) _____ 2) _____

3) _____ 4) _____

Did you have any adverse reactions? _____

When and where did you last receive medical or health care/operations?

_____

_____

For what reason?_____

Health History

Anemia	_____	Arthritis	_____
Asthma	_____	Bleeding Disorder	_____
Cancer	_____	Colitis	_____
Diabetes	_____	Emphysema	_____
Gastric/Duodenal Ulcer	_____	Gout	_____
Heart Murmur	_____	High Blood Pressure	_____
Injury	_____	Kidney Disease	_____
Migraine Headaches	_____	Pneumonia	_____
Thyroid Disorder	_____	Tuberculosis	_____
Venereal Disease	_____		

What medication do you presently take? Include any non-prescription items including vitamins, botanicals (herbs), or homeopathic.

_____

_____

_____

Are you allergic to any medications or other substances?

_____

_____

Family History

Please list ages, and if deceased what they died from and at what age:

Maternal Side	**Paternal Side**
Grandfather _____	Grandfather_____
Grandmother _____	Grandmother_____
Mother _____	Father_____

Sisters_____

Brothers _____

Has any blood relative had any of the following?

Anemia	_____	Glaucoma	_____
Arthritis	_____	Gout	_____
Arteriosclerosis	_____	Hay Fever	_____
Asthma	_____	Heart Attack	_____
Bleeding Disorder	_____	High Blood Pressure	_____
Cancer	_____	Sickle Cell Anemia	_____
Diabetes	_____	Stroke	_____
Eczema	_____	Thyroid Disorder	_____
Epilepsy/Seizure	_____	Tuberculosis	_____

Social History

Have you traveled outside of Canada in the Past?

When?_____

Where?_____

Health Habits

How often do you drink? Wine _____ Beer _____ Other Alcohol _____

Do you use tobacco? Yes _____ No _____ If yes, how much per day?_____

Total number of years you have smoked_____

Do you use drugs? Yes _____ No_____

If yes, which drugs and how often _____

How often do you exercise? _____

What forms of exercise do you do? _____

What is your present weight? _____

What was your weight 1 year ago? _____

Our services are covered by most Extended Health Care Plans

Please provide the receptionist with your insurance information booklet to determine how to best utilize your benefits
For Office Use Only

Skin
Rough, dry, scaly, bumpy, itchy (circle)
Rashes, warts, moles, cysts (circle)
Color change of skin, nails
Acne
Hives
Ridges, pits, or spots on the nails
Hair changes

Head
Headaches
Dizziness / vertigo
Fainting spells

Eyes
Poor eyesight (near or far sighted)
Light hurts eyes
Double vision
Glaucoma

Ears / Nose / Throat
Impaired hearing
Ringing
Pain
Discharge from ears
Nose bleeds
Loss of smell
Stuffiness
Sinus problems
Persistent horseness
Difficulty swallowing

Mouth / Neck
Sore mouth or tongue
Gum problems
Loss of taste
Neck stiffness
Swollen or painful glands

Respiratory
Chest pain when breathing
Unusual redness of palms
Black stools
Yellow stools, clay colored, mucous (circle)
Anal itch
Diarrhea
Heartburn
Belching
Stomach pain
Bad breath / halitosis
Excessive gas
History of constipation which alternates with diarrhea

Stomach pain that occurs 2 or 3 hours after eating, usually at night and is relieved by eating or drinking milk
Nervousness, shaky feeling, headaches, relieved by food
Strong craving for sweets or alcohol
Wheezing
Difficulty breathing
Shortness of breath
Daily cough
Asthma

Cardiovascular
Chest pain when walking
Ankle swelling
Heart palpitations (fluttering, beating fast)
Varicose veins
Leg pain when walking
Murmurs
Rheumatic fever

Gastrointestinal
Frequent or severe nausea
Vomiting
Vomiting blood
Constipation

Female Reproductive
Discharge from the vagina
Pelvic pain
Date of last menstrual period _____
Birth control: what type _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of abortions _____
Any complications of pregnancy
Infertility
Venereal disease
Lumps in breast
Discharge from nipple
Do you do self-breast exam

Musculoskeletal
Joint pain, swelling, stiffness
Muscle cramps
Arthritis

Genitourinary
Pain on urination
Frequent urination
Increased frequency at night
Difficulty starting to urinate
Blood in urine

Male Reproductive
Have you ever had prostate problems
Discharge from the penis
Venereal disease
Difficulty achieving or maintaining an erection
Painful erection
Difficulty with ejaculation

Wake up at night feeling hungry
Increase of appetite
Loss of appetite
Seizures / epilepsy
Tremor (shaking, trembling)
Paralysis
Lack of strength
Numbness / tingling
Loss of memory
Speech difficulties

Blood / Lymphatic
Swollen or painful lymph nodes
Wounds heal slowly
Bleed easily
Bruise easily
Blood transfusions

Endocrine
Increased thirst
Unexplained weight loss / gain (circle)
Heat / cold intolerance (circle)

Lumps, swelling or pain in the testicles
Infertility

Neurologic
Loss of balance
Increased hunger

Emotional / Mental
Depression
Mood swings
Anxiety / nervousness
Frequent nightmares
Insomnia
Feelings of worthlessness
Difficulty concentrating
Crying spells
Easily angered
Difficulty remembering
Suicidal feeling