Naturopathic Intake Forms
Dr. Denise Patterson, ND
Address: 265 Kent St W
Lindsay, ON K9V 2Z4
Phone: 705-878-0463

KAWARTHA THERAPEUTIC CENTRE

Patient & Contact Information

Name:_____
(First) (Middle) (Last)

Age:_____ Date of Birth:____/____/_____ Gender: ☐ Male ☐ Female ☐ Other _____
M D Y

Occupation:_____

Home Address:_____

City:_____ Province:_____ Postal Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____

Are you comfortable with the clinic calling and leaving voicemails on the above numbers? If so, please indicate which ones.
☐ Home ☐ Cell ☐ Work ☐All of the Above

Would you like to be added to our mailing list for news, events, and special offers? ☐ Yes ☐No

Emergency Contact:_____

Phone Number:_____ Relationship:_____

How did you hear about Dr. Denise, ND?
☐ Referral from another patient. If so, who _____
☐ Word of mouth
☐ Website
☐ Social Media
☐ Information Session
☐ Health Care Provider. If so, who_____
☐ Other:

Have you had previous naturopathic care? ☐ Yes ☐No

If so, when? _____

With whom? _____

Members of Your Health Care Team

Members of your healthcare team can include a medical doctor, specialists, chiropractor, physiotherapist, osteopath, massage therapist, etc

Medical Doctor:_____ Location:_____ Date of Last Visit:_____

Other Practitioner/Specialist:_____ Location:_____ Date of Last Visit:_____

Other Practitioner/Specialist:_____ Location:_____ Date of Last Visit:_____

Other Practitioner/Specialist:_____ Location:_____ Date of Last Visit:_____

Health Concerns & Goals

What are your health concerns/goals, in order of importance to you:

01. _____ 04. _____

02. _____ 05. _____

03. _____ 06. _____

What long term health goals do you have?

01. _____ 03. _____

02. _____ 04. _____

Current Medications & Supplements

Name of Medication	Reason for Taking	Dose & Frequency	Prescribed By	Side Effects, if any
01.				
02.				
03.				
04.				
05.				
06.				

Allergies & Sensitivities

Please list any allergies or sensitivities you have, including food, environmental, chemical or any medications.

01. _____ 04. _____

02. _____ 05. _____

03. _____ 06. _____

Have you ever had any allergy testing? □ Yes □ No If so, when_____

Are you currently following a specific diet? □ Yes □ No If so, please specify _____

GYNE

Do you experience any of the following:

□ Painful menstruation □ Excessive flow □ Hot flashes

□ Irregular/absent cycle □ Cramping/backache □ Vaginal discharge

□ Swollen breast □ Lumps in breasts

Are you currently on hormonal birth control?	Number of Pregnancies:
□ Yes □ No	Number of Children:

General Health Information

Height: Date of last physical exam:	How many hours of sleep do you get per night? Do you wake feeling rested? ☐ Yes ☐ No ☐ Sometimes	Do you exercise regularly? ☐ Yes ☐ No If so, what type?	Are you currently pregnant? ☐ Yes ☐ No Are you currently lactating? ☐ Yes ☐ No
How would you describe your general state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor	Please rate the following on a scale of 1-10 (10 being the best): Energy: Sleep: Mood:	Please rate your stress on a scale of 1-10 (10 being the unbearable): _____ What are your main stressors? ☐ Financial ☐ Job related ☐ Marriage ☐ Family ☐ Health ☐ Spiritual ☐ Other, please specify_____	

Do you currently or have you in the past used any of the following? If so, how much and how often?

☐ Coffee ☐ Alcohol ☐ Cigarettes ☐ Recreational Drugs
☐ Aspirin ☐ Tylenol ☐ Advil ☐ Laxatives
☐ Antacids ☐ Birth Control Pill ☐ Other:_____

Please check any medical concerns:

☐ Allergies ☐ Depression ☐ Cancer ☐ Mental Health Conditions
☐ Autoimmune ☐ Diabetes ☐ High blood pressure ☐ Heart/cardiovascular disease
☐ Asthma ☐ Thyroid problems ☐ Stroke ☐ Infertility
☐ Other:_____

Are your currently a smoker? ☐ Yes ☐ No If so, how much?	Did you smoke previously? ☐ Yes ☐ No If so, how much?	Have you ever been diagnosed with: ☐ Cancer ☐ HIV/AIDS ☐ Hep A/B/C

Past Medical History

Please list any past medical concerns, surgeries, hospitalizations, accidents, falls, broken bones, and any emotional traumas (deaths, loss of occupation, divorces, major life effects, etc.)

Year Nature & Details of Health Concern

01. _____
02. _____
03. _____
04. _____
05. _____

Is there any additional information you would like to provide?

Review of Systems

Y – Yes, currently P = Past

SKIN	Y	P
Eczema		
Psoriasis		
Itching/Dryness		
Hives		
Acne		
Night Sweats or excessive sweating		
Nail Changes		
Change in mole		
Poor wound healing		
Easy or unexplained bruising		
Other		

RESPIRATORY	Y	P
Cough		
Wheezing or Asthma		
Bronchitis		
Pneumonia		
Pain on breathing		
Shortness of breath		
Shortness of breath at night		
Shortness of breath when lying		
Other		

NECK	Y	P
Swollen glands		
Pain or stiffness		
Other		

PERIPHERAL VASCULAR	Y	P
Deep leg pain		
Cold hands/feet		
Varicose veins		
Leg cramps		
Extremity numbness		
Extremity coldness		
Extremity swelling		
Extremity ulcers		
Other		

URINARY	Y	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Urgency or hesitancy		
Other		

BLOOD/LYMPHATIC	Y	P
Anemia		
Easy bleeding		
Other		

MUSCULOSKELETAL	Y		P
Joint pain or stiffness			
Swollen Joints			
Pain or weakness of muscles			
Muscle spasms or cramps			
Other			

CARDIOVASCULAR	Y		P
Heart disease			
High blood pressure			
Chest pain			
Swelling in hands, ankles, feet			
Irregular heart beat			
Poor Circulation			
Dizziness or shortness of breath			
Other			

GASTROINTENSTINAL	Y		P
Difficulty swallowing			
Heartburn/Acid Reflex			
Change in thirst			
Change in appetite			
Nausea or Vomiting			
Loose Stools or Diarrhea			
Blood or mucous in stools			
Constipation			
Gas or bloating			
Abdominal pain or cramping			
Irregular bowel movements			
Ulcer			
Hemorrhoids			
Rectal bleeding			
Pain or itching of anus			

NEUROLOGIC	Y		P
Fainting			
Seizures/convulsions			
Paralysis			
Numbness or tingling			
Loss of memory			
Involuntary movement			
Loss of balance			
Speech problems			
Other			

MALE REPRODUCTIVE	Y		P
Hernia			
Testicular masses			
Testicular pain			
Erectile difficulties			
Prostate difficulties			
Abnormal discharge from penis			
Other			

EYES	Y	P
Visual Changes		
Blurred vision		
Eye pain		
Sensitive to light		
Infections		
Other		

EARS	Y	P
Loss of hearing		
Earache		
Ringing in ears		
Infections		
Other		

NOSE & SINUSES	Y	P
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

MOUTH & THROAT	Y	P
Frequent sore throat		
Loss of taste		
Sores		
Other		

HEAD	Y	P
Headaches		
Migraines		
Head injury or concussion		
Dizziness		
Other		

BREASTS	Y	P
Lumps		
Pain or tenderness		
Nipple discharge		
Other		

FEMALE REPRODUCTIVE	Y	P
Bleeding between periods		
Clots in menstrual blood		
Irregular periods		
Pain during intercourse		
Painful menses		
Excessive flow		
PMS		
Vaginal discharge		
Vaginal itching		
Menopausal symptoms		
Other		

FEE SCHEDULE

NATUROPATHIC SERVICES
(Visits Exempt from HST)

Initial Naturopathic Visit (60 min) - $175

15 min Follow – Up - $45
30 min Follow – Up - $80
45 min Follow – Up - $120
60 min Follow – Up - $150

Naturopathic services are NOT covered under OHIP, but may be partially or fully covered by extended health care benefits.

Unfortunately, I do not direct bill at this time and the cost of services must be paid in full at the time of each visit,

LABROTARY & SPECIALIZED TESTING

Please note that any additional testing such as bloodwork or specialized tests are NOT covered under OHIP and will be an additional cost. The cost varies according to the test ordered and will be discussed with the patient prior to the completion of such testing.

Additional laboratory testing must be paid at the time of the office visit. Laboratory costs are inclusive of administration and analysis fees.

PRESCRIPTION SUPPLEMENTS/PRODUCTS
(Subject to HST)

Prescription supplements/products may be purchased at the location suggested, online, or at the location of your choice.

ACUPUNCTURE

Naturopathic Doctors are licensed to perform acupuncture and undergo four vigorous years of training in Traditional Chinese Medicine and Acupuncture.
Acupuncture involves the gentle insertion of fine needles at designated acupuncture points along specific acupuncture meridians. Acupuncture can be used to treat numerous health concerns, including but not limited to, headaches, digestive concerns, pain management, stress relief, sleep concerns, women's health, and fertility.

EMAIL

Email correspondence may be used to clarify aspects of your current treatment plan. Please note that advice given via email will only be for clarification or informational purposes. Dr. Denise Patterson, ND cannot legally provide assessment, treatment or prescriptions over email. New or additional concerns require a phone or in-office consult. New or additional treatment advice will not be provided over email. Should your email require extended time to respond to, an email consultation fee will apply according to the fee schedule above.

MEDICAL LETTERS

Medical Letters & Reports are billed according to the time taken to prepare the report for you according to the follow up visit fee schedule.

CANCELLATION POLICY

Dr. Denise Patterson, ND respectfully requires patients to provide 24 hours notice for appointment cancellations. A late cancellation or missed appointment, without proper notice, may result in a charge to be paid prior to your next appointment. I am personally responsible for paying such cancellation charges.

PHONE & VIRTUAL VISITS

Virtual visits are available for existing patients and are subject to the same fee schedule listed above. Initial assessments cannot be done through a virtual visit and must be done in office in order to determine if the patient case is eligible for phone/virtual follow up visits.

Dr. Denise Patterson, ND, will use her professional judgment to consider the circumstances of each patient and each visit and decide if the use of telemedicine is in the patient's best interest. The patient's condition, their individual needs and the appropriate assessment and treatment will be considered, not just the convenience and time-effectiveness of conducting such consultations.

My Naturopathic Doctor has explained to me how the video conferencing technology will be used for my virtual consultation. I understand that this consultation will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my naturopathic doctor.

I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my healthcare provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.

I have had the alternatives to a virtual visit explained to me and in choosing to participate in a virtual visit, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

The risk involved with virtual visits include the potential release of private information due to the complexities and abnormalities involved with internet viruses, Trojans and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, there is the risk of being overheard by anyone near you if do not place yourself in a private area and open to

other's intrusions. The advantages of virtual visits include the benefit of continuity of care and the ability to be treated from any location at any time.

A copy of your credit card will be kept on file for payment of all virtual visits.

PRIVACY & SHARING OF INFORMATION	AUTHORIZATION TO RELEASE MEDICAL INFORMATION
I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.	I give Dr. Denise Patterson, ND my consent to release/obtain information from my family doctor, employer, or insurance company or any other party as it pertains to my care.

I have read and understand the above Fee Schedule. By signing, I agree to pay all visit fees and association costs at the time of my appointment.

Note: If patient is under the age of 18, signature of legal guardian or parent is required.

Signature of Patient: _____ Date: _____

Parent/Guardian Signature (if applicable) _____ Date: _____

Signature of Naturopathic Doctor: _____