



Adult Intake Form

Insight Naturopathic Clinic

586 Eglinton Ave. East Suite #606
 Toronto, ON M4P 1P2
 tel: (416) 322-9980

www.insightnaturopathic.com

Patient Information

Full Name: _____ D.O.B. _____
 Address: _____ Home #: _____
 _____ Cell #: _____
 _____ Work #: _____
 City, Prov, PC: _____ e-mail: _____

Emergency Contact Information

Full Name: _____ Home #: _____
 Address: _____ Cell #: _____
 _____ Work #: _____
 City, Prov, PC: _____ e-mail: _____

How did you hear about our clinic?

- Family or Friend
 Name: _____
- Patient from our clinic
 Name: _____
- Advertisement
 Describe: _____
- Healthcare Practitioner
 Name: _____
 Contact: _____
- Other
 Please specify: _____

Have you ever had previous Naturopathic care? Y / N

If yes, when? _____
 with whom? _____

Chief Concerns

Please list your chief medical concerns in order of importance with a brief description.

1	
2	
3	
4	
5	

Health Goals

Please briefly describe what your goals are with respect to your health and Naturopathic Medicine.



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Prescription and Over-the-Counter Medications

Please list ALL current medications (prescription, over-the-counter, etc.) and include the dosage, frequency, duration and the reason(s) for taking them.

Medication	Dosage	Frequency	Duration	Reason for taking them

Natural Health Products

Please list ALL current natural products (supplements, botanical tinctures, herbs, teas, homeopathics, etc.) and include the dosage, frequency, duration and the reason(s) for taking them.

Medication	Dosage	Frequency	Duration	Reason for taking them

Are you allergic to any medications or natural health products? Yes/No

If yes, please list: _____

Please list any other known allergies:

Family Health History

Please check any of the following conditions that are in your family (parents, siblings, children, grandparents, aunts, uncles, cousins).

- | | | | |
|--|---|---|--------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other |
| <input type="checkbox"/> Epilepsy, Seizures | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Hypertension | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anemia | <input type="checkbox"/> High Cholesterol | |
| <input type="checkbox"/> Psychiatric Illness | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Arthritis | |



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Other Healthcare Practitioners

Name:	_____	Address:	_____
Type:	_____		_____
Clinic Name:	_____	City, Prov, PC:	_____
Tel #:	_____	email:	_____
Name:	_____	Address:	_____
Type:	_____		_____
Clinic Name:	_____	City, Prov, PC:	_____
Tel #:	_____	email:	_____
Name:	_____	Address:	_____
Type:	_____		_____
Clinic Name:	_____	City, Prov, PC:	_____
Tel #:	_____	email:	_____



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Declaration of Consent to Naturopathic Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. Gentle techniques are used to stimulate the body's inherent healing capacity. Naturopaths assess the whole person, including physical, mental, emotional and spiritual aspects of the individual. Your visit may consist of a thorough case history of and a screening physical examination, including a breast exam for female patients. If your case indicates, the physical examination may also include more specific examination, such as genital or rectal examinations. It is important that we are informed of any diseases that you are suffering from and if you are on any medications or over-the-counter drugs. If you are pregnant, suspect you are pregnant or are breastfeeding, please inform us immediately.

There are some slight health risks to treatments in the Naturopathic scope of practice. These include but are not limited to: aggravation of pre-existing symptom; allergic reactions to supplements or herbs; pain, bruising or injury from acupuncture, cupping, venipuncture, intramuscular or intravenous injection; fainting or puncturing an organ with acupuncture needles. The results from Naturopathic treatments are not guaranteed and not all risk and complication can be anticipated nor explained.

I agree to abide by the financial policies as outlined, and I accept full responsibility for any fees incurred during the treatment. I agree to fully discharge this responsibility at the time of the visit via cash, debit or credit card (Visa or Mastercard).

I have read all of the foregoing information and I understand that: the ultimate responsibility for my health is *my own*; I will be seeing a Naturopathic Doctor (ND), *not* a Medical Doctor (MD); the Naturopathic Doctors at Insight Naturopathic Clinic work within the Naturopathic scope of practice; any advice or treatments given to me as a patient of Insight Naturopathic Clinic is not mutually exclusive from any advice or treatment that I have received in the past, receive now, or receive in the future from any other licensed healthcare practitioner; I am at liberty to seek or continue medical care from any other healthcare provider; No healthcare provider or employee under the direction of the Insight Naturopathic Clinic has made the recommendation to me to refrain from seeking or following the advice of another healthcare provider.

I declare that I have received a full and complete explanation of the treatment of services that I may receive at the Insight Naturopathic Clinic, and hereby authorize consent to treatment.

Consent Regarding Personal Information

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 and 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.

All staff members who come into 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.

Signature: _____ Date: _____

Printed Name: _____ 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 our office 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 also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Jill Shainhouse ND and/or Moira Kwok ND acts as the Privacy Information Officer

All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information. Attached to this consent form, we have outlined what our office 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, standards of our regulatory body, the Board of Directors of Drugless Therapy - Naturopathy (BDDT-N), and the law.

Do not hesitate to discuss our policies with any member of our staff. Please be assured that every staff person in this office is committed to ensuring that you receive the best quality Naturopathic care.

How Our Office Collects, Uses, and Discloses Patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office will use and disclose your information.

This office will collect, use, and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality care
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care, and services in relationship to preventative medicine, acute and chronic Naturopathic health care generally
- To communicate with other treating health-care providers, including specialists, family practitioners, referring physicians, and any other provider involved in the care of a patient
- To allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care, and billing
- For teaching and demonstrating purposes on an anonymous basis
- To comply with legal and regulatory requirements, including the delivery of patient's charts and records to the Board of Directors of Drugless Therapy - Naturopathy (BDDT-N), in a timely fashion, when required, according to the provisions of the Drugless Practitioner's Act (DPA).



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- To comply with the agreements / undertakings entered into voluntarily by the member with the Board of Director of Drugless Therapy - Naturopathy (BDDT-N), including the delivery and /or review of patient's charts and records to the Board in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the Naturopathic practice
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the Naturopathic Doctor's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To prepare materials for the Board of Directors of Drugless Therapy - Naturopathy (BDDT-N) complaints committee
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements
- To comply generally with the law

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 for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Drugless Practitioner's Act (DPA) for the purpose of the Board of Directors of Drugless Therapy - Naturopathy (BDDT-N) in Ontario fulfilling its mandate under the Drugless Practitioner's Act (DPA), and for the defense of a legal issue.

Our office will not, under any circumstances, supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent to use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the Code at any time.

I agree that *Jill Shainhouse ND* and/or *Moira Kwok ND* can collect, use, and disclose personal information about _____ as set out above in the information about the office's privacy policies.

Printed Name: _____ Date: _____

Signature: _____ Witness: _____