Seaway Naturopathic & Wellness Clinic

Patient Privacy Policy Consent Form

The privacy of your personal information is an important part of your care at Seaway Naturopathic & Wellness Clinic. We understand the importance of protecting your personal information and as such, we are committed to collecting, using and disclosing your personal information responsibly. 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, and are trained in the privacy and protection of this information.

Our privacy policy is designed to ensure that:

- Only necessary information is collected about you;
- We have your complete consent before we share your information;
- Storage, retention and destruction of your personal information complies with existing privacy legislation and privacy protection protocols of our regulatory body, the Transitional Council of the College of Naturopaths of Ontario.

To help you understand how we help protect your privacy, we will collect, use and disclose information about you for the following purposes:

- To assess your health concerns and advise you of treatment options
- To establish and maintain contact with you and 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 I have read and understand how Seaway Naturopathic & Wellness Clinic will use my personal information and the steps which the staff is taking to protect my information.

I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

Signature of Patient: _____ Date: _____

Name of Patient, Printed (or Parent/Guardian) _____

Located at: Seaway Naturopathic & Wellness Clinic
2-228 Second St. West, Cornwall, ON K6J 1G7
P: 613.938.9500 F: 855.820.1240

Seaway Naturopathic & Wellness Clinic

Dr. Daria Novy, ND
2-228 Second St. West
Cornwall, ON K6J 1G7
T: 613 938-9500 F: 855 820-1240

Patient Intake Form - Adult

Last Name:	First Name:		Middle Name:	
Birth Date (dd/mm/yyyy):	Age:	Sex: □M □F	Occupation:	
Address:	City:		Province:	Postal Code:
Telephone (W):	Telephone (H):	Mobile:	May we leave messages regarding your visit? □Yes □No	
Email:	Marital status:		Number of children:	
Emergency contact:	Relationship:		Telephone number:	

1. Healthcare Provider:	Specialty/focus:	Telephone:
2. Healthcare Provider:	Specialty/focus:	Telephone:
3. Healthcare Provider:	Specialty/focus:	Telephone:
Date of last medical doctor visit: _____	Date of last physical exam: _____	Date of last blood work: _____

How did you hear about the clinic?
If referred, please state by whom:
Have you ever been treated by a Naturopathic Doctor before? If yes, for what reason(s)?
Date of last visit to ND:
Are there other therapies you are currently using? (chiropractic, physiotherapy, acupuncture, etc.)

Current Health History:

Please list your main health concerns in order of importance to you:
1.
2.
3.
4.
5.

Current weight:	**Weight one year ago:**	**Maximum weight:**	**Height:**

List all previously diagnosed medical conditions:	**Date diagnosed:**

Vaccination/Immunization record (check please):

□ DPT (Diptheria, Pertussis, Tetanus)
□ MMR (Measles, Mumps, Rubella)
□ Gardasil/Cervarix (HPV Vaccine)
□ Haemophilus Influenza B
□ BCG (Tuberculosis)
□ Hepatitis A
□ Hepatitis B
□ Polio
□ Flu Vaccine
□ Other:
□ Pneumococcal Conjugate (Meningitis/Pneumonia)
□ Meningococcal C Conjugate (Meningitis)
□ Varivax/Varilrix (Chicken Pox)

Did any of your vaccines cause adverse reactions, if yes: _____

Have you had any of the following childhood illnesses:

□ Asthma
□ Rheumatic fever
□ Rubella (German measles)
□ Chicken pox
□ Polio
□ Scarlet fever
□ Whooping cough
□ Mumps
□ Roseola
□ Measles

List all allergies (environmental, medication, supplement, foods), and reaction type:

_____
_____
_____
_____
_____

Medication:

Please list all of your prescription and non-prescription medication, including over the counter medication (allergy medication, aspirin, antacid, etc.) :

Medication:	Dosage:	Since:	Reason:

Have you ever been prescribed antibiotics? □Yes □No	**Approximately how many prescriptions?**_____	**Longest duration:** _____

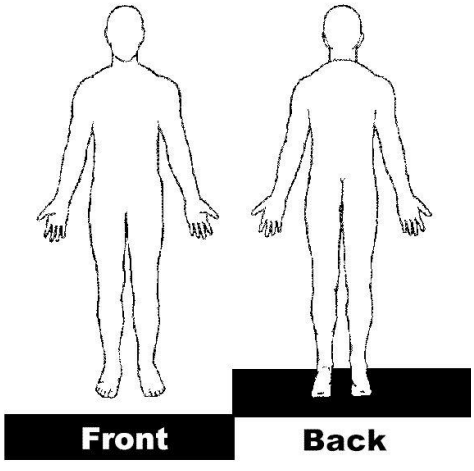
Supplements:

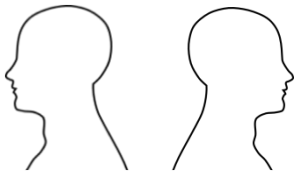
Please list any vitamin, mineral, or natural supplements you are taking with doses and brands

Supplement:	Dosage:	Since:	Reason:

Please list any past hospitalizations or surgeries:	Approx. date:
Please list any past injuries (fractures, concussions, sprains, hard falls, etc):	**Approx. date:**

Please indicate any painful or distressed areas:





Family Medical History:

Please check the '✓' box if any condition applies to you and/or a member of your family. Circle to whom it applies: ***Self****;* ***F****= father;* ***M****= mother;* ***G*** *= grandparent;* ***S*** *= sibling;* ***C =*** *child.*

*Circle if condition is resolved (****Past****) or ongoing (****Current****).*

Condition	✓	Relation	Date	Condition	✓	Relation	Date
Alcoholism/ drug addiction		Self F M G S C	Past /Current	**High blood pressure**		Self F M G S C	Past /Current
Allergies		Self F M G S C	Past /Current	**Low blood pressure**		Self F M G S C	Past /Current
Anemia		Self F M G S C	Past /Current	**Hepatitis**		Self F M G S C	Past /Current
Arthritis (osteo or rheumatoid)		Self F M G S C	Past /Current	**High cholesterol**		Self F M G S C	Past /Current
Asthma		Self F M G S C	Past /Current	**Headaches**		Self F M G S C	Past /Current
Bladder/urinary disease		Self F M G S C	Past /Current	**Kidney disease**		Self F M G S C	Past /Current
Cancer		Self F M G S C	Past /Current	**Skin disease**		Self F M G S C	Past /Current
Diabetes		Self F M G S C	Past /Current	**Stroke**		Self F M G S C	Past /Current
Depression/ mental illness		Self F M G S C	Past /Current	**Thyroid disease**		Self F M G S C	Past /Current
Eczema		Self F M G S C	Past /Current	**Tuberculosis**		Self F M G S C	Past /Current
Epilepsy		Self F M G S C	Past /Current	**Osteoporosis**		Self F M G S C	Past /Current
Lung disease		Self F M G S C	Past /Current	**Others:**		Self F M G S C	Past /Current
Heart disease		Self F M G S C	Past /Current	_____			

Women Only:

Are you pregnant? □Yes □No □Unsure	**Are you sexually active?** □Yes □No	**Date of last PAP test:**
	Sexual orientation: □Heterosexual □Homosexual □Bisexual □Undecided	**Any history of abnormal PAP results?** □Yes □No
Are you trying to get pregnant? □Yes □No	**Have you ever contracted a sexually transmitted disease?** □Yes □No **If yes, which?**_____	**Do you use contraception? If yes, what form?** □Yes _____ □No

Age at 1st menstrual period:	**First day of most recent menstrual period:**	**Length of period in days:**
Length in days between periods:	**Clots in menstrual flow?** □ Yes □No	**Colour of flow:**

Usual flow is (check please): □ light □ moderate □ heavy	**Do you have:** □painful periods □recurrent vaginal infections □missed periods □spotting between periods □unusual discharge

Please list number of Pregnancies: __ Live births: __ Miscarriages: __ Abortions: __	**Any complications during pregnancy/delivery/post-delivery?**
If post-menopausal, date of last menstrual period:	**If post-menopausal, have you had any vaginal bleeding since menopause?** □Yes □No
Please list any other concerns: _____ _____	

Men Only:

Are you sexually active? □Yes □No	**History of painful/difficult intercourse? Explain:**	
Sexual orientation: □Heterosexual □Homosexual □Bisexual □Undecided	**Have you ever contracted a sexually transmitted disease?** □Yes □No	**If yes, which disease(s)?**
Have you ever/do you experience painful/difficult urination? □Yes □No	**Do you wake at night to urinate?** □Yes □No **If yes, how many times?** _____	**Have you noticed a change in the direction/force of urinary flow?** □Yes □No
Have you had your prostate checked manually? □Yes □No **Any abnormalities?** □Yes □No	**Do you have difficulty achieving/maintaining erections?** □Yes □No	**Do you have concerns about your sex drive/libido?** □Yes □No
Please list any other concerns: _____ _____		

Dietary & Lifestyle Habits:

Exercise:	**How many times per week do you exercise?** □None □1x □2x □3x □4x □+5x
	What types of exercise/activity? (cardio, aerobic, flexibility)
Diet:	**Do you have any dietary restrictions?** □Yes □No
	Please describe a typical day's dietary intake: **Breakfast:** **Lunch:** **Dinner:** **Snacks:** **Beverages (and total quantity):**

	How much water do you drink a day?			
	Any food intolerances?		**How many bowel movements per day/week?**	
	Please list your favourite foods:			
	Any food cravings? □Yes □No	**If yes, to what?**		
	Do you drink coffee or cola? □Yes □No	**If yes, how many cups/day? _____** **_____**	**Do you drink black tea?** □Yes □No	**If yes, how many cups/day? _____**
Alcohol	**Do you consume alcohol?** □Yes □No	**If yes, how many drinks/week on average?** **_____**	**What type(s) of alcohol do you consume?** **_____** **_____**	
Tobacco	**Do you use tobacco?** □Yes □No	**If yes, how many/day?** **_____**	**How many years?** **_____**	**Are you/have you been exposed to second hand smoke regularly?** □Yes □No
Drugs	**Do you use recreational drugs?** □Yes □No	**If yes, what kinds?** **_____** **_____**	**How often?** □Daily □Weekly □Occasionally	
Sleep	**How many hours/night do you sleep?**	**Do you have any difficulty <u>falling</u> asleep?** □Yes □No	**Do you have any difficulty <u>staying</u> asleep?** □Yes □No	**Do you wake in the morning feeling rested?** □Yes □No
Energy:	**On a scale of 1-10 (10 = highest), how would you rate your energy in the:** **Morning: _____/10 Afternoon:_____/10 Evening:_____/10**			
Stress:	**Please rate your average level of stress from 1-10 (10=highest):_____/10**			
	Please list your top 3 sources of stress in your life: **1)_____** **2)_____** **3)_____**			
	Are you/have you ever been a victim of physical/emotional/sexual abuse? □Yes □No			
	Do you ever suffer from depression? □Yes □No	**Do you ever suffer from mood swings?** □Yes □No		
	Have you ever had psychiatric/psychological counseling? □Yes □No	**Do you have unresolved emotional issues or grief?** □Yes □No		
	How would you describe the emotional climate of your home? **_____**			
	List some activities you enjoy/ how do you relax? **_____** **_____**			

Environmental	**Do you have any pets in the home?** □Yes □No	**Do you have any seasonal allergies?** □Yes □No
	Are you affected by perfumes/scented products? □Yes □No	**If yes:** _____ _____
	Do you live in a(n): □apartment □house □basement	**Do you live:** □ in a rural/farm area □in a town □in a city □near a golf course
	Are you exposed to chemicals/hazardous materials on a daily basis? □Yes □No	**Are chemicals used on your garden/lawn?** □Yes □No
		Source of drinking water: _____
	What year was your house/dwelling built approximately?	**Source of heating in the house/dwelling:** _____

Is there any other important information that you feel I should know?

_____
_____
_____
_____

REVIEW OF SYSTEMS FORM

Please place a check in the Now or Past boxes as applicable for each condition listed. May double-check (✓✓) if symptom is significant.
If more than one condition is given, please circle which one you have or have had.

Condition	Now	Past	Condition	Now	Past
GENERAL					
Night sweats			Unintentional weight loss		
Chills / fever			Change in appetite		
SKIN & HAIR					
Acne			Eczema/ psoriasis		
Hives			Excessive hair loss/ growth		
Itching/ rashes			Changes in moles (size, colour)		
Dry hair/skin			Jaundice		
EYES					
Do you wear glasses/ contacts?			Floaters		
Impaired vision/ blurring			Glaucoma		
Cataracts			Macular degeneration		
Dry eyes			Poor night vision		
EARS, NOSE, & THROAT					
Recurrent ear infections			Allergies or sinus infections		
Impaired hearing			Frequent colds/ sore throats		
Tinnitus/ ringing in ears			Hoarseness		
Ruptured ear drum			Bleeding gums/ mouth		
Excess ear wax			Mercury dental fillings		
Frequent nose bleeds			Lumps/ swollen glands in neck		
Nasal or sinus congestion			Thyroid nodules		
Dry throat or excessive mucus			Grinding teeth		
Feeling of lump in throat			TMJ pain		
RESPIRATORY					
Cough			Frequent chest infections		
Pain on breathing			Emphysema		
Shortness of breath			Pneumonia		
Asthma/ wheezing			Tuberculosis		
CARDIOVASCULAR					
Chest pain/ angina			High cholesterol		
Heart disease			Coldness of hands/ legs/ feet		
Irregular heartbeat			Leg pain/ cramps		
Palpitations			Leg swelling/ edema		
High blood pressure			Varicose veins		
GASTROINTESTINAL					
Nausea or vomiting			Bloating/ Flatulence/ Gas		
Acid reflux or regurgitation			Hernia		
Indigestion			Hemorrhoids		
Peptic ulcer			Diarrhea		
Gallbladder stones/ removal			Constipation		
Blood in stool			Irritable bowel syndrome		

MUSCULOSKELETAL					
Joint pain/ stiffness			Osteopenia/ osteoporosis		
Back pain (low, mid, upper)			Sciatica/ nerve pain		
Carpal tunnel syndrome			Muscle cramps/ weakness/spasm		
Sore, cold or weak knees			Slow physical development		
NEUROLOGICAL					
Headaches/migraines			Slurred speech		
Fainting/ loss of consciousness			Loss of sensation		
Numbness/ tingling			Seizures		
Paralysis/ weakness			Loss of memory		
MENTAL/ EMOTIONAL					
Anxiety			Phobias		
Bipolar disorder			Thoughts of suicide		
Depression			Insomnia		
Obsessive compulsive disorder			Treated for substance abuse		
Schizophrenia			Forgetfulness/poor concentration		
Anger			Timidity/lack of courage		
Frustration/irritability			Indecisiveness		
Excessive stress			Other:		
ENDOCRINE					
Low iron/ other			Excessive thirst or hunger		
Unusual fatigue			Diabetes		
Excessive sweating			Poor appetite		
Feeling “wired but tired”			Low blood sugar/ hypoglycemia		
Sensitivity to hot or cold			Thyroid problems		
Hot flushes			Other:		
WOMEN’S HEALTH					
Breast lumps/ nipple discharge			Hormone replacement therapy		
Breast pain or tenderness			Infertility		
Breast cancer			Pain on intercourse		
Family history of breast cancer			PMS– premenstrual syndrome		
Ovarian cysts			Vaginal itching		
Endometriosis			Menopausal symptoms		
Fibroids			Prolapse of uterus		
MEN’S HEALTH					
BPH – enlarged prostate			Penile lesions or discharge		
Erectile dysfunction			Problems with sperm count		
Prostate cancer			Other fertility problems		
URINARY					
Kidney disease			Frequent urinary tract infections		
Kidney stones			Blood in urine		
Gout			Difficulty urinating		
Incontinence			Pain or burning on urination		

Thank you for taking the time to complete this form

Seaway Naturopathic &
Wellness Clinic

Dear New Patient:

I would like to take this opportunity to welcome you to my practice. As a naturopathic doctor, I utilize the principles and practices of Naturopathic Medicine as well as supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.
As part of your care, I will conduct a thorough case history, perform any necessary physical examination, including a breast exam and order blood and urine samples when necessary. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

Declaration of Informed Consent to Treatment

- As a patient of Dr. Daria Novy, I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications; therefore, the information I provide is complete and inclusive of all health concerns including: risk of pregnancy or current breast-feeding, all medications that are currently being taken, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to: aggravation of pre-existing symptoms; allergic reaction to supplements or herbs; pain, fainting, bruising or injury from injections, acupuncture or cupping; and muscle strains and sprains, disc injuries from spinal manipulations. Manipulative treatment has been associated with stroke; however, that association occurs very infrequently, and may be explained by an already damaged artery and/or the patient was progressing towards a stroke prior to seeking out services from the Naturopathic Doctor. Current medical and scientific evidence does not establish that manipulation either causes damage to an artery, or stroke.

- Herbal dispensary and supplements: Throughout the course of treatment, supplements may be prescribed from the clinic, or other available locations at the convenience of the patient. I understand that certain professional product lines are solely available through a Naturopathic Doctor, and that I am not obligated to purchase the supplements dispensed from Seaway Naturopathic & Wellness Clinic.
- Service Fees & Payment: I accept full responsibility for any fees incurred during care and treatment. I agree to provide at least 24 hours notice prior to a cancellation of an appointment; failure to do so incurs getting charged for the services that would have been provided. Consideration will be given in unforeseeable circumstances, at the discretion of Dr. Daria Novy. I understand that services provided are not covered by OHIP, but naturopathic expenses may be covered by private health insurance plans, and may be tax deductible. Naturopathic services and fees are clarified in advance, and are due at the end of each visit. All laboratory testing and supplements are not included in visit fees and will be paid for at the time of purchase.
- I understand that my Naturopathic Doctor will answer any questions that I have to the best of his/her ability.
- I also confirm that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating.
- 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 or elsewhere.
- The treatment and therapies rendered or recommended by Dr. Daria Novy may be different from and are not mutually exclusive of those offered by a medical doctor or other licensed health care provider.
- Though Dr. Daria Novy will endeavour to provide the best possible diagnosis and treatment, I understand treatment results are not guaranteed, as many factors determine actual results.

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- I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which to the doctor feels at the time, based upon the facts then known, is in my best interests.
- I am free to withdraw my consent and to discontinue treatment at any time. I understand that the ultimate responsibility for my health care is my own and that Dr. Daria Novy is here to support me in these efforts.
- I understand that Dr. Daria Novy reserves the right to discontinue services where it is apparent that my expectations and the type of services which she provides are not compatible.

I agree that I am at least 16 years old, and have read and understood this statement. By signing below, I agree with the aforementioned procedures, and that I have had an opportunity to ask questions regarding the information provided above.

Patient's name (please PRINT): _____

Signature of Patient: _____
(or Legally Authorized Guardian/Parent)

Signature of Naturopathic Doctor:_____
Dr. Daria Novy, ND #3073

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