ODETTE BULAONG, BSC(HONS), ND | LICENSED NATUROPATHIC DOCTOR

Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

ADULT MALE NEW PATIENT FORM

Name			Age
Date of Birth	Height	Weight	Gender
Marital Status	Occupation	Employer	
Address, City, Postal Code Email: _____ Would you like to join Odette Bulaong, ND's FREE e-newsletter list? Yes No	Phone Numbers [Home:] [Work:] [Cell:] May we leave you messages regarding your clinic visits? Yes No	In case of emergency notify: Phone number:	
Who referred you to or how did you hear about Odette Bulaong, ND?			

Health Care Providers (e.g. Medical Doctor, Specialist, Massage Therapist, Chiropractor)

Name Occupation: FAMILY DOCTOR OR GP Phone	Name Occupation Phone	Name Occupation Phone

Health Concerns

1. Please describe your main health concern(s). Please list when you first noticed the problem.

_____ Year Started: _____

_____ Year Started: _____

_____ Year Started: _____

2. Please list/describe any past major illnesses, injuries, surgeries, and hospitalizations:

_____ When: _____

_____ When: _____

_____ When: _____

When was your last physical exam with your family doctor? _____

When did you last have laboratory blood work done? _____

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Medication History

Please list all CURRENT and PAST prescription and over-the-counter medications (including aspirin, antacids, laxatives) you are taking or have taken:

	MEDICATION (E.G. ACETAMINOPHEN)	AMOUNT (E.G. TWO 325 MG CAPSULES)	# TIMES TAKEN/DAY (E.G. 2 TIMES/DAY)	LENGTH OF TIME TAKEN
CURRENT				
PAST				

On average, how many times have you been treated with ANTIBIOTICS? _____ Date of last time: _____

Natural Health Product History

Please list all CURRENT and PAST natural health products (vitamins, minerals, herbal medicines, homeopathic remedies) you are taking or have taken:

	NATURAL HEALTH PRODUCT *INCLUDING BRANDNAME (E.G. VITAMIN C)	AMOUNT (E.G. ONE 100 MG CAPSULE)	# TIMES TAKEN/DAY (E.G. 2 TIMES/DAY)	LENGTH OF TIME TAKEN
CURRENT				
PAST				

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Medical History

1. Please check all illnesses or diagnoses you have had in the past along with the year it started.

Illness	Year	Illness	Year
☐ AIDS/Positive HIV	_____	☐ Liver/Gall Bladder Condition	_____
☐ Allergies	_____	☐ Mental Illness	_____
☐ Anemia	_____	☐ Migraine Headaches	_____
☐ Arthritis	_____	☐ Mononucleosis	_____
☐ Cancer	_____	☐ Polio	_____
☐ Convulsions/Seizures	_____	☐ Benign Prostate Hyperplasia (BPH)	_____
☐ Depression	_____	☐ Rheumatic Fever	_____
☐ Diabetes	_____	☐ Sexually Transmitted Illness (STI)	_____
☐ Eating Disorder	_____	☐ Stomach/Duodenal Ulcer	_____
☐ Heart Disease	_____	☐ Thyroid problems	_____
☐ Heart Murmur	_____	☐ Tuberculosis	_____
☐ Hepatitis	_____	☐ Urethritis	_____
☐ High Blood Pressure	_____	☐ Other _____	_____
☐ High Cholesterol	_____		
☐ Kidney/Bladder Condition	_____		

2. **Family Illnesses:** Please list whether your *mother, father, siblings, children, maternal or paternal grandparents* have had any of the following conditions:

	WHO?		WHO?		WHO?
Allergies		Diabetes		Kidney Disease	
Anemia		Digestive Conditions		Liver Disease	
Asthma		Heart Disease		Mental Illness	
Birth Defect		Heart Attack		Stroke	
Bleeding Disorder		High Cholesterol		Thyroid condition	
Cancer Type:		High Blood Pressure		Other:	

3. Have you had any dental work procedures? Please describe and include the year it was done.

4. Please list any known or suspected allergies to foods, drugs, inhalants, environment or other substances:

5. Please list the 5 most significant stressful events in your life, from the most recent to the least recent. Please indicate if any of these situations are still impacting on your life.

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Lifestyle

1. Do you participate in regular physical activities? What type and how often?

2. Please describe if you follow a particular diet or avoid any specific foods?

3. Please list what you would usually eat in a day, including approximate amounts:

   Breakfast _____

   Lunch _____

   Dinner _____

   Snacks _____

   Beverages _____

   Approximate number of 250 mL glasses of water you drink per day: _____

4. Please indicate usage and circle whether per day/ week/month describes this amount best:

   Cigarettes _____ per day/wk/month
   Alcohol _____ per day/wk/month
   Recreational Drugs _____ per day/wk/month
   Chewing tobacco _____ per day/wk/month

5. Have you smoked in the past? How much and how long?

6. Are you now or have you been exposed to breathing in second hand smoke?
   If yes, for how long?

Review of Body Systems

Check the box and fill in the blank spaces for each of the symptoms you currently have. For symptoms you have had in the past but not currently, print the letter P beside the symptom box.

General
- ☐ Recurrent infections
- ☐ Swollen lymph nodes
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Strong, excessive thirst
- ☐ Thirst but no desire to drink
- ☐ Excessive appetite
- ☐ Recent change in appetite
- ☐ Fatigue
- ☐ Poor sleep
- ☐ Edema (water retention)
- ☐ Underweight
- ☐ Overweight
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Other _____

Skin
- ☐ Bleed easily
- ☐ Bruise easily
- ☐ Rashes
- ☐ Itching
- ☐ Eczema
- ☐ Psoriasis
- ☐ Dry skin/scalp
- ☐ Oily skin/scalp
- ☐ Loss of hair
- ☐ Dandruff
- ☐ Ulcerations
- ☐ Pimples
- ☐ Hives
- ☐ Fungal infection
- ☐ Recent moles
- ☐ Mole changes (colour, size)
- ☐ Other _____

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Head, Eyes, Ears, Nose, Throat
- ☐ Dizziness
- ☐ Concussions
- ☐ Headaches
- ☐ Ringing in ears
- ☐ Hearing aid
- ☐ Poor hearing
- ☐ Draining/discharge from ear
- ☐ Teeth problems
- ☐ Bleeding gums
- ☐ Dentures
- ☐ Sores on lips or tongue
- ☐ Dry mouth
- ☐ Grinding teeth
- ☐ Dry throat/hoarseness
- ☐ Jaw clicks
- ☐ Spots in eyes
- ☐ Wear glasses/contacts
- ☐ Color blindness
- ☐ Eye pain
- ☐ Cataracts
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Nose bleeds
- ☐ Snore
- ☐ Sinus problems
- ☐ Mucus in nose or throat
- ☐ Other _____

Cardiovascular
- ☐ Blood clots
- ☐ Fainting
- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Cold hands/feet
- ☐ Difficulty breathing
- ☐ Irregular heartbeat
- ☐ Swelling in hands/feet
- ☐ Other _____

Respiratory
- ☐ Coughing blood
- ☐ Coughing phlegm/mucus
- ☐ Tight chest
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Difficulty breathing when lying down
- ☐ Recurrent/persistent cough
- ☐ Other _____

Gastrointestinal
- ☐ Nausea
- ☐ Vomiting
- ☐ Gas
- ☐ Bloating
- ☐ Bad breath
- ☐ Constipation
- ☐ Use laxatives
- ☐ Diarrhea
- ☐ Bowel movement changes
- ☐ Abdominal pain or cramps
- ☐ Sensitive abdomen
- ☐ Indigestion/heartburn
- ☐ Belching
- ☐ Rectal pain
- ☐ Bloody stools
- ☐ Mucus in stools
- ☐ Hemorrhoids
- ☐ Black stools
- ☐ Other _____

Genito-Urinary
- ☐ Difficult to start urination
- ☐ Dribbling urination
- ☐ Wake up to urinate
- ☐ Urgency to urinate
- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Unable to hold urine
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Other _____

Musculoskeletal
- ☐ Neck ache/pain
- ☐ Back ache/pain
- ☐ Muscle pains
- ☐ Muscle spasm
- ☐ Muscle cramps
- ☐ Joint pain
- ☐ Stiffness
- ☐ Muscle weakness
- ☐ Orthotics
- ☐ Other _____

Neurological
- ☐ Numbness/tingling
- ☐ Twitching
- ☐ Tremors
- ☐ Loss of balance or coordination
- ☐ Nerve damage
- ☐ Vertigo
- ☐ Other _____

Behavioral
- ☐ Nervousness/anxiety
- ☐ Depression
- ☐ Easily stressed
- ☐ Moody
- ☐ Aggressive/bad temper
- ☐ Panic attacks
- ☐ Fear
- ☐ Other _____

Male
- ☐ Hernia
- ☐ Testicular mass
- ☐ Penile Discharge
- ☐ Penile Rashes/Sores
- ☐ Erectile Difficulties
- ☐ Impotence
- ☐ Fertility Issues
- ☐ Vasectomy
- ☐ Change in sex drive
- ☐ Last hernia exam date _____
- ☐ Last prostate exam date _____
- ☐ Last testicular exam date _____
- ☐ Other _____

Thank you ☺

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Declaration of Informed Consent to Naturopathic Diagnostic and Therapeutic Procedures

In order for your Odette Bulaong, ND to assess your health, identify risk factors for potential diseases and create a treatment plan for your existing health condition(s), the following **naturopathic diagnostic procedures** may be performed:

- A thorough Health History Intake
- Complaint-Oriented Physical Exam: body systems that may be affected by your health condition may be examined.
- Urinalysis
- Complete Screening Physical Exam: a basic examination of all major body systems.
- Laboratory Blood Work: a requisition to have your blood work drawn privately at LifeLabs will be provided or you may choose to have your blood work done through your family doctor as time permits.
- Additional In-House/Laboratory Work: salivary hormone testing, allergy testing, etc.
- Chinese tongue and pulse diagnosis: examination of the tongue and pulses to provide important information on body organs with respect to Chinese Medicine.
- Breast Exam
- Genital Exam

***Please note** that the clinic is not set up for rectal or prostate exams at this time. If your health condition requires these, you will be referred back to your family doctor to have these exams completed.

Naturopathic medicine is a form of primary health care that uses natural substances and treatments to support and stimulate the body's ability to heal itself. The **naturopathic therapeutic procedures** that may be used by Odette Bulaong, ND individually or in combination to address your health condition(s) are:

- Nutritional Counseling
- Botanical Medicine
- Acupuncture and Chinese Medicine
- Homeopathic Medicine
- Lifestyle Counseling
- Physical Medicine & Hydrotherapy
- Facial Rejuvenation Acupuncture

Although the above treatments are safe and natural, even the gentlest therapies can have complications. This is especially true in certain conditions or in very young children. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform Odette Bulaong, ND immediately of any disease process that you may be suffering from.

Some complications that can occur with naturopathic treatment include but are not limited to:

- Aggravation of pre-existing or existing symptoms
- Allergic reactions (for example to supplements or herbs)
- Minor bleeding or bruising from acupuncture needles, B12 shots
- Fainting or puncturing of an organ with acupuncture needles
- Accidental burning of the skin from the use of moxa or cupping
- Muscle strains and sprains, disc injures from spinal manipulation
- The potential for stroke is a concern in neck manipulation.

I understand that the results are not guaranteed. I do not expect Odette Bulaong, ND to be able to anticipate or explain all risks and complications. I will rely on Odette Bulaong, ND to exercise judgment during the course of treatment which she feels at that time is in my best interests, based on the facts then known. I, the undersigned, do hereby acknowledge that I have been informed of and understand the naturopathic diagnostic and therapeutic procedure(s) and have discussed to my satisfaction this and any requests for related information with Odette Bulaong, ND.

I further acknowledge and confirm that I have been informed of, and understand the diagnostic and therapeutic procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

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I do hereby voluntarily give my informed consent for the naturopathic **diagnostic procedure(s)** mentioned on the previous page except (please list exceptions):

_____

I do hereby voluntarily give my informed consent for the naturopathic **therapeutic procedure(s)** mentioned on the previous page except (please list exceptions):

_____

I understand that I may change the status of my voluntary informed consent for diagnostic and therapeutic procedures at any time by informing Odette Bulaong, ND.

Patient Name: _____
First **Middle** **Last**

Patient Signature*: _____ **Date Signed:** _____
***Parent/Legal Guardian to sign if patient younger than 16 years old** **Day** **Month** **Year**

Statement of Acknowledgement

In order to clarify the position of Odette Bulaong, ND and the mutual responsibilities in your health care, please read and sign this statement of acknowledgement.

1. I understand that I am obliged to inform Odette Bulaong, ND of any pre-existing medical conditions (especially diabetes, heart, liver or kidney disease) and procedures and/or any medications (prescribed or over the counter, conventional or natural).
2. I understand that I will be seeing a naturopathic doctor not a medical doctor and I am aware that the methods utilized by Odette Bulaong, ND may not be accepted practice by conventional (allopathic) medicine.
3. I understand that any naturopathic treatment or advice provided to me by Odette Bulaong, ND is not being provided in the place of or to the exclusion of any other treatment or advice that I may now be receiving or may in the future receive from a physician, surgeon, or any other licensed health care provider.
4. I am at liberty to seek and may continue to seek treatment or advice from a physician, surgeon or any other licensed health care provider.
5. I am aware of the fee schedule for naturopathic services and understand that payment is due at the time of service.
6. I understand that I will be charged $50.00 for any missed naturopathic appointments, unless I have advised Quarry Chiropractic Clinic of cancellation no less than twenty-four (24) hours in advance of the scheduled appointment.
7. I am aware that the fees for naturopathic treatment are not covered by OHIP and that it is my responsibility to confirm whether any company that provides me with private health insurance will reimburse me for the cost of such naturopathic treatments.
8. I am not an agent of any private or government agency attempting to gather information without so stating my intentions.

Patient Name: _____
First **Middle** **Last**

Patient Signature*: _____ **Date Signed:** _____
***Parent/Legal Guardian to sign if patient younger than 16 years old** **Day** **Month** **Year**

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Privacy Information

Privacy of your personal information is important to this clinic while I provide 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.

Collection of Personal Health Information

We collect personal health information about you directly from you or from the person acting on your behalf. The personal health information that we collect may include, for example, your name, date of birth, address, health history, records of your visits with Odette Bulaong, ND and the care that you received during those visits. Occasionally, we collect personal health information about you from other sources if we have obtained your consent to do so or if the law permits.

Uses and Disclosures of Personal Health Information

We use and disclose your personal health information to:

- Assess your health care needs;
- Develop effective treatment plans for you;
- Provide you with treatment, health services, and care of an acute, chronic and/or preventive nature;
- Research and inform you of additional treatment options you may benefit from;
- Inform you of clinic services, events, updates, and health care information;
- Contact you and maintain communication with you;
- Contact you to book and confirm appointments;
- Follow up with treatment, care, health status and billing;
- Communicate with other treating health care providers, including specialists, family practitioners, referring physicians, and any other health provider involved in your care;
- Plan, administer and manage our internal operations;
- Conduct risk management and quality improvement activities;
- Teach, demonstrate or conduct research on an anonymous basis;
- Conduct patient satisfaction surveys;
- Compile statistics on an anonymous basis;
- Invoice, process payments and collect unpaid accounts for goods and services;
- Permit potential purchasers, practice brokers or advisors to evaluate the naturopathic practice and/or conduct an audit in preparation for a practice sale;
- 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;
- Comply with legal and regulatory requirements, and fulfill other purposes permitted or required by law;
- Comply with legal and regulatory requirements, including the delivery of patient's charts and records to The College of Naturopaths of Ontario (CONO) in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act (RHPA);
- Comply with the agreements/undertakings entered into voluntarily by the member with CONO, including the delivery and/or review of patient's charts and records to the Board in a timely fashion for regulatory and monitoring purposes;
- Prepare materials for CONO complaints committee, if necessary.

Your information may be accessed by regulatory authorities under the terms of the RHPA for the purpose of CONO fulfilling its mandate under the RHPA and/or for the defence of a legal issue.

You may access and correct your personal health records, or withdraw your consent for some of the above uses and disclosures by informing Odette Bulaong, ND in writing (subject to legal exceptions). If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

We take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal. We conduct audits and complete investigations to monitor and manage our privacy compliance.

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Consent to Privacy Information and the Collection, Use and Disclosure of Personal Health Information

I, _____, have reviewed Odette Bulaong, ND's written statements concerning privacy information and the collection, use and disclosure of personal health information.

I understand that Odette Bulaong, ND is seeking my consent to collect, use and/or disclose my personal health information from me or about the person I am acting on behalf of, as outlined in the written statements above.

I understand that Odette Bulaong, ND will only collect, use and disclose my personal health information with my consent as set out above unless a particular collection, use or disclosure is permitted or required by law without my consent.

I also understand that I can refuse to sign this consent form. I can also withdraw my consent any time by informing Odette Bulaong, ND in writing.

By signing this form, I hereby authorize Odette Bulaong, ND to collect, use and disclose my personal health information for the purposes that are indicated in the written statements above.

Patient Name: _____
First **Middle** **Last**

Patient Signature*: _____ **Date Signed:** _____
***Parent/Legal Guardian to sign if patient younger than 16 years old** **Day** **Month** **Year**