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 - Child

Last Name:	First Name:		Middle Name:	
Birth Date (dd/mm/yyyy):	Age:	Sex:	Who is filling out this form? (name, relationhip):	
Address:	City:		Province:	Postal Code:
Telephone (W):	Telephone (H):	Mobile:	May we leave messages regarding your visit? □Yes □No	
Email:	Siblings (names and ages):			
1. Emergency contact:	Relationship:		Telephone number:	
2. 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:
Has your child ever been treated by a Naturopathic Doctor before? If yes, for what reason(s)?
Date of last visit to ND:
Are there other therapies that the child is currently using? (chiropractic, physiotherapy, acupuncture, etc.) □No □Yes _____

Current Health History:

Please list your child's main health concerns in order of importance:
1.
2.
3.
4.
5.

Current weight:	**Current height:**	**Was the child adopted?** □Yes □No	**Does the child receive regular age-specific physical exams? (height, weight, vision, hearing, etc.)** □Yes □No

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

Vaccination/Immunization record (check those that apply):
Please note vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule 2004

□ **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)
□ **Rotarix TM** (Rotavirus)

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

Did your child have any of the following childhood illnesses? (check those that apply)

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

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

_____
_____
_____
_____
_____

Medication:

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

Medication:	Dosage:	Since:	Reason:

Has your child ever been prescribed antibiotics? □Yes □No	**Approximately how many prescriptions?**_____	**Longest duration:** _____

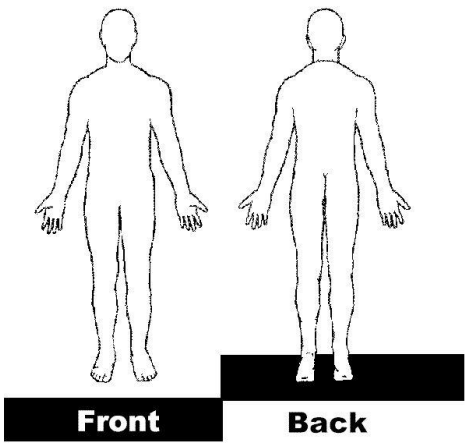
Supplements:

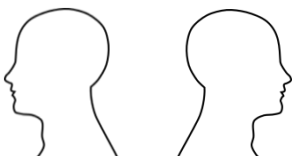
Please list any vitamin, mineral, or natural supplements the child is taking, with doses and brands:

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	_____			

Prenatal History:

Pregnancy weight gain:	**Mother's age at conception:**	**Father's age at conception:**	**Was your child conceived naturally?** □Yes □No
Did the mother experience any of the following during pregnancy: □ excessive bleeding □ emotional trauma □ diabetes □ physical trauma □ thyroid problems □ nausea □ high blood pressure □ vomiting		**If fertility interventions were used, pleased indicate:** **Did the mother receive prenatal medical care?** □Yes □No	
Please check any of the following that the mother has used during pregnancy: □ Tobacco □ Alcohol □ Recreational drugs □ Others: _____ □ Prescription and over-the-counter medication (please specify dosage): _____ _____ □ Supplements (please specify brand, dosage): _____ _____			
Please rate the mother's general health during pregnancy: □ excellent □ good □ fair □ poor □ unknown			
How was the mother's diet during pregnancy? □ excellent □ good □ fair □ poor □ unknown			
The mother's diet during pregnancy was primarily: □vegan □vegetarian □omnivore (both veg/meat) □ pescatarian (eats fish, but not meat) □other:_____			

Birth History:

Term length: □ full-term □ premature _____weeks □ late _____weeks			**Birth weight:**
What type of delivery? □ vaginal □ c-section □ in-hospital □home-birth			**Birth length:**
Length of labour:	**The labour was:** □spontaneous □induced	**Any complications? Please describe:**	
Were any delivery interventions used? □Yes □No	**If so, which of the following:** □episiotomy □forceps □epidural □suction	**Was the mother 'Strep B positive'?** □Yes □No **If yes, were antibiotics used during birth?** □Yes □No	
Did the child experience any of the following at or after birth? □ jaundice □ seizures □ infections □ congenital conditions _____ □ rashes □ birth injuries □ poor feeding □ other:_____			
Were any of the following used? □ silver nitrate □ vitamin K drops □ other:_____			

Dietary & Lifestyle Habits:

Diet:	**Was your infant fed breast milk?** □Yes □No **If yes, for how long?** _____	**Was your infant fed formula?** □Yes □No **If yes, what type/brand?**_____
	At what age did your child first have solid food? _____	**What foods were introduced before 6 mos?** _____ _____ **At 6-12 mos?**_____ _____
	Which typical diet does the child eat: □Vegan □Vegetarian □Omnivore (veg/meats) □Pescatarian □Other:_____ **Restrictions:** _____	
	Did your child ever experience colic? □Yes □No **How severe?** Mild Moderate Severe	
	Any food intolerances/food allergies? _____ _____	**How many bowel movements per day?** _____ **How many times does the child urinate?** _____
	Typical diet in 24 hours: **Breakfast:**_____ **Dinner:**_____ **Lunch:**_____ **Snacks:**_____ **Beverages, and quantity:**_____	
Sleep/rest:	**How many hours does the child sleep on average?**_____	**Does the child nap?** □Yes □No
	Does the child have trouble falling asleep? □Yes □No	**Does the child have trouble staying asleep?** □Yes □No
	Child's usual sleep-time:_____ **Child's usual wake-time:**_____	**Does the child:** □Snore □Wet the bed □Have nightmares □Sleep walk □Sleep talk

<table>
<tr><td rowspan="5">Social / Behaviour / Development</td><td colspan="2">How would you describe your child's behaviour/temperament with siblings/friends?
_____</td></tr>
<tr><td colspan="2">Does your child enjoying playing/interacting with other children? □Yes □No</td></tr>
<tr><td colspan="2">Does your child have any learning disabilities? □Yes □No
If so, please describe:_____</td></tr>
<tr><td>Does the child exercise?
□Yes □No
If yes, how much on a daily basis, and what forms/sports?
_____
Any other extracurriculars activities?
_____</td><td>How often does the child watch TV / play video games?
□less than 1 hr/day
□1 hr/day
□2 hrs/day
□2hrs+/day</td></tr>
<tr><td></td></tr>
<tr><td rowspan="3">Environmental:</td><td>Does anyone in the home smoke?
□Yes □No</td><td>Are there pets in the home?
□Yes □No If yes, please list_____</td></tr>
<tr><td colspan="2">How would you describe the emotional climate at home?
_____
Describe the environment at school (performance, reports, bullying, etc):
_____
Do you know of any toxins or other hazards the child is regularly/might be exposed to?
□No □Yes _____</td></tr>
<tr><td colspan="2">How is the child's home heated?
□Natural gas □Oil □Electric □Wood □Other:_____</td></tr>
</table>

Is there anything that you feel is important that has not been covered?

_____
_____
_____
_____
_____

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.

Seaway Naturopathic &
Wellness Clinic

- 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

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