

Vanessa Lee, BSc, ND

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416.969.7218

Please bring:

- Completed set of New Patient Forms
- Lab/blood test results (if available)
- List of current supplements & medications (including brands & doses)

Payments: **Cash or Cheque** only (sorry no debit/credit cards).

- 1-hour Initial Consultation \$140
- 45-min Second Visit \$100
- Subsequent visits: 30min \$75; 45min \$100; 60min \$120

Saturdays & after 5pm: Notify security of your appointment with me to gain elevator access to the 4th floor. If security is not at the desk, please call my office.

On the 4th floor: Turn left at the receptionist's desk, and left again at the end of that hallway; office #32 is the first door on the left. If the door is closed, please have a seat; I will be with you shortly.



www.naturopathichealth.info
mail@naturopathichealth.info



Vanessa Lee BSc, ND
Naturopathic Doctor

Name: _____ Date: _____

Date of birth: M _____ D _____ Y _____ Sex: Male Female

Address: _____

E-mail Address: _____

Telephone: Home# _____ Work# _____

Mobile# _____ May we leave messages related to your visits? Y / N

Emergency contact Name: _____

Phone number: _____ Relation: _____

How you heard about us: _____ Referred by: _____

Other health care providers you are seeing (please indicate name, specialty & phone number):

- | | | |
|-------|-------|-------|
| 1. | 2. | 3. |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

What are your main health concerns, in order of importance to you?

1. _____
2. _____
3. _____
4. _____
5. _____

For office use only:





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Medical history

How is your health in general? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, injuries, and hospitalizations, along with dates.

Do you have allergies? (drugs, environmental, food, etc.)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, etc.)

Please list past prescription medications.

Do you frequently use any of the following? (circle)

Aspirin | Laxatives | Antacids | Diet pills | Birth control: pills / implants / injections

Alcohol: _____ per day or _____ per week Tobacco: _____ per day

Caffeine: form and amount/day _____

Recreational drugs: what and how often _____

How many times have you taken antibiotics? _____ Have you had bad reactions? Y / N

Have you ever had bad reactions to immunization shots? Y / N

Do you get regular screening tests from another doctor? (Pap, blood tests, etc.)? Y / N

Females: Are you currently pregnant? Y / N Are you planning to get pregnant? Y / N

Diet

Please list any food allergies or intolerances. _____

Do you have any dietary restrictions (religious, vegetarian/vegan, health-related, etc.)?





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Family history

Please indicate if a close relative has had any of the following:

| | Who? | | Who? |
|---------------------|------|-----------------------|------|
| Allergies | | Depression | |
| Asthma | | Other mental illness | |
| Heart disease | | Kidney disease | |
| High blood pressure | | Drug abuse/alcoholism | |
| Cancer | | Other | |
| Diabetes | | | |

I don't know my family medical history

Environment

Occupation _____

Hobbies _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Are you regularly exposed to toxins/hazards at work, home, hobbies, etc.? Please describe.

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

Thank you for taking the time to complete this form.





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Consent to Treatment & Fees Policy

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 and a screening physical examination, including a breast exam for females. If your case requires, the physical may include more specific examinations such as rectal or genital exams.

It is important that we are informed of any diseases that you are suffering from and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or are breast-feeding, please let us know immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising or injury from acupuncture or cupping; fainting or puncturing of an organ with acupuncture needles. Results are not guaranteed and not all risks and complications can be anticipated and explained.

Payment is made by cash or cheque at the time of the visit as follows:

- First visit (1 hour) - \$140
- Second visit (45 minutes) - \$100
- Subsequent visits - \$75 (30minutes), \$100 (45 minutes), \$120 (1 hour)
- \$25 fee for NSF cheques
- \$30 for copies of patient files, telephone consultations longer than 15 minutes, and missed appointments without *24-hour* notification.
- Supplements & products are individually priced. Patients are not required to purchase the supplements recommended in their treatment protocols from this office and are free to choose where they are purchased.

Your identity will be protected at all times and a record will be kept of the health services provided. Patients may look at their medical record at any time and can request a copy of it by paying the appropriate fee. The information from medical records may be analyzed for research purposes and all identities will be protected and kept confidential.

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.

At this office, Vanessa Lee, 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 trained in the appropriate use and protection of your information.





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Our privacy policy outlines what our clinic 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 the existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

How our clinic collects, uses and discloses patients’ personal information:

To help you understand how we protect your personal information, we have outlined here how our clinic is using and disclosing your information:

- To assess your health concerns.
- To provide health care.
- To advise you of treatment options.
- To establish & maintain contact with you.
- To send newsletters and other information mailings.
- To 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 of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners Act*.
- To invoice for goods and services.
- To process credit card payments.
- To collect unpaid accounts.
- To assist this clinic to comply with all regulatory requirements.
- To comply generally with the law.
- To allow potential purchasers, practice brokers or advisors to conduct and audit in preparation for a practice sale

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 as outlined above.

Patient Consent:

I, _____ (patient name) agree that Vanessa Lee, ND may collect, use and disclose personal information as set out above regarding the clinic’s privacy policies. I also consent to diagnostic and therapeutic procedures for the entire course of treatment for my present condition(s), and understand that I am free to withdraw consent and to discontinue participation in these procedures at any time. I have read and fully understand and agree to the outlined fees and policies, and understand that the fees may change without prior notice.

Signature: _____ Date: _____

Guardian Signature (patients under age 16): _____





Name: _____ **Date:** _____

Y = Condition you have now **P** = Condition you had in the past **skip** if you've never had it

| | | |
|--------------------|--------------------------------|-------|
| 1. GENERAL | | |
| Current Weight: | Current Height: | |
| Weight 1 year ago: | Maximum weight (non-pregnant): | When? |

| | | | | | |
|------------------|---|---|-------------------|---|---|
| 2. SKIN | | | | | |
| Rashes | Y | P | Lumps | Y | P |
| Eczema, hives | Y | P | Dryness/Moistness | Y | P |
| Acne, boils | Y | P | Nail changes | Y | P |
| Itching | Y | P | Change in Mole | Y | P |
| Color changes | Y | P | Skin Cancer | Y | P |
| Comments: | | | | | |

| | | | | | |
|------------------|---|---|-----------|---|---|
| 3. HEAD | | | | | |
| Headache | Y | P | Dizziness | Y | P |
| Head injury | Y | P | | | |
| Comments: | | | | | |

| | | | | | |
|--------------------|---|---|-----------------|---|---|
| 4. EYES | | | | | |
| Impaired vision | Y | P | Cataracts | Y | P |
| Glasses/Contacts | Y | P | Bothered by sun | Y | P |
| Eye pain | Y | P | Itching | Y | P |
| Tearing or dryness | Y | P | Redness | Y | P |
| Double vision | Y | P | Discharge | Y | P |
| Glaucoma | Y | P | Blind spot | Y | P |
| Comments: | | | | | |

| | | | | | |
|------------------|---|---|------------|---|---|
| 5. EARS | | | | | |
| Impaired hearing | Y | P | Discharge | Y | P |
| Earache | Y | P | Infections | Y | P |
| Dizziness | Y | P | | | |
| Comments: | | | | | |

| | | | | | |
|----------------------------|---|---|----------------|---|---|
| 6. NOSE and SINUSES | | | | | |
| Frequent colds | Y | P | Hay fever | Y | P |
| Nose bleeds | Y | P | Sinus problems | Y | P |
| Stuffiness | Y | P | | | |
| Comments: | | | | | |



7. MOUTH and THROAT

| | | | | | |
|----------------------|---|---|-----------------|---|---|
| Frequent sore throat | Y | P | Hoarseness | Y | P |
| Sore tongue/mouth | Y | P | Dental cavities | Y | P |
| Gum problems | Y | P | Loss of taste | Y | P |
| Comments: | | | | | |

8. NECK

| | | | | | |
|------------------|---|---|-------------------|---|---|
| Lumps | Y | P | Goiter | Y | P |
| Swollen glands | Y | P | Pain or stiffness | Y | P |
| Comments: | | | | | |

9. RESPIRATORY

| | | | | | |
|-------------------|---|---|--------------------------------|---|---|
| Cough | Y | P | Emphysema | Y | P |
| Sputum | Y | P | Difficulty breathing | Y | P |
| Spitting up blood | Y | P | Pain on breathing | Y | P |
| Wheezing | Y | P | Shortness of breath | Y | P |
| Asthma | Y | P | Shortness of breath at night | Y | P |
| Bronchitis | Y | P | Shortness of breath lying down | Y | P |
| Pneumonia | Y | P | Tuberculosis | Y | P |
| Pleurisy | Y | P | Tuberculin Test | Y | P |
| Comments: | | | Date of Last Chest x-ray: | | |

10. CARDIOVASCULAR

| | | | | | |
|--|---|---|--------------------------|---|---|
| Heart disease | Y | P | Chest pain | Y | P |
| Angina | Y | P | Swelling in ankles | Y | P |
| High blood pressure | Y | P | Palpitations, fluttering | Y | P |
| Murmurs | Y | P | Cyanosis | Y | P |
| Past ECG & Date | Y | P | Rheumatic fever | Y | P |
| Other heart tests & Comments: | | | | | |

11. PERIPHERAL VASCULAR

| | | | | | |
|------------------|---|---|--------------------|---|---|
| Deep leg pain | Y | P | Extremity numbness | Y | P |
| Cold hands/feet | Y | P | Extremity coldness | Y | P |
| Varicose veins | Y | P | Extremity swelling | Y | P |
| Thrombophlebitis | Y | P | Extremity ulcers | Y | P |
| Leg cramps | Y | P | | | |
| Comments: | | | | | |

12. BLOOD/LYMPHATIC

| | | | | | |
|---------------------------|---|---|---------------------|---|---|
| Anemia | Y | P | Past transfusions | Y | P |
| Easy bleeding or bruising | Y | P | Lymph node swelling | Y | P |
| Comments: | | | | | |

| 13. GASTROINTESTINAL | | | | | |
|------------------------|---|---|---|---|---|
| Trouble swallowing | Y | P | Belching or passing gas | Y | P |
| Heartburn | Y | P | Food allergy | Y | P |
| Change in thirst | Y | P | Indigestion | Y | P |
| Change in appetite | Y | P | Ulcer | Y | P |
| Nausea | Y | P | Blood in stool | Y | P |
| Vomiting | Y | P | Rectal bleeding | Y | P |
| Vomiting blood | Y | P | Hemorrhoids | Y | P |
| Hernias | Y | P | Black, tarry stool | Y | P |
| Jaundice (yellow skin) | Y | P | Diarrhea | Y | P |
| Liver disease | Y | P | Abdominal pain | Y | P |
| Gall Bladder disease | Y | P | Bowel movements (per day & per week) | | |
| Comments: | | | Is this a change? | Y | N |

| 14. URINARY | | | | | |
|---------------------|---|---|-------------------------|---|---|
| Pain on urination | Y | P | Kidney stones | Y | P |
| Increased frequency | Y | P | Blood in urine | Y | P |
| Frequency at night | Y | P | Urgency | Y | P |
| Frequent infections | Y | P | Hesitancy | Y | P |
| Comments: | | | Inability to hold urine | Y | P |

| 15. MALE REPRODUCTIVE | | | | | |
|--------------------------|---|---|---------------------|---|---|
| Hernias | Y | P | Sexual difficulties | Y | P |
| Testicular masses | Y | P | Venereal disease | Y | P |
| Testicular pain | Y | P | Discharge or sores | Y | P |
| Are you sexually active? | Y | P | | | |
| Comments: | | | | | |

| 16. FEMALE REPRODUCTIVE | | | | | |
|---|---|---|-----------------------------|---|---|
| Age menses began | | | Number of pregnancies | | |
| Average number of days of bleeding | | | Number of live births | | |
| Length of cycle | | | Number of miscarriages | | |
| Last menstrual period | | | Number of abortions | | |
| Bleeding between periods | Y | P | Painful menses | Y | P |
| Are cycles regular | Y | P | Excessive flow | Y | P |
| Pain during intercourse | Y | P | PMS | Y | P |
| Difficulty conceiving | Y | P | Vaginal discharge | Y | P |
| Sexual difficulties | Y | P | Vaginal itching | Y | P |
| Venereal Disease | Y | P | Last PAP - (date) | | |
| Are you sexually active? | Y | N | Type of birth control? | | |
| Do you do self- breast exams regularly? | Y | P | Breast pain (or tenderness) | Y | P |
| Breast lumps | Y | P | Nipple discharge | Y | P |
| Comments: | | | | | |

17. MUSCULOSKELETAL

| | | | | | |
|-------------------------|---|---|----------------|---|---|
| Joint pain or stiffness | Y | P | Weakness | Y | P |
| Arthritis | Y | P | Joint swelling | Y | P |
| Broken bones | Y | P | Backache | Y | P |
| Muscle spasms or cramps | Y | P | | | |
| Comments: | | | | | |

18. NEUROLOGIC

| | | | | | |
|----------------------|---|---|----------------------|---|---|
| Fainting | Y | P | Loss of memory | Y | P |
| Seizures/Convulsions | Y | P | Involuntary movement | Y | P |
| Paralysis | Y | P | Loss of balance | Y | P |
| Muscle weakness | Y | P | Speech problems | Y | P |
| Numbness or tingling | Y | P | | | |
| Comments: | | | | | |

19. ENDOCRINE

| | | | | | |
|--------------------------|---|---|--------------------|---|---|
| Heat or cold intolerance | Y | P | Excessive sweating | Y | P |
| Thyroid trouble | Y | P | Diabetes | Y | P |
| Excessive thirst | Y | P | Hypoglycemia | Y | P |
| Excessive hunger | Y | P | Hormone therapy | Y | P |
| Excessive urination | Y | P | | | |
| Comments: | | | | | |

20. ALLERGIC HISTORY

| | | | | | |
|-------------------------------|---|---|---------------------|---|---|
| Drug sensitivity | Y | P | Reaction to vaccine | Y | P |
| Other Allergies? Please list. | | | | | |

21. EMOTIONAL

| | | | | | |
|------------------------|---|---|--------------------|---|---|
| Depression | Y | P | Phobias | Y | P |
| Mood swings | Y | P | Alcohol/Drug abuse | Y | P |
| Anxiety or nervousness | Y | P | Insomnia | Y | P |
| Tension | Y | P | | | |
| Comments: | | | | | |

22. HOBBIES/HABITS

| | | | | | |
|---|---|---|------------------------------------|---|---|
| Do you eat three meals daily? | Y | N | Do you take vacations? | Y | N |
| Do you awake rested? | Y | N | Do you enjoy your work? | Y | N |
| Do you sleep well? | Y | N | Do you read? | Y | N |
| Do you average 6-8 hours sleep? | Y | N | How often do you exercise? | | |
| Do you use recreational drugs? | Y | N | Do you drink alcohol? | Y | N |
| # of times treated for drug dependence: | | | # of times treated for alcoholism: | | |
| What are your main interests and hobbies? | | | How much TV do you watch? | | |



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Name: _____ **Start Date:** _____

| | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
|---|--------|---------|-----------|----------|--------|----------|--------|
| Breakfast | | | | | | | |
| Lunch | | | | | | | |
| Dinner | | | | | | | |
| Snacks & Fluid Intake | | | | | | | |
| How do you feel today? (Mentally, Physically & Emotionally) | | | | | | | |

