

Vanessa Lee, BSc, ND

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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

Child's Name: _____ Date: _____

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

Address: _____

Phone: _____

Contacts (in order of preference)

Name: _____ **Relationship:** _____

Address: _____

Phone: _____ (h) _____ (w) _____ (c)

Name: _____ **Relationship:** _____

Address: _____

Phone: _____ (h) _____ (w) _____ (c)

Whom does the child live with? _____

How did you hear about us? _____

Other health care providers (Name, specialty):

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

What are the child's health concerns, in order of importance:

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





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Medical history

How is the child's health in general? Excellent Good Fair Poor

How was the child's health in the first year? Excellent Good Fair Poor Unknown

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

Please list any allergies (drugs, environmental, food, etc.):

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

Please list past prescription medications.

Which of the following has the child had? (0 – never, 1 – mild, 2 – average, 3 – severe)

- | | | |
|------------------------|------------------------|-----------------------|
| 0 1 2 3 Whooping cough | 0 1 2 3 Roseola | 0 1 2 3 Impetigo |
| 0 1 2 3 Measles | 0 1 2 3 Scarlet fever | 0 1 2 3 Mononucleosis |
| 0 1 2 3 Chicken pox | 0 1 2 3 Strep throat | 0 1 2 3 Rubella |
| 0 1 2 3 Mumps | 0 1 2 3 Ear infections | (German measles) |

How many times has the child had antibiotics? _____

Please indicate what immunizations you have had:

- | | | |
|---|--|--|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> "Flu" | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Polio | <input type="checkbox"/> Tetanus booster |
| <input type="checkbox"/> Other: _____ | | When? _____ |

Please describe any adverse reactions: _____

What screening tests have the child had (blood, hearing, vision, etc.): _____





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Prenatal health

What was the health of the parents at conception?

Mother Excellent Good Fair Poor Unknown

Father Excellent Good Fair Poor Unknown

How was mom's health during pregnancy? Excellent Good Fair Poor Unknown

Mother's age at child's birth? _____

How was mom's diet during pregnancy? Excellent Good Fair Poor Unknown

Did the mother receive prenatal medical care? Yes No Unknown

Did the mother experience any of the following during the pregnancy:

- Bleeding High blood pressure Nausea Vomiting
- Diabetes Thyroid problems Physical or emotional trauma

Others: _____

Did the mother use any of the following during the pregnancy?

Tobacco Alcohol Recreational drugs: _____

Prescription medications: _____

Over-the-counter medications: _____

Supplements: _____

Other: _____

Birth history

Term length: Full term Premature (by _____ wks) Late (by _____ wks)

Length of labour: _____ Weight at birth: _____

Any complications? _____

Type of birth: Vaginal C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?

Jaundice Rashes Seizures Birth injuries _____

Birth defects _____

Other _____





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Diet

How was the infant fed?

Breast fed (How long? _____) Formula. Milk/Soy/Other: _____

Does your child have any food allergies or intolerances? Please list.

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

Family history

Indicate if a close relative (parent, sibling) has had any of the following:

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Other	
Juvenile arthritis			

I don't know the family medical history

Do either of the parents have chronic illnesses? Yes No If yes, please describe:

Environment

Is the child in: school daycare home care other: _____

Is the child exposed to smoke? Yes No; Are there animals in the home? Yes No

Is the child regularly exposed to any toxins or other hazards (home, school, hobbies, etc.)?

How is the emotional climate of the child's home? _____

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:

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/Head injuries	Y	P	Dizziness	Y	P
Comments:					

4. EYES					
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
Comments:					

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

6. NOSE and SINUSES					
Frequent colds	Y	P	Hay fever	Y	P
Nose bleeds	Y	P	Sinus problems/Stiffness	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	Difficulty breathing	Y	P
Spitting up blood	Y	P	Pneumonia	Y	P
Wheezing	Y	P	Tuberculosis	Y	P
Asthma	Y	P	Tuberculin Test	Y	P
Bronchitis	Y	P	Date of Last Chest x-ray:		
Comments:					

10. CARDIOVASCULAR					
Heart disease	Y	P	Chest pain	Y	P
Murmurs	Y	P	Cyanosis	Y	P
Past ECG & Date	Y	P	Rheumatic fever	Y	P
Other heart tests & Comments:					

11. PERIPHERAL VASCULAR					
Leg cramps	Y	P	Extremity numbness	Y	P
Cold hands/feet	Y	P	Extremity coldness	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
Change in thirst	Y	P	Change in appetite	Y	P
Nausea	Y	P	Blood in stool	Y	P
Vomiting	Y	P	Rectal bleeding	Y	P
Vomiting blood	Y	P	Abdominal pain	Y	P
Hernias	Y	P	Black, tarry stool	Y	P
Jaundice (yellow skin)	Y	P	Diarrhea	Y	P
Gall Bladder disease	Y	P	Bowel movements (per day & per week)		
Liver disease	Y	P			
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

Review of Systems

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	Testicular pain	Y	P
Testicular masses	Y	P	Discharge or sores	Y	P
Comments:					

16. FEMALE REPRODUCTIVE

Age menses began			Last menstrual period		
Average number of days of bleeding			Length of cycle		
Bleeding between periods	Y	P	Painful menses	Y	P
Are cycles regular	Y	P	Excessive flow	Y	P
Comments:					

17. MUSCULOSKELETAL

Joint pain or stiffness	Y	P	Weakness	Y	P
Muscle spasms or cramps	Y	P	Joint swelling	Y	P
Broken bones	Y	P	Backache	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	Excessive urination	Y	P
Comments:					

21. EMOTIONAL

Depression	Y	P	Phobias	Y	P
Insomnia	Y	P	Tension, Anxiety, Nervous	Y	P
Comments:					



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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)							

