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Adult Package

Dear new patient/family,

Congratulations for putting your health first and for wanting to incorporate a naturopathic approach to supporting your health. This new patient package will get you ready to visit me in an effective way so I can do my best to assess and help you to improve your overall well being, or for your loved ones.

The principles of naturopathic medicine help guide my suggestions for you and include:

- Finding and treating the *cause(s)* of the problem
- Viewing each person as a *whole, unique person* – mind, body and spirit
- *Educate* to *prevent* occurrence or recurrence of problems, since prevention is the best treatment
- Recognizing and maximizing your own *innate healing ability*
- Encouraging you to take control of your own health

In making your appointment you have implied that you are ready to make some changes in your life to experience better health. Taking your precious time to fill out these forms will help me to understand what your goals and expectations are. All the information you share with me will be kept confidential and I am the only person who reviews the forms. If you are uncomfortable answering some of the questions, just leave them and we will discuss them during your visits.

After an initial visit, preliminary testing and examination I will develop a health program that will work for you, to optimize your health and healing ability. Note: just as we have great abilities to achieve goals in our lives, so does our body have the potential to heal and renew to great or improved health.

If you have to cancel or reschedule your appointment, please be considerate and phone the office with 24 hours notice to avoid the cancellation fee.

Our office is located at 305 Carrville Road, West of Yonge St, and East of Bathurst. Note that Carrville Road has two other names: "Rutherford Road" to the West and "16th Avenue" to the East. **When you arrive, please *angle-park* on the *left side* of the driveway. The office entrance is not at the front; walk to the entrance down the *right (West) side of the building* at the rear extension of the building – come through the double-door entrance and you will be in the waiting room.**

I sincerely thank you for sharing your important information and I look forward to working with you.
Dr. Rahim B. Habib BSc, ND

Included in this new patient package you will find:

- The Naturopathic Services Fee Guide – keep this page for your records
- The Patient Agreement – please have this signed before your first visit
- Adult Intake Form – please have this accurately filled for your first visit
- Consent regarding Personal Health Information
- Informed Consent to Assess and Treat – please sign at your first visit
- Food and Activity Diary – please have this filled and brought to your second visit

Note: make sure to provide your email address for informative articles and newsletters, information on upcoming events and new features to the clinic

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Naturopathic Services Fee Guide

NOTE: Naturopathic services may be covered under employee/extended health insurance plans.

All prices in Canadian dollars. Prices do not include the 13% H.S.T.	
Naturopathic Assessment & Examination (1st visit)	$225 (up to 90 min) Not including tests / treatments $140 – Colon Hydrotherapy Assessment
Examination Visit (2nd)	$95 (30 min)
Program Visit (3rd visit)	$140-185 (45 – 60 min)
Treatment Visits (also see below) See articles in binder and on website	$75 (up to 30 min), or as stated below -Acupuncture -Pulsed Electromagnetic Field Therapy (PEMF) – $50 -Vagus Nerve Stimulation therapy (with or without neurostim) - $50-140 -Colon Hydrotherapy - $125 per treatment -Oil-Dispersion Hydrotherapy - $125 -Far-Infrared Sauna Detox/Pain Therapy - $35 -Whole Body Vibration - $35 Other Treatments: -Injection Therapies – see below -Mind-Body Relaxation Session; Castor Oil Pack, Reflexology
15/30/45 /60 min Consultation OR Seasonal Assessment	$50 / 95 / 140 / 185
Annual Physical Exam	$140 (45 minute visit including brief consultation)
Injections -intradermal -intramuscular -intravenous (see article on injections)	-B-vitamin: (eg: B12, methylfolate, B-complex, B1 (thiamine)) - $30 -Mistletoe/Iscador/Helixor/Viscosan - $25 + vial package (material) cost *Intravenous: -Glutathione – small/regular/large -Myers IV 'Cocktail' (vitamins + minerals) -IV Vitamin C -other combinations based upon individual prescription *Total cost = pharmacy charge + IV materials + time to administer
Acute Care Visit (Eg: colds, flu, cough, rehab adjunct, etc.)	$50 per 15 minutes
Telephone Consultation	Same rate as above.
Home/Hospital Visit	$250/hr + travel/parking consideration (one hour minimum charge)
In-house Preliminary Testing	-Urine Dip (Vitamin C, acidity, glucose, infection screen) – $20 -Hair analysis (minerals + toxic metals) - $100, Hair Cortisol - $100
Laboratory Testing	Inquire regarding prices on additional tests, eg: blood, urine, saliva, stool: Eg: Urine Organic Acids (vitamins, energy, neurotransmitters, toxicity) Eg: Stool analysis (yeast/bacteria, digestion, absorption, inflammation) Eg: Blood tests for hormones, autoimmunity and neuro-inflammation Eg: Food sensitivity test

Programs Offered:

□ Alzheimer's / Cognitive	□ Cancer Support	□ Detoxification	□ Holistic Stop Smoking
□ Immune Balancing	□ Mental-Emotional	□ Pain & Fibromyalgia	□ Hormone Balance
□ Bowel / Digestive Health	□ Weight Management-Metabolic Diet Program		□ Autism-ADHD Spectrum

Nutritional, Botanical & Homeopathic Preparations and Supplements

Cost is based upon individual prescription. For your convenience, supplements are available for purchase here at the clinic or at reduced prices online at https://ca.fullscript.com/login/rhabib. They may be purchased from other medical supply, pharmacies, or health food stores. Items may be shipped anywhere in North America by courier (shipping charge applies).

NOTE: Phone/Online-Virtual Consultations are Available

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Patient Agreement with Four Seasons Naturopathic Wellness

To my patients:
For us to provide you with the best naturopathic care possible, and to get you better as quickly as possible, we feel that you should be involved and informed. The following outlines the details about your treatment.

Appointments:
Appointments should be made and/or confirmed at the end of each visit. Your next appointment will be recorded on a card or at the bottom of your receipt or treatment plan for easy reference – please record the date where you know you'll see it, such as on your calendar/organizer.

Lateness, Cancellations & No Shows:
Please give at least 24 hours notice should you need to cancel or change your appointment. Failure to cancel or change your appointment in a timely manner will result in a charge equivalent to the amount of time booked. Unfortunately, patients who are late for their appointments cannot be guaranteed treatment for that day although best efforts will always be made.

Treatment Program/Schedule:
Your treatment program has been designed specifically to maximize your recovery. It is in your best interest to adhere to your treatment program/schedule we have created together. Failure to do so may slow your progress or response to treatment. If you have concerns with the program, please discuss it with me for clarification or options.

Payments:
Naturopathic services are not covered by the provincial Ontario Health Insurance Plan (OHIP) and you are responsible for the full payment at the end of each visit. Please note that this policy applies to all individuals, including WSIB and Motor Vehicle accident patients. Payment options include Cash, Cheque, VISA, or Mastercard. Make cheques payable to "Dr. Rahim Habib ND" or "Four Seasons Naturopathic Clinic for Detoxification & Healing." Fortunately, more and more private/employee insurance plans are covering naturopathic services – please check to see whether your plan covers it, or bring it in for us to review it with you.

Treatment Costs:
Refer to the Naturopathic Services Fee Guide in your new patient package, or ask for a copy.

Agreement:
"I clearly understand that Dr. Rahim Habib ND is not a medical doctor, but a naturopathic doctor, a specialist in natural therapeutics. I also understand that his philosophy of medicine and treatments may not be accepted by my MD, pharmacist, dietician, or nurse and this is acceptable to me. I acknowledge that I have read and understand this agreement, and guarantee full payment for all services that I receive. I also understand that any unpaid balance is subject to a 1.5% charge per month on the outstanding balance."

_____	_____	___/___/_____
Patient/Guardian/POA* Signature	Printed Patient Name	Date (mm/dd/yyyy)

Dr. Rahim B. Habib N.D. or Representative Signature

***POA = power of attorney for personal/health care decisions (not for property)**

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NATUROPATHIC INTAKE FORM – ADULT

The information requested is personal, yet crucial to your proper full assessment.
All information is kept confidential unless you indicate otherwise.

Full Legal Name: _____ Today's Date: _____

Date of Birth: (mm/dd/yy)____/____/_____ Age: ____ Legal Sex: M F Gender identity/pronoun: _____

Marital Status: _____# of Children & Ages:_____ Form completed/assisted by : _____

Complete Address: _____

City: _____Postal Code: _____

You Live with: _____

Tel #s: Home (___)_____ Work (___)_____ Cell (___)_____

Email Address: _____ May we email you? (clinic updates, newsletter) Yes No

Occupation(s): _____ Current Hours Working / Week: _____

Employer + Address: _____

Emergency Contact Name: _____Relation: _____ Tel: (___)_____

Emergency Contact Address: _____

Power of Attorney for Personal/Health Care Name and Address: _____
(not for Property)

Other Current Health Care Providers (name, occupation, phone & fax number, address): Initials:

1. _____ ☐

2. _____ ☐

3. _____ ☐

Please initial in the boxes (above right), which health providers we have your permission to contact

How did you hear about us?
□ Google:_____ □ Brochure □ Article: _____ □ Fair _____
□ Seminar:_____ □ Directory:_____ □ Word of Mouth
□ Social Media: _____ □ Other: _____

Source of Referral (eg: articles, friends, health provider, etc.) _____

Do your employee benefits or extended health care plan cover naturopathic services (may be listed under 'Paramedical Services')? Yes No

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CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires.

Why did you choose to come to this clinic?

What do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?
1.
2.
3.

What *long term* expectations do you have from working with our clinic?

What is your role or responsibility in your health care?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your symptoms/condition that relate to your lifestyle? Rate from 0 to 10, (10 = 100% committed).

0% Commitment	0	1	2	3	4	5	6	7	8	9	10	100% Commitment

a) If below 8/10, what will it take to increase your level of commitment?

What behaviours or lifestyle habits do you currently regularly do that you believe improves your health?

What behaviours or lifestyle habits do you currently regularly do that you believe are harmful to your health?

What are your top three priorities or values in your life presently?
1. 2. 3.

What resources do you *currently* allocate to your health and well being? ie, how much time, money and energy do you invest in your health right now? And, how much time, money, and energy are you *willing* to invest in your health?

What potential obstacles do you foresee in addressing the lifestyle factors which may undermine your health, and in adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

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LIFE WELLNESS BALANCE

'Wellness' is a balance of many factors. Circle the number which reflects the level of your satisfaction in each area of your life. For example, if you are 60% satisfied in your career, circle the number 6 in the career line.

Career	0	1	2	3	4	5	6	7	8	9	10
Money	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10
Fun & Recreation	0	1	2	3	4	5	6	7	8	9	10
Personal & Spiritual Growth	0	1	2	3	4	5	6	7	8	9	10
Family & Friends	0	1	2	3	4	5	6	7	8	9	10
Physical Environment	0	1	2	3	4	5	6	7	8	9	10
Significant Other/Romance	0	1	2	3	4	5	6	7	8	9	10

CHIEF HEALTH CONCERNS

Please list *in order of priority*, your most important health concerns

#	Health Concern	Date Experienced Since	Suspected Cause(s) and Associations
1			
2			
3			
4			
5			

PAST MEDICAL HISTORY

Level of Health as an Infant:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Level of Health as a Child:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Level of Health as an Adolescent:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Level of Health as an Adult:	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Level of Health as a Senior:	☐ Excellent	☐ Good	☐ Fair	☐ Poor

IMMUNIZATIONS/VACCINATIONS – It is important to know if you had any reactions to your vaccinations, even as a baby.

Immunization/Vaccination	When	Effects if Any
DPT (Diptheria, Pertussis, Tetanus)		
Polio		
MMR/V (Measles,Mumps,Rubella,Varicella)		
Influenza ('flu shot')		
Hepatitis B		
Pneumococcal Vaccine		
Haemophilus B		
Rotavirus		
Human Papilloma Virus (HPV)		
COVID-19 (Types:_____)		
Other(s)		

DENTAL PROCEDURES

Please check which dental procedures you have had and approximately when they were performed

☐ Cavity Fillings_____& Type of Filling Material:_____

☐ Root Canal_____ ☐ Wisdom Teeth Removal_____ ☐ Extraction_____

☐ Bridge_____ ☐ Mercury Amalgam Replacement _____ ☐ Crown_____

☐ Other (please specify, eg: gum disease, abscess, etc.): _____

OPERATIONS, MAJOR INJURIES, HOSPITALIZATIONS (include even mild head injuries)

What	When	Results/Long Term Effects

SCREENING TESTS

Check any screening test you have had in the past 5 years; provide the approximate date of the test.

☐ Blood Test_____ ☐ Urine Test_____ ☐ PAP Smear_____ ☐ Stool Sample_____

☐ Tuberculin Test_____ ☐ Allergy Test_____ ☐ ECG_____ ☐ Rectal Exam_____

☐ Mammogram_____ ☐ Prostate Exam_____ ☐ Hair Analysis_____ ☐ Enterro/VEGA Test_____

☐ Bone Density_____ ☐ Other (specify name)_____

Tests showing significant results:_____

CURRENT MEDICAL HISTORY

FOOD AND LIFESTYLE

Examples of Typical Daily Food:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Number of times you go out to eat each week: _____ Food/beverage restrictions:_____

List any foods/beverages you feel you react to: _____

How do you feel/react after eating? _____

Which of these substances are you currently taking: ☐Tobacco ☐Caffeine ☐Alcohol ☐Recreational Drugs

# of antibiotic treatments & approximately which dates? _____

Please describe any toxins or other work hazards you are/*were* regularly exposed to (work, home, hobbies, cottage, community, etc.): _____

What pets do you have, or used to have?: _____ Your last time out of the country: _____

# of times per week you exercise: _____ Which types and for how long? _____

Hobbies: _____ Rate your *current* level of health (10 is the best): 1 2 3 4 5 6 7 8 9 10

How many times per week do you take time to relax? Describe: _____

Hours of TV/games each day _____ Hours of computer/smartphone/tablet use each day _____ ☐ WIFI use (wireless)
How many hours of sleep do you get each night? ____ Rate your sleep: ☐Poor ☐Fair ☐Good ☐Excellent
Describe a typical day for you: _____

ILLNESSES YOU CURRENTLY HAVE OR MAY HAVE HAD AND WHEN:
Please check the appropriate box on the left side of the symptom/illness, write in the date you have had it since (mm/yyyy)

	Abscess/Infection		Depression		Inflam. Bowel Dz.		Prostate disease
	Abuse		Dementia (eg: Alzheimer's)		Jaundice		Rheumatic Fever
	Abortion		Diabetes (Type I/II)		Kidney Disease		Rubella
	Alcoholism		Ear Infection		Lyme Disease		Scarlett Fever
	Anemia		Emphysema		Malaria		Shingles
	Anxiety		Epilepsy		Measles		Skin Disease
	Arthritis		Epstein-Barr Virus		Meningitis		Stroke
	Asthma		Eye disease		Miscarriage		Strep Throat
	↓ / ↑Blood Pressure		Fibromyalgia		Mononucleosis		Syphilis
	Breast Disease		Flu – freq/chronic		Multiple Sclerosis		Testicular Disease
	Calcification		Gonorrhea		Mumps		Tonsilitis
	Cancer(s)		Gout		Ovary disease		Tuberculosis
	Chicken Pox		Gallstones		Parkinson's Dz		Typhoid Fever
	Chronic Fatigue		Hayfever		Peritonitis		Ulcers
	Cold Sores		Heart disease		Pelvic Inflam. Dz.		Warts
	Colds – freq/chronic		Hepatitis		Pleurisy		Whooping Cough
	Cysts		Herpes		Pneumonia		Worms
	Cytomegalovirus (CMV)		Hernia		PMS		Yellow Fever

Any other minor/major illnesses, head injuries?_____

Are there any of the above illnesses *after which you have never been totally well since*, or which have been more severe than usual? Which ones? Please describe: _____
_____

FAMILY HISTORY
Specify if any of the above listed illnesses currently affects, or has led to the death of any of your family members?

Relation	Condition	Age of Onset	Current Age / Age Deceased
Mother			/
Father			/
Brother/Sister			/
Brother/Sister			/
Uncle/Aunt			/
Uncle/Aunt			/
Maternal Grandmother			/
Maternal Grandfather			/
Paternal Grandmother			/
Paternal Grandfather			/

What is/are your ethnic-cultural background/s?_____

ALLERGIES (medications, environmental, food, other; include items you feel you are sensitive to, underline anaphylactic):
_____
_____

CURRENT / RECENT PRESCRIPTION MEDICATIONS

Medications	Condition	Date Taken Since	Adverse Effects

OVER THE COUNTER MEDICATIONS
Do you take any of the following (circle):
Acid-blocking Antacids Anti-histamine Birth control Laxatives Pain relievers Cortisone

OTHER TREATMENTS YOU ARE CURRENTLY TAKING
(Eg: supplements, herbs, different therapies such as chiropractic, massage, Chinese, homeopathy, physiotherapy, etc)

Treatment & Amount/Frequency	Condition	Date Taken Since	Results

Other care you are receiving (eg: personal support worker, home nursing/medical, etc.); _____
_____

PSYCHOSOCIAL
Have you ever been abused? Yes No ☐Physically ☐Mentally ☐Sexually ☐Other:_____
Rate your social interactions with your:

Family	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Friends	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Work mates	☐ Excellent	☐ Good	☐ Fair	☐ Poor

How would you describe the emotional climate of your home?_____
_____

List your top stressors (eg: work relationships, traffic, fears…), and rate their intensity from 1-10 (10=very frequent or the effects are severe). _____
_____
_____

Describe a perfect day: _____
_____
_____

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REVIEW OF SYSTEMS

GENERAL
What is your weight now?_____ Weight one year ago?_____ Maximum weight?_____ Ideal weight?_____
Circle your energy level on the scale from one to ten (10 feeling the best): 10 – 9 – 8 - 7 – 6 – 5 – 4 – 3 – 2 - 1
How is your body temperature? ☐Cold ☐Warm ☐ Hot ☐Fine
Where do you seem to store your tensions? (eg: head, neck, etc.)_____
Where do you currently experience pain/discomfort/weakness on or in your body? _____
_____

SKIN
Have you noticed any changes in your skin, nails, or hair lately? Yes No
Specify any concerns below:
☐ Color ☐ Rashes ☐ Lumps ☐ Moles ☐ Scaling ☐Ridges/Spots ☐ Swelling
☐ Sores ☐ Itching ☐ Dryness ☐ Pain ☐Symmetry ☐ Distribution
Other_____

HEAD
How often do you get headaches? _____ Rate their severity from 1 - 10 (ten is most severe): _____
When did they first start? _____ Is the discomfort on one side, or both? (please circle)
Is the discomfort throbbing or steady? (circle) Any mild/major head injuries? Dates: _____
Do you experience nausea or vomiting or other symptoms in association with the headache? Specify_____
Does coughing, sneezing, or changing the position of your head affect the headache? _____

EYES
Do you wear glasses or contact lenses? Yes No Since when?_____
When was your last eye test? _____
Specify any concerns with your eyes or vision below:
☐ Blurry Vision ☐ Specks/Spots ☐ Sudden Visual Loss ☐ Watery Eyes ☐ Light Sensitivity ☐Dry Eyes
☐ Pain ☐ Flashes ☐ Redness ☐ Double Vision ☐ Discharge ☐Itchy
Other _____

EARS
Please rate your hearing: ☐Excellent ☐Good ☐Fair ☐Poor
How much exposure do you have to noise? ☐High ☐Moderate ☐Average ☐Low
Specify any concerns with your ears/hearing/balance below:
☐ Earache/Pain ☐ Lack of Balance ☐ Dizziness ☐ Infections Other_____
☐ Ringing ☐ Hearing Loss ☐ Discharge ☐ Itchy _____

NOSE & SINUSES
How many colds & flus do you get each year? _____ How long do they last? Few days 1 week Longer
Specify any concerns below:
☐ Runny Nose ☐ Sneezing ☐ Pain ☐ Nose Bleeds ☐ Sinus Pain/Headache
☐ Stuffed-up Nose ☐ Itching ☐ Tenderness ☐ Post-nasal Drip ☐ Recurrent / Chronic Infections
Other_____

MOUTH, THROAT AND NECK
If you know, are your respiratory infections mostly viral/bacterial/fungal? (circle) [Eg: sore throat, bronchitis, pneumonia,..]
Specify any concerns below:
☐ Bleeding Gums ☐ Sore Throat ☐ Stiffness ☐ Goiter (Enlarged Thyroid Gland)
☐ Sore Tongue ☐ Hoarseness ☐ Color Change ☐ Sores on Tongue/Lips/Mouth
☐ Cough ☐ Wheezing ☐ Lumps in Neck
Other_____

BREASTS
Do you have your breasts examined? Yes No By whom? ☐ Doctor ☐ Self ☐ Other How often?_____
Specify any concerns below:
☐Pain ☐Lumps ☐Discomfort ☐Discharge from Nipples ☐Breast Tenderness ☐Self Examination
Other_____

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CHEST
Does your heartbeat feel as if it is “skipping”, “racing”, “fluttering”, “pounding”, or “stopping”? Yes No
Specify any concerns below:
☐ Discomfort ☐ Difficulty Breathing ☐ Swelling (feet/waist/head) ☐ Spit up Blood
☐ Pain ☐ Wheezing Breath ☐ Difficulty Breathing Lying Down ☐ Chronic Cough
☐ Difficulty Breathing at Night ☐ Pain on Exertion ☐ Colds Move to Lungs
Other_____

DIGESTIVE SYSTEM
How often do you get bowel movements each week?_____
Specify any concerns below:
☐ Difficulty Swallowing ☐ Heartburn ☐ Bloating ☐ Nausea ☐ Diarrhea
☐ Pain on Swallowing ☐ Frequent Belching ☐ Flatulence ☐ Smelly Stools ☐ Vomiting Blood
☐ Abdominal Pain ☐ Low/High Appetite ☐ Regurgitation ☐ Blood in Stool ☐ Straining to defecate
☐ Change in Thirst ☐ Change in Appetite ☐ Vomiting ☐ Rectal Bleeding
☐ Hemorrhoids ☐ Constipation ☐ Red/Black/Yellow/Gray Stools (circle)
Other_____

URINARY SYSTEM
Specify any concerns below:
☐ Urinary Urgency ☐ Involuntary Urination ☐ Frequent Urination ☐ Inability to Urinate ☐ Kidney disease
☐ Pain on Urination ☐ Excess Urination ☐ Blood in Urine ☐ Dark/Reddish Urine
☐ Burning During or After Urination ☐ Frequent Bladder Infections
How often do you wake at night to urinate? ☐Never ☐Once ☐ Twice ☐ Three times ☐ Other _____
Other concerns:_____

GENITAL SYSTEM - FEMALE
Age at first menstruation _____
When did your last two periods start (when flow starts)? 1)_____2)_____
Average length of your menstrual cycle in days _____ How long does your menstrual flow last?____days
Are your periods regular or irregular? ☐Regular ☐Irregular
Have you stopped menstruating? Yes No If so, when did it stop?_____
What sexual orientation are you?_____
Are you sexually active? If so, for how long? _____
Have you maintained an interest in sex? Yes No Are you able to reach climax? Yes No
Do you get sexually aroused? Yes No Are you satisfied with your sex life? Yes No
Number of Pregnancies and When: _____
Have you ever had a miscarriage? Yes No Have you ever had an abortion? Yes No
Types of birth control you use(d), and for how long:
☐ Rhythm Method ☐ Condoms ☐ Spermicidal Foam ☐ IUD Time Length / Other _____
☐ Oral Contraceptive ☐ Diaphragm ☐ Temperature & Cervical Mucus _____
Specify any concerns below:
☐ Bleeding Between Periods ☐ Pain Before/During Periods ☐ Irregular Periods ☐ Increased Flow
☐ Bleeding After Intercourse ☐ Absence of Periods ☐ Spotting ☐ Vulvar Sores/Lumps
☐ Vaginal Discharge ☐ Vaginal Itch ☐ Painful Intercourse ☐ Pelvic Infection(s)
☐ Post-Menopausal Bleeding ☐ Hot Flushes/Night Sweats ☐ Sexually Transmitted Infections
Please list any other concerns you have:_____
_____

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GENITAL SYSTEM - MALE
What sexual orientation are you?_____
Are you sexually active? If so, for how long? _____
Have you maintained an interest in sex? Yes No Are you able to reach climax? Yes No
Do you get sexually aroused? Yes No Are you satisfied with your sex life? Yes No
Specify any concerns below:
☐ Penile Discharge ☐ Scrotal Swelling/Pain ☐ Inability to Ejaculate ☐ Prostate Disease
☐ Penile Sores/Growths ☐ Premature Ejaculation ☐ Impotency ☐ Uncircumcised Penis
Types of birth control you use(d), and for how long: _____
Please list any other concerns you have:_____
_____

EXTREMITY CIRCULATION
Do your fingertips change color in the cold? Yes No
Specify any concerns below relating to your arms and hands, or legs and feet:
☐ Numbness ☐ Swelling ☐ Redness ☐ Tenderness ☐ Ulcers ☐ Cold Hands/Feet
☐ Leg Cramps ☐ Pain ☐ React to Cold ☐ Slow Healing
Other_____

MUSCULOSKELETAL SYSTEM
Specify any concerns below:
☐ Joint Pain ☐ Joint Stiffness ☐ Redness ☐ Limited Motion ☐ Neck Pain
☐ Joint Swelling ☐ Joint Warmth ☐ Muscle Pain ☐ Backache ☐ Broken Bones
☐ Weakness ☐ Numbness/Tingling ☐ Poor posture ☐ Muscle Spasms/Cramps

Other_____

NERVOUS SYSTEM
Have you ever fainted or passed out? Yes No
Have you ever had a seizure, or any fits or convulsions? Yes No
Do you feel weakness of any part of the body? Yes No
Are you unable to move a specific body part? Yes No
What are you sensitive to: ☐Noise ☐Smells ☐Taste ☐Touch ☐ Visual/Sights ☐Electrical items/appliances
Specify any concerns: ☐ Trembling ☐ Numbness ☐ Prickling sensation ☐ Restlessness of Legs
☐ Shakiness ☐ Tingling ☐ Burning/Feeling of warmth ☐ Poor fine-motor skills
Other_____

BLOOD AND LYMPHATICS
Have you ever needed a blood transfusion? Yes No If so, when and why?_____
Blood Type: ☐A ☐B ☐AB ☐O ☐ Rh Positive ☐ Rh Negative
Specify any concerns below:
☐ Anemia ☐ Lymph Node Swelling ☐ Bleed Excessively /Bruise Easily ☐ Auto-immunity ☐ Poor Immunity
Other_____

ENDOCRINE SYSTEM
Specify any concerns below:
☐ Hormone Therapy ☐ Excessive Sweating/flushing ☐ Low Blood Sugar ☐ Sleep Problems
☐ Excessive Thirst ☐ Mood/Energy Level Changes ☐ High Blood Sugar ☐ Excessive Hunger
☐ Excessive Urination ☐ Altered sexual interest/function ☐ Altered Hair Growth / Skin Texture
Other_____

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MENTAL-EMOTIONAL

Do you express your emotions easily? Yes No

How comfortable are you in intimate relationships? Poor Fair Good Excellent

Any difficulty in socializing? Describe: _____

Your most traumatic events in your life, & when: _____

_____

_____

Have you ever had psychiatric/psychological or alternative forms of counseling? Specify:_____

Specify any concerns below:

☐ Memory ☐ Worrier ☐ Easily Angered ☐ Overly Self-conscious ☐ Isolation/Avoid People

☐ Sad/Low Mood ☐ Fears ☐ Anxiety/Nervousness ☐ Sleep Problems ☐ Aggressive/Disruptive

☐ Mood Swings ☐ Tension ☐ Addictions (internet, food, smoking, drugs, etc.) ☐ Paranoid/Suspicious

☐ Inattentive ☐ Disorganized/Messy ☐ Performance Anxiety ☐ Poor concentration ☐ Difficulty with Instructions

☐ Obsessive ☐ Inflexible Routine ☐ Physically Hits/Kicks ☐ Ritualistic/compulsive behaviours

☐ Self-injury ☐ Oppositional ☐ Hand gestures ☐ Withdrawn ☐ Verbally hurtful ☐ Destructive ☐ Hyperactive

Other_____

Describe your personality:_____

_____

_____

CONNECTEDNESS / SPIRITUAL

Do you have some form of religious/spiritual practice or sense of connection with the world ? Yes No

Describe:_____

_____

Do you consider yourself well grounded?	Never	Seldom	Often	Always
Rate your ability to acknowledge and express your feelings	Poor	Fair	Good	Excellent
How would you rate your ability to manifest your will?	Poor	Fair	Good	Excellent
How often do you feel happy?	Never	Seldom	Often	Always
Rate your ability to communicate your ideas	Poor	Fair	Good	Excellent
Are you able to plan and project for the future?	Never	Seldom	Often	Always
Do you meditate or have strong spiritual experiences?	Never	Seldom	Often	Always
Are you consciously aware of your thoughts, actions, motives, and the consequences of your actions?	Never	Seldom	Often	Always
How often do you experience a sense of profound unity with the world/universe or a higher power?	Never	Seldom	Often	Always

OTHER IMPORTANT INFORMATION

Is there anything you feel is important, that you feel has not been covered? Please specify (continue on the back or on separate paper as necessary): _____

_____

Thank you. We look forward to helping you in any way we can.

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STATEMENT OF INFORMATION PRACTICES

Also posted in reception binder

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 to **Four Seasons Naturopathic Wellness** 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:

- treat and care for you,
- get payment for your treatment and care (from WSIB, your private insurer or others),
- plan, administer and manage our internal operations,
- conduct risk management and quality improvement activities,
- teach,
- conduct research,
- compile statistics,
- comply with legal and regulatory requirements, and
- fulfill other purposes permitted or required by law.

Your Choices

You may access and correct your personal health records, or withdraw your consent for some of the above uses and disclosures by contacting us (subject to legal exceptions).

Important Information

- 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.
- We take steps to ensure that everyone who performs services for us protect your privacy and only use your personal health information for the purposes you have consented to.

How to Contact Us

Our privacy contact person is Dr. Rahim Habib, Naturopathic Doctor.

For more information about our privacy protection practices, or to raise a concern you have with our practices, contact us at:

Four Seasons Naturopathic Wellness

305 Carrville Rd, Richmond Hill, L4C 6E4

T: 905-597-7201 F: 905-597-7204

admin@familynaturopath.ca

You have the right to complain to the Information and Privacy Commissioner/Ontario if you think we have violated your rights. The Commissioner can be reached at:

Information and Privacy
Commissioner/Ontario
2 Bloor Street East
Suite 1400
Toronto, Ontario
M4W 1A8

1-800-387-0073

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

I, _____, have reviewed **Four Seasons Naturopathic Wellness'**s written statement
(Patient/Guardian/POA* Name)

concerning the collection, use and disclosure of personal health information.

I understand that **Four Seasons Naturopathic Wellness** is seeking my consent for it to collect, use and/or disclose my personal health information from me or from the person acting on my behalf to (indicate YES or NO):

_____ disclose personal health information to an insurance provider to obtain payment

_____ conduct patient satisfaction surveys

_____ conduct research (patient identity is private)

_____ teach outside Four Seasons Naturopathic Wellness (patient identity is private)

I understand that **Four Seasons Naturopathic Wellness** will only collect, use and disclose my personal health information with my consent **[as set out in its privacy policy]** 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 writing to Dr. **Rahim Habib, Naturopathic Doctor.**

I hereby authorize **Four Seasons Naturopathic Wellness** to collect, use and disclose my personal health information for the purposes that I have indicated above.

Name: _____

Signature: _____ Date: _____

*POA = power of attorney for personal/health care decisions (not for property)

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Informed Consent to Assessment and Treatment

I hereby request and consent to the performance of physical, functional, and/or vocational assessment/treatment procedures on me by the service provider(s) identified below and/or anyone working as a Naturopathic Doctor, or for the naturopathic doctor at the Four Seasons Naturopathic Clinic for Detoxification and Healing. I have been informed about the following:

- What the assessment/treatment is;
- Who will be performing the assessment/treatment;
- The reasons why I should have the assessment/treatment;
- The alternatives to having the assessment/treatment;
- What might happen if I do not have the assessment/treatment; and
- What potential risks and/or side effects exist for the proposed assessment/treatment

By consenting to assessment/treatment, you are authorizing access to your file, personal information, and authorizing payment of services and tests given. Please ask to review the privacy policy if you have questions about the use of your personal information.

Even the gentlest therapies have their risk of complication in certain physiological conditions such as pregnancy, lactation, in patients who are very young/very old, or in people who take multiple medications, or in patients with severe or very longstanding conditions. Some therapies must be used with caution in certain diseases such as diabetes, lung, heart, liver, or kidney disease. It is very important that you are completely open in informing your naturopathic doctor of any disease process currently going on in your body, congenital and genetic issues, and if you are on any prescription medication or over-the-counter (OTC) drugs. If you are pregnant, suspect you are pregnant, or you are breast-feeding, please inform your naturopathic doctor immediately.

There are some slight health risks to naturopathic treatment. Theses include, but are not limited to the following:
-aggravation of pre-existing conditions or symptoms
-allergic reactions to supplement or botanical (herbal) preparations
-pain, bruising, or injury from venipuncture or acupuncture
-fainting, organ puncture with acupuncture needles, accidental burning of the skin from the use of moxa
-muscle strains, sprains, disc injuries, stroke/emboli from spinal vertebral manipulation

I understand that my naturopathic doctor keeps a record of services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that my identity will be protected and kept confidential.

I understand that the results of naturopathic treatment are not guaranteed. I do not expect my naturopathic doctor to be able to anticipate and explain all risks and complications. I will rely on my naturopathic doctor to exercise good judgment in my best interests, based on the facts and findings then known. With this knowledge, I voluntarily consent to a physical exam, indicative, diagnostic, and therapeutic procedures, except for (please list): _____.

I understand the explanations and have no further questions. My consent is voluntary and I intend this consent form to cover the entire course of assessment/treatment for my present condition, and future conditions, commencing on the date indicated below. I understand that I may ask questions at any time and that I am free to withdraw this consent in writing, at any time, except for actions already taken.

Informed Consent to Assessment and Treatment Patient Name: _____

_____	_____	_____	_____
Guardian/POA Name	Patient/Guardian/POA Signature	ND Signature	Date (mm/dd/yyyy)

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3-Day Consumption & Activity Diary **Name:**_____ **Date:**_____

Time of Day	Day 1	Day 2	Day 3	Notes on your Routines and Patterns
Energy (1-10) & Lows				
Daily Over-view				

Instructions: list ***all*** items you consume/chew/drink under each 24 hour day column (don't forget night snacks!), include condiments, the time you eat/drink & item sizes (cups/tsp/oz/g/ml). Include times you actually feel hungry. Ex: 2pm - medium baked potato with 3 tsp sour cream with pinch of chives & salt. Write your routines (eg: 6am wake, shower, make breakfast, 8am eat at work, noon 30 min aerobics, etc) & eating patterns for the week. Rate your average daily energy level out of 10, & time(s) of low energy. Under daily overview write time and type of: exercise, sleep quality, digestion & bowel movements, emotions, stress and triggers & other signs from your body.

Bowel Transit Time Test: eat a half cup serving of corn/peas with a meal, note the time you ate it, & then the time you notice the corn/peas in your stool.