Natalie Engelbrecht ND #812, Naturopathic Doctor
Westside Natural Health Clinic - 114 Westside Drive, Oakville, ON, L6K 1P3 - 905-845-4994
westsidehealthclinic@sympatico.ca - www.wnhc.ca

Westside Natural Health Clinic Introduction Letter

Thank you for choosing Westside Natural Health Clinic to help you with your health needs. We are here to help in any way possible achieve your wellness goals. If you have any questions, please feel free to ask.

Enclosed is a new patient information packet which contains:
1) Medical History and Intake forms
2) Patient Payment Responsibility
3) Acknowledgment of Receipt of Notice of Privacy Practices
4) Consent to treat for Naturopathic Medical Services.

All of these forms need to be filled out completely to the best of your ability and signed.

Please bring in any and all medications, vitamins or supplements you are currently taking. If you have any questions, please ask!

Please bring a copy of any lab work that you have had in the last 24 months, including blood work, MRI, bone density, ultrasounds, CAT scans etc.

Please give 24 hours notice to cancel an appointment. There is a $60.00 missed appointment fee per 25 minutes missed.

If you have any questions please feel free to contact the office during our office hours.
Tuesday 9am to 3pm
Wednesday 9am to 3pm
Thursday 11am to 6pm (alternate weeks 12pm to 7pm)
Friday 9am to 3pm.
We are closed from 12pm-1pm for lunch except for Thursdays when we are closed 3pm-4pm
Any changes in scheduling will be noted on the phone message.

We also ask that you please not wear any perfume or strong smelling lotions, as these can be irritating to those sensitive to fragrances. Thank you.

We ask that you please review the website www.wnhc.ca prior to you appointment.

Please write your name and date on the bottom of each sheet of your intake as indicated.

Yours in Health,

Natalie Engelbrecht ND
Naturopathic Doctor

Name: Date:

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Health History Questionnaire

SUCCESSFUL HEALTH AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE DOCTOR HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Name	
Date	
Address -City, Province, Postal Code	
Telephone - Home	
Telephone - Work	
Telephone - Cell	
E-mail	
How did you hear about the clinic?	
Have you had Naturopathic care before? When?	
Occupation?	
Date of Birth? Age?	
Marital status?	
Emergency contact? Relationship? Phone number?	
Are you currently receiving health care? From whom? For what reason?	

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Name	
What are your main health concerns? List in order of importance:	1 2 3 4 5
Do you have any known contagious diseases at this time? If yes what?	

Family History

Answer or Check if applicable:	**Father**	**Mother**	**Brother**	**Sister**	**Spouse**	**Child**	**Child**
Age (if living)							
Health(G=good/P=poor)							
Age at death & Cause							
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
Stroke							
Epilepsy							
Mental Illness							
Asthma/Hay fever/Hives							
Anemia							
Kidney Disease							
Glaucoma							
Tuberculosis							

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For all the following sections please write Y, P or N on the line:
Y= a condition you have now, **P**= a condition you have had in the past, **N**= never had

Childhood Illness	YNP	Childhood Illness	YNP	Childhood Illness	YNP
Scarlet Fever		Diphtheria		Measles	
Mumps		Rheumatic fever		German measles	

Hospitalizations and Surgery

What hospitalizations or surgeries have you had?

_____Date:_____
_____Date:_____
_____Date:_____
_____Date:_____

X-Rays and Special Medical Tests

X-rays, CAT scans, or other medical tests you have had:

_____Date:_____
_____Date:_____
_____Date:_____
_____Date:_____

Electrocardiogram?_____Date:_____
Electroencephalogram?_____Date:_____

Immunizations	YNP	Immunizations	YNP	Immunizations	YNP
Polio		Measles		Diphtheria	
Tetanus		Pertussis		Other? What?	

Allergies

Are you hypersensitive or allergic to:
Any drugs?_____
Any foods?_____
Any environmental?_____
And please specify.

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Current Medications & Type	YNP	Current Medications & Type	YNP	Current Medications & Type	YNP
Laxatives		Prednisone		Appetite suppressant	
Cortisone		Birth Control & type		Thyroid medication	
Tranquilizers		Pain Relievers		Hormone Replacement	
Antacids		Antibiotics		Sleeping pills	
Antidepressants		Blood pressure		Other	

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking now.
1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____

Typical Food Intake

Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Drinks:_____
Foods you crave:_____
Foods you dislike:_____
Foods you are allergic/sensitive to:_____

Do you eat margarine? Y N How often?
Do you eat aspartame? Y N How often?
Do you eat brown rice? Y N How often?
Do you eat leafy greens? Y N How often?
Do you eat additives? Y N How often?
Do you eat dyes? Y N How often?
Do you eat gluten? Y N How often?
Do you eat dairy? Y N How often?
Do you have coffee? Y N How often?

General

Height:_____ Weight:_____ Weight 1 yr ago:_____
Max Weight: When:_____
When during the day is your energy the best?_____
The worst?_____

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Mental/Emotional	YNP	Mental/Emotional	YNP	Mental/Emotional	YNP
Treated for emotional problems		Anxiety		Memory problems	
Depression		Mood swings		Tension	
Poor concentration		Considered suicide		Phobias	

Endocrine	YNP	Endocrine	YNP	Endocrine	YNP
Hypothyroid		Diabetes		Hypoglycemia	
Excessive thirst		Fatigue		Excessive hunger	
Heat/cold intolerance		Seasonal Depression		Hyperthyroid	

Immune	YNP	Immune	YNP	Immune	YNP
Vaccinations		Reactions to Vaccinations		Chronic fatigue syndrome	
Chronic infections		Chronically swollen glands		Slow wound healing	
HIV		Scarlet fever		Rubella	
Measles		Mumps		Whooping cough	

Neurological	YNP	Neurological	YNP	Neurological	YNP
Seizures		Loss of memory		Easily stressed	
Muscle weakness		Vertigo/ dizziness		Fainting	
Numbness/tingling		Paralysis		Loss of balance	
Multiple sclerosis		Speech problems		Other	

Musculoskeletal	YNP	Musculoskeletal	YNP	Musculoskeletal	YNP
Joint pain or stiffness		Arthritis		Sciatica	
Broken bones		Weakness		Muscle spasms or cramps	

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Musculoskeletal	YNP	Musculoskeletal	YNP	Musculoskeletal	YNP
Backache		Joint swelling		Gout	

Blood/Peripheral vascular	YNP	Blood/Peripheral vascular	YNP	Blood/Peripheral vascular	YNP
Easy bleeding/bruising		Anemia		Varicose veins	
Deep leg pain		Cold hand/feet		Thrombophlebitis	

Skin	YNP	Skin	YNP	Skin	YNP
Rashes		Perpetual hair loss		Eczema/ Psoriasis	
Acne		Night sweats		Colour change	
Lumps		Boils		Hives	

Head	YNP	Head	YNP	Head	YNP
Headache		Head injury			
Migraines		Jaw/ TMJ problem			

Eyes	YNP	Eyes	YNP	Eyes	YNP
Spots in eyes		Colour blindness		Glasses or contacts	
Impaired vision		Double vision		Eye pain/strain	
Blurriness		Cataracts		Tearing/dryness	
Glaucoma					

Nose and sinus	YNP	Nose and sinus	YNP	Nose and sinus	YNP
Frequent colds		Sinus problems		Hay fever	
Stiffness		Nose bleeds		Loss of smell	

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Mouth and Throat	YNP	Mouth and Throat	YNP	Mouth and Throat	YNP
Frequent sore throat		Dental cavities		Hoarseness	
Teeth grinding		Excessive saliva		Jaw clicks	
Gum problems		Sore tongue/lips		Herpes	

Neck	YNP	Neck	YNP	Neck	YNP
Lumps		Pain/stiffness			
Goiter		Swollen glands			

Respiratory

Cough?_____
Spitting up blood?_____
Asthma?_____
Pneumonia?_____
Emphysema?_____
Pain on breathing?_____
Shortness of breathing at night? _____
Sputum?_____
Wheezing?_____
Bronchitis?_____
Pleurisy?_____
Difficulty breathing?__
Shortness of breath?__

Cardiovascular

Heart disease?_____
High blood pressure?___
Murmurs?_____
Fainting?_____
Rheumatic fever?_____
Swelling in ankles?_____
Angina?_____
Low blood pressure?_____
Blood clots?_____
Phlebitis?_____
Palpatations/Fluttering?_____
Chest pains?_____

Gastrointestinal

Trouble swallowing?_____
Change in thirst?_____
Nausea?_____
Vomiting blood?_____
# of Bowel Movements per week? _____
Is this a change?_____
Constipation?_____
Diarrhea?_____
Gall bladder disease? _____
Heartburn?_____
Change in appetite?_____
Vomiting?_____
Blood in stool?_____
Pain/Cramps?_____
Belching/Gas?_____
Black stools?_____
Jaundice?_____

Name: Date:

Ulcer?_____ Liver disease?_____
Hemorrhoids?_____

Urinary

Pain on urination?_____ Increased frequency?___
Frequency at night?_____ Inability to hold urine?_____
Frequent infections?_____ Kidney stones?_____

Male Reproduction

Hernias?_____ Testicular masses?_____
Testicular pain?_____ Prostate disease?_____
Venereal disease?_____ Discharge/sores?_____
Are you sexually active?_____ Chlamydia?_____
Sexual orientation?_____ Gonorrhea?_____
Impotence?_____ Condyloma?_____
Premature ejaculation?_____ Herpes?_____
Syphilis?_____ Birth control?_____
What type?_____

Female Reproduction

Age of 1st menses?_____
Date of last menses?___
Are cycles regular?_____
Length of cycle?_____
Bleeding between cycles?_____
Duration of menses?_____
Painful menses?_____ Clotting?_____
Heavy/Excessive flow?_____ Discharge?_____
PMS?_____ Sexually active?_____
PMS Symptoms?_____
Birth Control?_____ What type?_____
Number of pregnancies?_____ Number of live births?
Number of miscarriages?_____ Number of abortions?
Endometriosis?_____ Ovarian cysts?_____
Difficulty conceiving?_____ Cervical Dysplasia?_____
Menopausal Symptoms?_____ Abnormal PAP?_____
Pain during intercourse?_____ Sexual difficulties? _____
Chlamydia?_____ Gonorrhea? _____
Herpes?_____ Condyloma?_____
Syphilis?_____ Do you do breast exams?_____
Sexual orientation?_____ Breast tenderness/lumps?_____
Nipple discharge?_____

Pediatric

Habits

Main interest and
hobbies?_____

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Do you have a religious or spiritual practice?_____
What?_____
Do you exercise?_____ How often?_____
What kind of exercise?_____
Hours of sleep?_____ Enjoy your work?_____
Sleep well?_____ Take vacations?_____
Awaken rested?_____ Spend time outside?_____
Have a supportive relationship?_____
Watch television?_____
Have a history of abuse?_____
How many hours?_____
Any major traumas?_____ Read?_____
Used recreational drugs?_____
How many hours?_____
Been treated for drug dependence?_____
Use alcoholic beverages?_____
Do you eat three meals a day?_____
Treated for alcoholism?____
Do you go on diets often?_____
Do you use tobacco?_____
Smoked previously?_____
How many years?_____
How many packs per day?____
Do you drink coffee?_____
Do you drink black/green tea?_____
Do you drink cola/soda?_____
Do you eat refined sugar/artificial sweeteners?_____
Do you add salt?_____

How does your condition affect you?_____

What do you think is happening?_____

Why?_____

What do you feel needs to happen for you to get better?_____

What do you enjoy most about your life?_____

How much effort are you willing to make at this time to improve your health?
[ ] Minimal [ ] Some [ ] Complete

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On the back of the intake form please complete a timeline of any known major events and any illness from the time you were conceived until current:

Please write any additional information below:

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Westside Natural Health Clinic Office Policies and Patient Payment Agreement

Dear Patient,

This letter is to keep you informed of the policies regarding your payment responsibilities and office policies.

As a patient of Westside Natural Health Clinic you are responsible for the total charges incurred from each visit to your practitioner. Charges are to be paid at the time of each visit.

We recognize and appreciate that health care can involve major financial commitment. We aim to provide you with effective and affordable health care.

Visa, MasterCard, Amex, Checks and Cash are all acceptable forms of payment.

Please remember that you have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. We will provide you with the appropriate receipt with the appropriate codes needed for you to be reimbursed by your insurance company. You will need to mail the receipt provided to your insurance company and your insurance company will reimburse you for the amounts covered. Before your first visit you may want to contact your insurance company or refer to your insurance contract agreement regarding coverage for Naturopathic Medical services. Items to note are: 1) the service is covered, 2) for which diagnosis is covered, 3) how many visits are allowed per calendar year, 4) the amount of your deductible, 5) are there any limitations. Answers to these questions will help clarify treatment and financial responsibility.

Patients will be billed a missed appointment fee for any missed appointment or cancellation with less than a 24 hour notice. This charge will not be submitted to your insurance.

We endeavor to keep scheduled appointments on time. Please note that when you arrive late for your appointment, only of the balance of time that was reserved for you will be used. You will be charged for the full appointment. Complications and emergencies do arise and in the event of running late, we appreciate your patience and understanding.

Payment for all pharmacy items is due at the time of the visit. Most insurance companies do not cover Naturopathic Medical pharmacy items, but you can submit your receipts under your medical expenses for taxes.

We reserve the the right to discharge or not accept any case where:

a. we feel the case is outside the scope of practice of this clinic
b. the patient refuses to co-operate with the recommendations mutually agreed upon.

Please sign this form acknowledging you have read and agreed to the above notice. Please feel free to contact us regarding any questions.

Signature:_____Date:_____
I have read the above stated policies of Westside Natural Health Clinic and will comply with them henceforth.

Name: Date:

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Westside Natural Health Clinic Privacy Policy

Westside Natural Health Clinic is committed to protecting your privacy. Any personal information you provide to us is kept in strict confidence.

What is personal information?
Personal information is any information that identifies an individual. For example, your name, address, and credit card number are considered personal information.

Disclosure
We do not share, trade, rent, or sell your personal information. However, you should be made aware that personal information is not protected from law enforcement agencies, contact for life-threatening emergencies, internal security protection, or when requested by court authorities.Please understand that your personal information will never be used without your permission to do so.

A record will be kept of health services provided to you. This record will be kept confidential and will not be released to others unless you give your consent or the law requires it. You may look at your medical record at any time and can request a copy of it by paying the appropriate fee for copying charges.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, herby acknowledge that **Westside Natural Health Clinic** has provided me with a copy of its Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information. I understand that if I have questions or complaints I may contact Natalie Engelbrecht ND

I also understand that I am entitled to receive updates upon request if **Westside Natural Health Clinic** amends or changes its Notice of Privacy Practices in a material way.

_____ _____
Signature Relationship to patient, if Signed by someone other than the patient

_____
Date

_____

THIS SECTION IS TO BE COMPLETED BY BE WESTSIDE NATURAL HEALTH CLINIC IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices form the above-named patient, but was unable to because:

[ ] Patient declined to sign this Written Acknowledgement.
[ ] Other (specify) : _____

_____ _____
Name and title of person responsible Date

Name: Date:

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NATUROPATHIC CONSENT TO TREATMENT FORM

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.
A number of different approaches are used. Diet and Nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy and lifestyle counseling are the mainstays of naturopathic medicine.
Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes and promote health.
Botanical Medicine is a plant based medicine using herbal teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease.
Homeopathy is a form of medicine based on the Law of Similars- that is the use of tiny extremely diluted doses of the very thing that causes symptoms in healthy people.
Asian Medicine includes acupuncture, as well as the use of botanical formulas and dietary changes. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the surface of the body.
Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.
As naturopathic medicine is a holistic approach to health, lifestyle is considered relevant to most health problems.
I will take a thorough case history, do a screening physical examination including breast examination if indicated.
Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform me immediately of any disease process that you are suffering from or if you are taking any medications. If you are pregnant, suspect you are pregnant or you are breast-feeding please inform me as well.
There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Temporary aggravation of pre-existing symptoms
- Allergic reactions to herbs or supplements
- Bruising from acupuncture, intramuscular injection

I _____ understand that my naturopathic doctor will answer any questions to the best of her ability. I understand that results are not guaranteed. I do not expect my naturopath to be able to anticipate and explain all risks and complications. I will rely on my naturopathic doctor to exercise judgement during the course of the procedure which they feel at that time is in my best interests based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list any exceptions below)
_____
I understand this consent form to cover the entire course of my treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
Patient Name: (please print) _____
Signature of Patient or Guardian: _____
Date: _____

Name: Date: