The Macdonald Centre for Natural Medicine Ltd.

-10th Street | *Dr. Deidre Macdonald* | *Phone 250-897-0235*
rtenay, BC V9N 1P6 | *Naturopathic physician* | *Fax 250-897-1797*

Dear New Patient,

Congratulations for putting your health first and deciding to investigate Naturopathic Medicine. I am confident that you will greatly expand your knowledge of your health care options and I look forward to sharing that experience with you.

Together we will endeavor to achieve your health goals. In order to understand you as a whole, I need to gather a significant amount of information. One the most efficient and therefore cost-effective tools I have is this comprehensive set of in-take forms. Please do your best to be thorough in filling them out, but if you don't understand or don't feel comfortable with a question, leave it out and proceed from there.

Please drop off your completed forms to my office prior to your visit. I will then have an opportunity to assess the information and make good use of your time during your scheduled appointment. Alternatively, you may fax your package to 897-1797.

My office is located at 448-10th Street in Courtenay in a house/office. If you turn at the Dairy Queen on Cliffe Ave., that will put you on 10th Street and we are 1.5 blocks up on the left between England and Fitzgerald Ave.

If the clinic is not open when you wish to drop off your forms, please seal the envelope, put your name on it, and place it in the **mail slot** of the front door. I am the only person who reviews these forms and your confidentiality will be strictly maintained. I sincerely thank you for sharing this important information with me and look forward to our first visit!

Love and blessings,

Dr. Deidre Macdonald
Naturopathic physician

(P.S. Out of consideration for my patients with allergies and chemical sensitivities, I request that you refrain from wearing perfume or cologne on the days you will be visiting our office. Thank you.)

Check us out at *www.getwellhere.com*

c:/mkt/newptlet

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The Philosophy of Naturopathic Medicine

THE HEALING POWER OF NATURE

The healing process is ordered and intelligent. The body has the inherent ability – the vitality – not only to heal itself and restore health, but also to ward off disease. Illness is not caused simply by an invasion of external agents or germs, but is a manifestation of the organism's attempt to defend and heal itself. The physician's role is to identify and remove agents blocking the healing process, bolster the patient's healing capacity, and support the creation of a healthy internal and external environment.

TREAT THE WHOLE PERSON

Health and disease result from a complex interaction of physical, mental, emotional, genetic, spiritual, environmental, social, and other factors. The harmonious function of all aspects of the individual is essential to health. Within the body, the different systems are intimately connected, dynamically balanced. "Dis-ease" or imbalance in one part directly affects – may cause disease in – other parts of that whole. There is never a single cause for disease. All of the "pieces" must be integrated in order to create a whole picture of an individual and his/her illness. Therapy can then be directed at underlying as well as immediate causative factors, thus treating the whole person.

FIRST DO NO HARM

Respecting the inherent ability of the organism to heal itself, the physician must be ever-mindful of the consequences or side effects of treatment. The more gentle and non-invasive the therapy, the less disruptive it will be to the patient's integral whole. Whenever possible, suppression of symptoms is avoided as suppression may interfere with the healing process.

IDENTIFY AND TREAT THE CAUSE

Illness does not occur without cause, and symptoms (nausea, rash, headache) are not the cause of illness. Symptoms are signals that the body is out of balance and are an expression of the body's attempt to heal itself. Causes originate on many levels, but are often found in the patient's lifestyle, diet, habits, or emotional state. When only the symptoms are treated, the underlying causes remain and the patient may develop a more serious, chronic condition.

PREVENTION IS THE BEST CURE

Health is a reflection of how we choose to live. Physicians help patients recognize their choices and how those choices affect their health. The physician assesses risk factors and hereditary susceptibility to disease and makes appropriate intervention to prevent illness.

DOCTOR AS TEACHER

The original meaning of the word "doctor" was "teacher". A physician is a facilitator for a patient's healing process. One of a physician's principle responsibilities is to educate the patient and encourage self-responsibility for health. A cooperative doctor-patient relationship has inherent therapeutic value.

C:\handouts\naturopathic philosophy

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PATIENT INTAKE FORM

tifying Data

: ____ Age: __________

Home Address: ____________________________________ Sex **M** or **F** Marital Status_____________

_____________________________________ Date of Birth: (M/D/Y) ______/______/______

Province: __________________________ Nationality/Race: _________________________________

Postal Code: ________________________ Number of Children: _______________________________

Telephone #: (home): ___________________ (work): __________________ Cell: ___________________________

Family MD: _____________________________________ Referred by: ______________________________________

Occupation: _________________________________ e-mail address: ___________________________________

Are you on the Premium Assistance program with MSP? Yes____ No____ If Yes, CareCard #: ___________________
Extended Health Coverage? Yes ____ No ____

Have you attended a seminar by Dr. Macdonald? Yes ____ No ____

or Health Concerns – Please state and describe your primary reason(s) for attending our clinic. When did it start, any significant events that preceded the beginning of your concern or factors that you suspect brought it on or make it worse.

____

____

____

____

____

____

Other practitioners you are currently seeing or have recently seen and treatments you are receiving.

Name	Type of Practitioner	Treatment

Family Medical History Please list the current age and all relevant medical problems. If deceased, list age and cause of death.

Mother:____
Father: ____
Brothers: ____
Sisters: ____
Spouse: ____
Children: ____
Any familial diseases?: ____

Which childhood diseases have you had? Chicken pox mumps measles whooping cough rheumatic or scarlet fever diphtheria polio other_____________________

As an infant were you breast fed?: yes or no For how long? ______ (months)

Immunizations: complete or partial Adverse reactions ___________________________________

____

Past surgeries: (circle and state your age at the time)

Tonsils _______ appendix _________ gallbladder ________ hysterectomy _____

hernia ________ tubal ligation ______ Vasectomy ________ prostate _________

back _________ minor surgery _____ varicose veins ______ skin lesions ______

cosmetic ______ other(s) __________ Other hospital stays ___________________

Major stresses: List the 5 most significant, stressful events in your life. Indicate with a * which ones currently impact you.

____

____

____

____

____

Other Medical Concerns: (Describe all you have at this time)

____

____

____

Dental History: (circle and state age)

Silver amalgams/crowns ______________ gold amalgams/crowns ______ wisdom teeth removed ______

Dental appliances/bridges/dentures _____dental implants ______________ root canals ________________

What condition are your teeth and gums in? ____

Allergies and Drug Reactions: list and describe the reaction.

Drug: ____

Food: ____

Chemical: ____

Pollens/Molds: ____

Insects/Animals: ____

Current Medication: List all prescription drugs/medications, and over the counter medications and why.

____

____

____

____

Vitamins, Supplements, Herbs, etc. List all that you take regularly, and why.

____

____

____

____

Menstrual History: (females)

Age of onset ____________ Date of last period ____________ Date of last PAP smear__________

Was PAP normal? _________ # of days between periods _______ Duration of bleeding ___________

Amount of blood loss _______ PMS _______ Cramps _______ Is your period regular? __________

List any past menstrual or gynecological problems ____

Difficulty conceiving? ______ # of pregnancies? ____________ # of deliveries? ______________

Any birth complications? _____ # of caesarian sections? ________ # of miscarriages _____________

# of abortions ____________ # of D & C's ________________ Age at menopause _____________

Current menopausal symptoms ____

PERSONAL PROFILE / SOCIAL HISTORY

Dietary Habits: Briefly list what you eat and drink at a typical meal.

Breakfast: ____

Lunch: ____

Supper: ____

Snacks: ____

How do you rate your diet? Excellent good average poor terrible

Do you follow a specific diet? Yes or No What kind? ___________________________

Amount of water drank daily? __________ What type? Tap Bottled Filtered

Do you smoke? Yes or No Recreational drug use: Yes or No

Is this a concern for you? Yes or No

Alcohol use: Daily Several times per week Weekends only Occasional Rarely Never

Alcoholic beverage of choice __________________ Amount consumed per use __________________

Coffee _____________ cups/day Black Tea _____________ cups/day

Employment History: How many hours per week do you work? _____________ Please list briefly all major jobs/occupations in the past ____

____

____

Education: What is the highest level of education you've completed? ____

____

Travel History: Have you been out of the country recently? Yes or No When? ___________________________

For how long? _______________________________ Where? ____

Are any of your health problems related to your travels? Yes or No

Relationship History: Any major problems with your marriage/relationship? Yes or No

Any past divorces? Yes or No How many? _____________ Are you sexually active? Yes or No

Any sexual related concerns? Yes or No Please briefly describe ____

____

General Health:

Do you exercise regularly? Yes or No Type(s) ____________________________________

How often? _____________ For how long? ______________________________

Do you sleep well? Yes or No # hours per night ____________________________

Do you sleep through the night? Yes or No How long to fall asleep? ___________________________________

Do you awaken feeling rested? Yes or No Any financial difficulties? Yes or No

Recent or long term? _____________ Pets at home? Yes or No

How many? _____________ What kind? ____

Do you regularly relax, meditate or pray? Yes or No

What do you do for stress management? ____

Age of the home you live in? _____________ Is dust or mould a problem in your home? Yes or No

Has there been any recent renovations done to your home in the last 3 years? Yes or No

REVIEW OF SYSTEMS

Please circle **Y** – a condition you have now. **P** – a condition you have had in the past, but is okay now. **N** – a condition you have never had. Record significant details in the margins or on the dots.

Present weight ____________ (lbs) Desired weight ___________(lbs)

Maximum weight _________ (lbs) Height ___________________

When? _______________

General Body

Fatigue…… Y P N
Fever…… Y P N
Chills…… Y P N
Night sweats…… Y P N

Skin

Eczema/rash…… Y P N
Psoriasis…… Y P N
Acne, boils…… Y P N
Hives…… Y P N
Peculiar moles…… Y P N
Lumps…… Y P N
Bruising…… Y P N
Pigmentation change…… Y P N
Itch…… Y P N

Hair

Abnormal loss…… Y P N
Change in texture…… Y P N

Nails

Brittle…… Y P N
Ridging…… Y P N
Pitting…… Y P N
Abnormal curvature…… Y P N
Not growing…… Y P N

Head

Stress headache…… Y P N
Migraine headache…… Y P N
Head injury…… Y P N
Head pain…… Y P N

Eyes

Impaired vision…… Y P N
Cataracts…… Y P N
Glaucoma…… Y P N
Eye pain…… Y P N
Discharge…… Y P N
Tearing…… Y P N
Dryness…… Y P N
Redness…… Y P N
Burning/itching…… Y P N
Light sensitivity…… Y P N
Blindness…… Y P N
Glasses or contacts…… Y P N

Ears

Impaired hearing…… Y P N
Ringing…… Y P N
Dizziness…… Y P N
Recurrent infections…… Y P N
Discharge…… Y P N

Nose / Sinuses

Impaired smell…… Y P N
Nose bleeds…… Y P N
Nasal/sinus congestion…… Y P N
Runny nose…… Y P N
Recurrent infection…… Y P N
Post nasal drip…… Y P N
Seasonal allergies…… Y P N

Mouth / Throat

Impaired taste…… Y P N
Recurrent sore throat/infection…… Y P N
Gum disease…… Y P N
Sore tongue…… Y P N
Hoarseness/laryngitis…… Y P N
Bad breath…… Y P N
Canker sores…… Y P N

Respiratory

Chronic cough…… Y P N
Shortness of breath…… Y P N
Wheezing…… Y P N
Blood in coughed up mucous…… Y P N
Chest pain…… Y P N
Recurrent pneumonia/bronchitis…… Y P N
Asthma…… Y P N
Emphysema…… Y P N
Tuberculosis…… Y P N

Cardiovascular

High blood pressure…… Y P N
Murmurs, arrhythmia…… Y P N
Angina…… Y P N
Valve disease…… Y P N
Palpitations…… Y P N
Cold extremities…… Y P N
Varicose veins/phlebitis…… Y P N
Swelling in ankles…… Y P N
Strokes / heart attacks…… Y P N

Please circle **Y** – a condition you have now. **P** – a condition you have had in the past, but is okay now. **N** – a condition you have never had. Record significant details in the margins.

Gastro-intestinal

Change in appetite…… Y P N
Impaired swallowing…… Y P N
Heartburn/indigestion…… Y P N
Gas…… Y P N
Bloating…… Y P N
Abdominal pain…… Y P N
Nausea…… Y P N
Vomiting…… Y P N
Bowel Movement/Day________________
Blood in stool…… Y P N

Constipation……………………………….. Y P N
Diarrhea…………………………………… Y P N
Liver disease/Jaundice………………….. Y P N
Gallbladder disease…………………….. Y P N
Ulcers...…………………………………… Y P N
Irritable bowel syndrome……………… Y P N
Hemorrhoids…………………………… Y P N

Urinary

Pain on urination………………………… Y P N
Increased frequency……………………… Y P N
Awakening at night to urinate…………… Y P N
Urinary urgency………………….……… Y P N
Blood in urine…………………………… Y P N
Recurrent bladder, kidney infection…….. Y P N
Kidney stones…………………………… Y P N
Incontinence…………………………….. Y P N

Female Reproductive

Pelvic pain……………………….……… Y P N
Post intercourse bleeding……………….. Y P N
Post menopausal bleeding……….……… Y P N
Sexually transmitted disease……………. Y P N
Discharge or sores…………...…………. Y P N
What do you use for birth control? ______________
PMS – Premenstrual symptoms................. Y P N

Breasts

Do you self exam?……………………… Y P N
Lumps…………………………………... Y P N
Cysts……………………………………. Y P N
Pain or tenderness……………………… Y P N

Nipple discharge………………………… Y P N

Musculoskeletal

Joint swelling/inflammation……………. Y P N
Joint pain/stiffness…………….……… Y P N
Arthritis…………………………………. Y P N
Impaired range of motion………………. Y P N
Weakness………………………………. Y P N
Muscle cramps…………………………. Y P N
Bone fractures………………………….. Y P N
Disc disease……………………………. Y P N

Neurological

Seizures…………………………….……… Y P N
Fainting spells…………………………… Y P N
Tremor…………………………………… Y P N
Paralysis…………………………….……… Y P N
Numbness/tingling……………….……… Y P N
Loss of memory…………………….……… Y P N
Weakness………………………………… Y P N
Balance problems………………………… Y P N
Speech difficulties……………………….. Y P N

Blood/Lymphatic

Anemia…………………………………… Y P N
Leukemia………………………………… Y P N
Bruising/bleeding easily………………… Y P N
Lymph gland swelling…………………… Y P N
Transfusions……………………………… Y P N

Endocrine/Hormonal

Heat/cold intolerance…………………….. Y P N
Excessive thirst/hunger………………….. Y P N
Thyroid problems/goiter………………… Y P N
Diabetes……………………………….……… Y P N
Excessive facial hair (female)…………… Y P N

Immune

Frequent colds/infections………………… Y P N
Allergic disorders (eg) seasonal allergies…. Y P N
Asthma, eczema, hives, etc………………. Y P N
Do odors bother you?……………………. Y P N

Please circle Y – a condition you have now. P – a conditon you have had in the past, but is okay now. N – a condition you have never had. Record significant details in the margins. If yes, then how often. Rate 0-4. 0=Rarely, 1=seldom, 2=sometimes, 3=often, 4=very often

Psychological

Psychiatric problems or hospitalization Y P N ___
Anxiety………………………… Y P N ___
Depression………………………… Y P N ___
Drug or alcohol abuse………….. Y P N ___
Mood swings…………….……… Y P N___
Violence potential………….…… Y P N ___
Obsessive/compulsive……….…. Y P N___
Phobias…………………………. Y P N ___

Stressed out…………………….. Y P N___

Additional medical history not included elsewhere that you feel is relevant, or additional health concerns you may wish to address.

For your care at this office to be a true win for you, what do you see happening over the next three months?

What obstacles do you see and/or feel exist to your achieving superior health and happiness?

What is your present level of commitment to learn and implement the healthy changes which will improve your health and well-being? (Rate from 1 to 10, 10 being the highest)

If below 8, what will it take to increase your level of commitment?

C:forms\patient intake

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Fees and Payments

The following information will explain the fees at our office:

ALL FEES ARE DUE AT THE TIME THE SERVICE IS RENDERED.

First Naturopathic Visit (45 min): $140.00

Follow up Naturopathic Visits (1/2 hr): $70.00

Extended Follow up Naturopathic Visits (1 hr): $120.00

Medicines & Tests: *Fees for medicines and testing (such as Vega food allergy testing) may be incurred in addition to visit fees.*

CANCELLATION NOTICE: **Please allow 2 days notice to inform our office of appointment cancellations. Appointments cancelled under 48 hrs or missed will be charged $25.00 for each visit or testing appointment.**

EXTENDED MEDICAL BENEFITS:
Extended Health Plans often cover some or all of the fees for Naturopathic *visits*. Contact your extended health carrier to determine how much is covered per visit and per year. **We recommend inquiring about all the "fine print" regarding reimbursement.** Patients are responsible for submitting their receipts to their companies for reimbursement.

If supplements have a DIN number (Drug Identification Number), write the number on the receipt and sometimes the extended health insurer will reimburse for those products.

PREMIUM ASSISTANCE:
MSP will reimburse $23.00 for patients that qualify for Premium Assistance to a maximum of 10 combined specialist (naturopathy, chiropractor, physiotherapy, etc.) appointments.
Additional fees for supplements are the responsibility of the patient.

- MSP refers to MEDICAL SERVICES PLAN, this is your BC health care.
- MSP Premium Assistance = subsidy for the BC health care plan for low income.
- Dr. Macdonald's office will submit a form to MSP on your behalf. *Please advise the receptionist if you qualify for 'Premium Assistance'* at each visit
- MSP will mail reimbursements directly to you the patient in 6-8 weeks.

This office accepts Cash, Cheques, Interac, Visa & Mastercard.

I have read the above and fully understand the contents.

Signed ____ Date __________________________