The Macdonald Centre for Natural Medicine, HPC

448-10th Street *Dr. Deidre Macdonald* *Phone 250-897-0235*
Courtenay, BC V9N 1P6 *Naturopathic physicians* *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 of 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

The Macdonald Centre for Natural Medicine Ltd.

448-10th Street *Dr. Deidre Macdonald and Dr. Amy Davis* *Phone 250-897-0235*

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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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NEW PATIENT INTAKE FORM

DATE:_____

Identifying Data

Name: _____ Age**:** _____

Home Address: _____ Sex **M** or **F** Marital Status_____

City: _____ 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: _____

*I consent to receive email correspondence from Dr. Macdonald □ Yes □ No

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

Major 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
1)			
2)			
3)			

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? _____

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) When? _____

Maximum weight _____ (lbs) Desired weight _____(lbs)

Height _____

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?

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CONSENT FORM and OFFICE POLICIES

PRIVACY:
I understand that a record of the health services provided to me will be kept by the MCNM clinic. This record will be kept completely confidential and will not be released without my personal consent or that of my representative, unless it is required by law.
At times, the MCNM staff, will need to contact you by phone.

I give MCNM consent to leave phone messages regarding my appointments, or a message to return a call to MCNM at the phone numbers I have provided. **(please circle) YES or NO**

FEES:
I accept full responsibility for any fees incurred during care and treatment.

Visit Fees:

Initial Visit $160.00
Follow-up visit 80.00
Extended Follow-up 140.00

Vega testing:

Allergies & Candida $80.00
Organ Screen 40.00
Recheck 25.00
Allergy Desensitization 80.00

Laser Sessions:

30 min 48.00
45 min 88.00

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

CANCELLATION NOTICE: Please allow 2 business 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. Subsequent missed appointments will be charged the full visit fees.

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. Patients are responsible for submitting their receipts to their companies for reimbursement.

PREMIUM ASSISTANCE with MSP/BC Care Card:

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

- 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.

TAXES:

Naturopathic services are eligible to be claimed for a medical expense tax credit.

CONSENT:

The Macdonald Centre for Natural Medicine offers a diverse array of procedures and therapeutic modalities to assist in the diagnosis and treatment of your health concerns:

Potential risks: side effects are rare but may include, but are not limited to: pain, discomfort, allergic reactions to prescribed herbs, supplements or prescription medication; injury from physical therapy and aggravation of pre-existing symptoms.

Potential benefits: restoration of health and the body's maximal functional capacity, relief of pain and other symptoms of disease, assistance in disease and injury recovery, and prevention of disease or it's progression.

Notice for pregnant women: all female patients must alert the doctor if they know or suspect that they are pregnant, or could possibly be pregnant as some treatments could present a risk to the pregnancy.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to treatment at MCNM. I realize that no guarantees have been given to me by the MCNM Clinic, or any of its personnel, regarding cure or improvement of my condition(s).

I authorize Dr Macdonald and her staff at MCNM to gather my information and perform procedures as deemed necessary to facilitate my diagnosis and treatment. I understand the fee policies.

_____ _____

Patient's Name (PRINT) Guardian/Parent Name (PRINT)

_____ _____

Patient's Signature Signature of Guardian/Parent

_____ _____

Date (mm/dd/yy) Relationship