

The Macdonald Centre for Natural Medicine Ltd.

448-10th Street
Courtenay, BC

Dr. Deidre Macdonald and Dr. Shawn Peters
Naturopathic physicians

Phone 250 897-0235
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

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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.

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PEDIATRIC/ADOLESCENT/HISTORY FORM Date _____

PATIENT'S FULL NAME _____ AGE _____ SEX _____ Weight _____

BIRTHDATE month/day/yr ____/____/____ Do you have extended health coverage? Yes _____ No _____

Are you on the Premium Assistance program with MSP? Yes _____ No _____ If Yes, CareCard #: _____

PARENTS' NAMES _____

ADDRESS _____

CITY _____ POSTAL CODE _____

HOME PHONE _____

PARENT'S WORK PHONE _____ (Mother, Father, Other) Cell phone _____

E-MAIL _____

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

Have you attended a seminar of Dr. Macdonald's? Yes _____ No _____

FAMILY PHYSICIAN _____

SPECIALIST _____

HOW DID YOU HEAR ABOUT DR. MACDONALD? _____

PRESENT HEALTH PROBLEMS: PLEASE LIST MOST IMPORTANT HEALTH CONCERNS/PROBLEMS

MEDICATIONS: _____

SUPPLEMENTS: _____

ALLERGIES: (medications, pollens, animals, food) _____

IMMUNIZATIONS: Up to date _____

Partial _____

None _____

Adverse reactions _____

PATIENT'S MEDICAL HISTORY:

	Now	Past	Never		Now	Past	Never
ACNE	____	____	____	EPILEPSY/SEIZURES	____	____	____
ALLERGIES	____	____	____	FATIGUE	____	____	____
ANEMIA	____	____	____	FREQUENT INFECTION	____	____	____
ASTHMA	____	____	____	HEADACHES	____	____	____
BED WETTING	____	____	____	HEART MURMUR	____	____	____
BIRTH DEFECTS	____	____	____	HIGH FEVER	____	____	____
COLIC	____	____	____	HYPERACTIVITY	____	____	____
CONSTIPATION	____	____	____	INSOMNIA	____	____	____
COUGH/WHEEZE	____	____	____	JAUNDICE	____	____	____
ECZEMA	____	____	____	LEARNING DISORDER	____	____	____
DEPRESSION	____	____	____	MOODINESS	____	____	____
DIARRHEA	____	____	____	STUFFY NOSE	____	____	____
EARACHES	____	____	____	THRUSH	____	____	____

SURGERIES (Age/ Type):

HOSPITALIZATIONS:
(Age & Reason)

INJURIES/ACCIDENTS:
(Age & Cause)

OTHER CONDITIONS:

WHAT IS YOUR INFANT'S/CHILD'S/ADOLESCENT'S DISPOSITION?

FAMILY HISTORY:

FATHER (age)* _____ MOTHER (age)* _____ BROTHERS (ages)* _____ SISTERS (ages)* _____

*If deceased, Please list age at death and circle.

IDENTIFY ALL FAMILY MEMBERS WHO HAVE EVER HAD ANY OF THE FOLLOWING: (INDICATE FAMILY MEMBER BY: F for FATHER, M for MOTHER, B1, B2, S1, etc.)

____ ALCOHOLISM	____ CELIAC	____ HIGH BLOOD PRESSURE
____ ALLERGIES	____ COLITIS	____ MENTAL ILLNESS
____ ANEMIA	____ DIABETES	____ OBESITY
____ ASTHMA	____ ECZEMA	____ STOMACH ULCERS
____ BIRTH DEFECTS	____ EPILEPSY	____ STROKE
____ BLEEDING DISORDER	____ HEART DISEASE	____ THYROID DISORDER
____ CANCER of _____	____ HEARING LOSS	____ TUBERCULOSIS

OTHER _____

DOES PATIENT HAVE ANY OF THE ABOVE? If Yes, which ones. _____

PRENATAL/BIRTH/FEEDING HISTORY:

MOTHER'S HEALTH DURING THE PREGNANCY WITH THIS PATIENT

AGE _____ TRAUMA/INJURY _____ ALCOHOL CONSUMPTION _____ DRUGS _____

BLEEDING _____ STRESS (Scale 1-10) _____ TOXEMIA _____ NAUSEA _____

HIGH BLOOD PRESSURE _____ SMOKING _____ ILLNESS _____ X-RAYS _____

ANTIBIOTICS: DURING PREGNANCY _____ DURING BIRTH _____ DURING BREAST FEEDING _____

MEDICATIONS: _____

FULL TERM? _____ PREMATURE? _____ FULL BIRTH WEIGHT _____

WAS THE PREGNANCY EASY? _____ DIFFICULT? _____

WAS THE BIRTH STRAIGHT FORWARD? ____ DIFFICULT? _____ C-SECTION? _____

FEEDING OF INFANT

BREAST FED _____ HOW LONG? _____

COW'S MILK? _____ WHEN STARTED? _____

FORMULA FED _____ HOW LONG? _____ TYPE OF FORMULA _____

AGE SOLID FOODS BEGUN _____ WHAT FOODS? _____

ANY FOOD ALLERGIES OR INTOLERANCES? _____ TO WHAT FOODS? _____

6. CURRENT SAMPLE DAILY DIET (Choose a typical day and include food and liquids)

SOCIAL HISTORY:

PARENTS: MARRIED _____ SEPARATED _____ DIVORCED _____ JOINT / SOLE CUSTODY? (Please provide details on back of page if relevant.)

MOTHER'S OCCUPATION _____ FULL TIME _____ PART TIME _____

FATHER'S OCCUPATION _____ FULL TIME _____ PART TIME _____

OTHER GUARDIAN: _____ RELATIONSHIP _____

OTHERS RESIDING IN HOME _____ RELATIONSHIP _____

DAYCARE/PRESCHOOL/SCHOOL: HOW MANY HOURS EACH DAY? _____ # DAYS OF THE WEEK? _____

INTERACTION WITH RELATIVES: WHO? _____ HOW OFTEN? _____

DO YOU HAVE ANY **OTHER HEALTH CONCERNS** YOU WOULD LIKE TO DISCUSS? PLEASE EXPLAIN.

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Dr. Deidre Macdonald and Dr Amy Davis
Naturopathic physicians

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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	\$175.00
Follow-up visit	87.00
Extended Follow-up	150.00

Vega testing:

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

This office accepts Cash, 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.

SUPPLEMENTARY BENEFITS with MSP/ Care Card (low to middle income):

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

- 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 its 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.

Notice to parents: In most cases, both parents are legally entitled to have knowledge of and/or influence health care decisions made for the child. To avoid issues, divorced parents are wise to be aware of each parents' "Rights and Responsibilities" regarding health care in their parenting agreement.

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