CORE HEALTH
NATUROPATHIC WELLNESS CENTER

Dr. Brandy Strelec, B.Sc.(Hons),N.D.
Board Certified Naturopathic Doctor

Welcome to the Clinic

In order to serve you as efficiently and effectively as possible, please complete the enclosed forms prior to your appointment. If you have any questions please feel free to call the clinic.
We respectfully request 72 hours notice in the event that you cannot keep your first appointment. The first consultation can involve upwards of 1.5 – 2hours time, depending on the individual

Please bring to your appointment

This completed form.
Any remedies (vitamins, minerals, homeopathics, herbs, and drug etc) you are currently taking.
Any relevant test results already completed.
First morning urine sample in a clean, disposable container

As a large number of patients of this clinic have environmental/chemical sensitivities the offices are perfume-free zones. We would ask that you refrain from wearing any perfumes on your appointment.

Your appointment is on_____

Full payment is to be made at the time of your visit. Cash, Cheque, Debit, Visa or Mastercard are all accepted tender for transactions.

Full Name _____

Date of Birth _____ _____ _____
yy mm dd

Address_____

City _____

Postal Code_____

Phone Number ( )_____-_____

Cell Phone Number _____

Email_____

Occupation:_____

Emergency Contact_____
Relationship_____Phone Number _____

Marital Status: single married widowed

Number of Children:__ages: _____ If the patient is a child, give parents names:

Mother_____

Father_____

HOW DID YOU LEARN OF OUR OFFICE:

Friend Relative Health Care Professional
Name: _____

HAVE YOU HAD PREVIOUS NATUROPATHIC CARE:

If yes, when? _____
With whom? _____

Major health concerns in order of importance

1	4
2	5
3	6

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PRESCRIPTION medications you take on a regular basis, including birth control and allergy shots				
Name of prescription medication	Dose	Frequency	Duration	Side effects, if any

Use the back of this sheet if additional paper is necessary

NON-PRESCRIPTION medications you take on a regular basis, including vitamins/minerals/herbs				
Name and brand	Dose	Frequency	Duration	Side effects, if any

Use the back of this sheet if additional paper is necessary

Have you had all standard vaccinations YES NO
Have you had: Flu Vaccine YES NO
Have you had: HPV Vaccine YES NO

Please list any medications/immunizations that you stopped because of side effects or allergic reaction

Name of Medication	Type of side-effect/reaction	Age	Year

Are you following any special diets
Other treatments you are currently following (massage, rehab, diets etc)
List all surgeries
List all major injuries, accidents, or falls
List all hospitalisations

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Family History: In your parents, siblings or grandparents is there a history of:

□Anemia □ arthritis □ eczema □ glaucoma □ seizure or epilepsy □ thyroid problems
□hypertension □ heart disease □ high cholesterol □ diabetes □ asthma □ alcoholism
□psychiatric illness □ cancer □ other _____

Chronologic account of persistent, recurrent or significant illness or injuries, surgical procedures etc
(please provide a summary of your major health issues in the order in which they occurred in your life)

Year	Nature of health problem	Remarks (medications, test, surgery etc)

Have you had a birth defect? o Yes o No
If yes, explain _____

Have you had a birth injury? o Yes o No
If yes, explain _____

Your usual health is: □ Excellent □ Good □ Fair □ Poor

Number of times per week you exercise at least 30 min: □ 0 □ 1-2 □ 3-5 □ over 5 times/week

Record the number of servings you consume daily of each of the following:

coffee _____ decaf coffee _____ regular tea _____ herbal tea _____ soft drinks _____ milk _____ juice ____

water _____ beer _____ spirits _____ other _____

Have you linked any symptoms with drinking any of them? If so which symptoms?

_____

Do you eat fish? yes no On average, how many days per week?_____

Type(s) of fish eaten (eg. tuna/salmon etc.)? _____

Please list any foods or beverages that do not agree with you (eg. stuffy runny nose, heartburn, bloating, diarrhea, sleepiness, difficulty thinking or concentrating, etc.) or cause allergic reactions (eg. hives, other rashes, shortness of breath, wheezing, anaphylaxis, etc.):

List foods/drinks that are a problem	What problem(s) do they give you?	Approximately how often do you eat / drink them?			
		Never	Occasionally	Daily	More

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PHYSICAL INFORMATION

Weight now		Ideal weight	
Weight 1 year ago		Height	
Maximum weight		Date of last physical examination	

List any foods/beverages that you crave or that help you to feel better:

List foods/drinks that you crave	What problem(s), if any, do they give you?	Approximately how often do you eat / drink them?			
		Never	Occasionally	Daily	More

Reactions/Sensitivities/Allergies to natural substances

Are you allergic to pollen, animal dander, dust, mites, or moulds? yes no
(please specify) _____
Have you ever had allergy tests? yes no

Reactions/Sensitivities/Allergies to Synthetic Substances

Have you ever had symptoms you linked with exposure to any synthetic (man-made) chemical at a level that did not seem to bother most people (eg paints, perfumes, cosmetics, diesel exhaust, tar etc), if yes please explain below

Man-made chemical	Symptoms linked with exposure	Presently affected	In the Past

DENTAL AMALGAMS

How many mercury fillings do you have?		How many gold fillings/caps do you have?	
How many mercury fillings have you replaced?		Do you have any other metal in your mouth?	

SMOKING HISTORY

Do you currently smoke tobacco? yes no ___	If yes how many/day:____For how many years ____
If you smoked previously when did you quit?____	How many/day_____For how many years _____

TRAVEL ILLNESSES: Have you ever experienced significant illness when travelling

Illness	Location	Age	Year

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COMMUNICABLE DISEASE: Check items which apply. Do you now or have you ever had?

Measles	o YES o NO	Rheumatic Fever	o YES o NO
German Measles	o YES o NO	Polio or Meningitis	o YES o NO
Mumps	o YES o NO	Tuberculosis	o YES o NO
Chicken Pox	o YES o NO	Valley Fever	o YES o NO
Whooping Cough	o YES o NO	Infectious Mononucleosis	o YES o NO
Diphtheria	o YES o NO	Syphilis	o YES o NO
Influenza	o YES o NO	Gonorrhea	o YES o NO
Scarlet Fever	o YES o NO	Other: _____	

Studies: Check items which apply: In the past 10 years have you had any of the following studies:

	Yes	No	If yes, when?
X-ray of the sinuses			
X-rays of the chest			
X-rays of the stomach, gallbladder or colon			
X-rays of the teeth (dental examination)			
Scans of the whole body, bone or brain			
Electrocardiogram			
Hearing tests			
Blood or Urine tests			
Tuberculin Skin Test (TB skin test)			
Prostate Examination			
Mammography			

Psychological: Check items which apply:

o feel groggy	**o fainting spells**	**o often break out in cold sweats**
o short attention span	**o blackouts**	**o profuse sweating**
o unable to reason	**o worried by little things**	**o cry often**
o unable to concentrate	**o sweats with anxiety**	**o feel insecure**
o forgetful	**o frustration**	**o pale**
o startled by sudden noises	**o psychiatric care**	**o restless legs**
o shaky	**o amnesia**	**o considered clumsy**
o considered a nervous person	**o had shock therapy**	**o unable to coordinate muscles**
o frequently keyed up/jittery	**o go to pieces easily**	**o have difficulty falling asleep**

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STRESSES: Do you currently face or have faced, any of the following stresses (please check if yes)

	yes	Year		yes	Year
Loss of someone close			Divorce		
Illness of someone close			Pregnancy		
Loss of job			Alcohol/Drug addiction		
Change of job			Alcohol/Drug addiction (in someone else)		
Change of workplace			Physical abuse		
A move			Emotional abuse		
Marriage			Sexual abuse		
Separation			Other (please specify)		

Sleep

How many hours of sleep do you get? _____

Do you wake up rested? o YES o NO

Do you wake in the middle of the night? o YES o NO **If yes, what time? _____**

Do you recall dreaming? o YES o NO

Do you have recurrent dreams? o YES o NO

Environment: Check the items that apply:

Do you live in an apartment? o YES o NO **How old? _____**

Do you live in a house? o YES o NO **How old? _____**

Other type of housing: mobile home, farm, ect. Be specific: _____

Is there a garage attached? o YES o NO

Is there an abundance of vegetation immediately around your home? o YES o NO

Does your home tend to get dustier than other homes? o YES o NO

Does your home have a basement? o YES o NO

Have you ever noticed mold or mildew in your home?(basement, bathroom, closet, windowsills,ect) o YES o NO

POLLEN: Check items which apply:

- o worse outdoors
- o worse on windy days
- o watery eyes
- o itchy eyes
- o redness of eyes
- o worse on clear sunny days
- o worse outdoors from 7am to 11am
- o air conditioning helps

Does it flare when going from an air conditioned room to open air? o YES o NO

Does the cool air of air conditioning increase your symptoms? o YES o NO

Are nasal and eye symptoms both present? o YES o NO

DUST: Check items which apply:

- o worst indoors
- o better outdoors
- o productive cough
- o dusting or sweeping increases symptoms
- o sinus trouble
- o frequent colds

o worse in damp air **o purulent secretions**
o intermittent fever

Flare shortly after going to bed?	**o YES**	**o NO**
Symptoms accentuate on waking?	**o YES**	**o NO**
Symptoms recur or increase each year with the return of cold weather?	**o YES**	**o NO**
Do you experience definite nasal symptoms:		
With little or no itching of your eyes?	**o YES**	**o NO**
With itching of your eyes?	**o YES**	**o NO**
Are your symptoms worse when the furnace goes on for the year?	**o YES**	**o NO**

Other? _____

MOLD: Check items which apply:

o worse outdoors between 4:30 and 8:30pm **o worse after sundown**
o better in your house **o worse in a certain room**
o cool evening air increases your symptoms **which room? _____**
o worse in damp places **o worse when mowing or playing on grass**
o flare in the basement **o worse in a certain home**
o worse on windy days **o worse in your house, but not in others**
o Other: _____

PILLOW: Check items which apply:

o Feather o Synthetic o Down o Foam Rubber o Other_____

MATTRESS: Check items which apply:

o water bed o conventional o box spring
o cotton o futon (cotton/foam) o other: _____
o foam rubber o plastic covered o spouse/roommate's mattress: _____

BLANKETS: Check items which apply:

o wool o quilt o cotton o synthetic o spouse/roommate's blanket: _____

ANIMALS OR PETS: Check items which apply:

o dog o cat o bird o fish o rabbits o horse (own/ride)
o hamster o guinea pig o cattle o other
Animals in house? o YES o NO
Animals in bedroom? o YES o NO

PLANTS: Check items which apply:

Do you have indoor plants o YES o NO
If yes, how many and where?
_____

FLOORING: Check items which apply:

- Carpet/rugs: o cotton o wool o synthetic o foam o felt o straw/fiber padding
- Tile: o vinyl o marble o terrazzo o ceramic

APPLIANCES: Check items which apply:

Stove: o Gas o Electric Exhaust fan? o YES o NO
Dryer: o Gas o Electric
Refrigerator: o Gas o Electric
Water Heater: o Gas o Electric Location: _____

CLIMATE CONTROL SYSTEMS: Check items which apply:

Heating:

o Gas forced air o Floor Furnace o Oil Forced air o Gas or Kerosene heating unit
o Radiator steam/hot water heat o Fireplace o Electric baseboard or panel
o Wall furnace o Space heater (vented/ unvented)
o Other: _____

Air Conditioning:

o Window Filters: o Electrostatic o HEPA o Fume control o Carbon
o Central
Other: _____

FURNISHINGS: Check items which apply:

Upholstery: o cotton o synthetic
Cushions: o foam o cotton o synthetic
Window Coverings: o metal o wooden o synthetic o cotton

CHEMICALS: Check items which apply:

Do you use strong chemicals (ie; disinfectants, bleaches, oven and drain cleaners) in your home? o YES o NO
If yes, name them:_____
Do you use floor & furniture wax and wax remover: o Yes o NO
Do you use pesticides in your home? o YES o NO
If yes, name them: _____
Do you, or have you used a lawn care company? o YES o NO
If yes, name the company: _____
When was the last time? _____
How often do you have the treatments? _____
Do you regularly have your home treated for insects? o YES o NO
If yes, name the company and list the specific name of the chemical _____
Have you had your home treated for termites? o YES o NO
If yes, when? _____
List the product used: _____

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ELECTROMAGNETIC FORCE

Do you live near a power generating station? o YES o NO
If yes, how near? o 150 meters or less o 3-5 km o 10km o 15km
Do you live near an electric distribution substation? o YES o NO
If yes, how near? o 150 meters or less o 3-5km o 10km o 15km

Do you live near high voltage electrical transmission lines? o YES o NO
If yes, how near? o 150 meters or less o 3-5km o 10km o 15km
Is there a power transformer near your home? o YES o NO
If yes, how near? o 150 meters or less o 3-5km o 10km o 15km

Do you live in direct line of a television transmitter? o YES o NO
If yes, how near? o 150 meters or less o 3-5km o 10km o 15km
Do you live near a microwave tower? o YES o NO
If yes, how near? o 150 meters or less o 3-5km o 10km o 15km
Do you notice symptoms produced from these?
o TV transmitter o Generating Station o Electric Lines o Transformer
o Electric distribution substation o Microwave tower

List symptoms produced, in order of severity:
TV transmitter 1._____ 2._____ 3._____
Electric Lines 1._____ 2._____ 3._____
Transformer 1._____ 2._____ 3._____
Generating Station 1._____ 2._____ 3._____
Electric Substation 1._____ 2._____ 3._____
Microwave tower 1._____ 2._____ 3._____

What type of electric lights do you have?
o incandescent o fluorescent o full spectrum
Do you notice any symptoms from your lighting? o YES o NO
If yes, list the symptoms in order of severity:
1._____ 2._____ 3._____
On what type of equipment do you prepare your food?
o gas o electric o microwave
Do you notice any symptoms when near the microwave oven? o YES o NO
Do you notice any symptoms from exposure to the TV? o YES o NO
Do you have a TV antenna on your home? o YES o NO
Do you have cable television? o YES o NO
Do you work with computers &/or electric typewriters? o YES o NO

Do you use electric blankets? o YES o NO

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If you experience symptoms, please list in order of severity:

Microwave	**1.**_____	**2.**_____	**3.**_____
Antenna	**1.**_____	**2.**_____	**3.**_____
Cable	**1.**_____	**2.**_____	**3.**_____
Computers	**1.**_____	**2.**_____	**3.**_____
Weather Changes	**1.**_____	**2.**_____	**3.**_____
Electric Blankets	**1.**_____	**2.**_____	**3.**_____

Do weather changes cause a change in your mental or physical health? **o YES** **o NO**

Explain:_____

INHALANT AND CHEMICAL EXPOSURE: Check your occupation exposures

o Office Worker	**o Work around cosmetics**	**o Professional worker**
o Factory worker	**o Work around fumes**	**o Farm worker**
o Work in extreme heat	**o Work in extreme cold**	**o Work indoors**
o Salesperson	**o Construction worker**	**o Painter**
o Hospital worker	**o Teacher**	**o Work with animals**

o Other: _____

Check if exposed to: DOUBLE CHECK if you have symptoms from:

o Dust	**o Fireplace**	**o Old home**	**o Marshy area**	**o Desert area**
o Woody area	**o Prairie**	**o Tobacco smoke**	**o Linoleum**	**o New carpet**
o Old carpet	**o Rugs**	**o Wooden floors**	**o Diesel fumes**	**o Gasoline fumes**
o Photocopy paper	**o Varnish**	**o Solvents**	**o Lacquer**	**o Furniture polish**
o Floor wax	**o Incense**	**o Mothballs**	**o Disinfectants**	**o Plastic**
o Dyes	**o Paints**	**o Turpentine**	**o Dry cleaning**	**o Pesticides**
o Herbicides	**o Grain dust**	**o Mildew**	**o Dog inside**	**o Cat inside**
o Bird inside	**o Other pets inside**	**o Tar**	**o Rubber**	**o Chemicals**
o Potted plants	**o Cosmetics**	**o Nail polish**	**o Perfume**	

List 4 symptoms from these exposures in order of severity:

1._____ **2.**_____ **3.**_____ **4.**_____

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Health Questionnaire

EYES, EARS, NOSE, THROAT

o Eyes sensitive to bright light	o Discharge from eyes	o Eyes red or itchy
o Puffiness or dark circles under eyes	o Cataracts	o Wear corrective glasses
o Get boils or styes	o Ear discharge or ears stuffed up	o Ear infection- past or present
o Runny nose	o Nose bleeds	o Post nasal drip
o Sinusitis/rhinitis	o Hay fever	o Allergies
o Breathe through mouth	o Loss of smell	o Loss of taste
o Throat infections	o cold sores, fever blisters	o Inflamed or bleeding gums
o Mucous in throat	o Swollen tongue	o Frequent sore throats
o Swollen glands	o Metallic taste in your mouth	o Burning sensation on your tongue

DIGESTIVE SYSTEM

o Nausea	o Excessive salivation	o Mouth too dry
o Pain on swallowing	o Get full quickly	o Don't get full quickly
o Poor appetite	o Excessive appetite	o Chronic stomach pain
o Stomach pain when emotionally upset	o Relief of stomach pain by drinking carbonated beverages	
o Relief of stomach pain by drinking milk		o Excessive burping
o Fullness for extended time after meals	o Bloating	o Abdominal cramping
o Stomach upsets easily	o History of heartburn	o History of ulcers or gastritis
o Known food allergies	o Fatigue after eating	o Excess gas
o Digestion very rapid	o Hemorrhoids	o Frequent need for laxatives
o History of constipation and diarrhea	o History of diarrhea	o Roughage and fiber cause constipation
o Dependency on antacids	o Intolerance to greasy foods	o Headaches if meal missed

STOOL

o Light coloured stool	o Black stool	o Hard stool
o Thin stool	o Poorly formed stool	o Painful to pass stool
o Blood in stool	o Undigested food in stool	o Mucous in stool

Number of bowel movements/day:

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LIVER

o Jaundice
o Hepatitis A, B, or C
o High total cholesterol
o Cholesterol level above 5.2 mmol/L
o Low HDL cholesterol
o Strong smelling urine
o Triglyceride level above 2.3mmol/L
o Trouble waking up in morning
o Sugar causes irritability & mood swings
o anemia unaffected by iron
o Work with hazardous chemicals
o Periodic constipation
o Sensitive to exhaust fumes, smoke, smog & petrochemicals
o Can't tolerate much exercise
o Dizziness upon standing
o Migraine headaches

CARDIOVASCULAR

o Shortness of breath
o Chest pain while walking
o Heaviness in legs
o Calf muscles cramp while walking
o Heart pounds easily
o Feel jittery
o Heart misses beats or has extra beats
o Swelling of feet and ankles
o Pain in left arm
o Exhausts with minor exertion
o Bright red nose
o Cold hands and feet
o Numbness in extremities
o Poor concentration
o Ringing in ears
o Pain on waking, in back of head and neck
o Dizziness
o Vertigo
o Fatigue easily
o Bruise easily
o Blushing with no apparent cause
o Varicose veins
o Chest Pains
o Dizziness when standing suddenly
o Loss of vision when standing suddenly
o Angina
o Heart murmur
o Abnormal EKG(electrocardiogram)
o Night sweats
o Need to drink coffee to get started
o Impatient, moody, nervous
o Boils and leg sores
o Cuts take a long time to heal
o Overweight
o Feel energized from exercise
o Failing eye sight
o Family history of diabetes
o Sugar in urine

PULMONARY

o Persistent cough
o Difficulty breathing
o Coughing up blood
o Coughing up phlegm
o Pain around ribs
o Shortness of breath
o Rattling mucous when breathing
o Chronic lung congestion
o Sensitive to smog
o Infections settle in lungs
o Work around people who smoke
o Asthma
o Hay fever
o Bronchitis
o Difficulty breathing
o Slow to recover from cold or flu

BLADDER

o Frequent urination
o Rarely need to urinate
o Difficulty passing urine
o Urinate when you cough or sneeze
o Painful/burning when passing urine
o Dripping after urination
o Can't hold urine/stress incontinence
o Rose coloured(bloody) urine
o Cloudy urine
o Strong smelling urine
o History of bladder infections
o Have used antibiotics for urinary tract infections

If yes, when did you last use them? _____

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MALES ONLY

o Difficulty urinating **o A sense of bladder fullness** **o Pain or burning while urinating**
o Increased straining with smaller and smaller amounts of urine passed **o Wake up to urinate during at night**
o Dripping after urination **o Lack of sex drive** **o Ejaculation causes pain**
o Premature ejaculation **o Pain/coldness in genital area** **o Infertile**
o Varicose veins of scrotum **o Low sperm count** **o Discharge from penis**
o Swollen genitals **o Swelling in groin**
o Sexually transmitted disease(gonorrhea, syphilis, herpes, other)

FEMALES ONLY

o Menstrual pain **o Monthly weight gain** **o Depression**
o Mood swings **o Nausea and/or vomiting** **o Anxiety**
o Leg cramps and tenderness **o Asthma attacks** **o Headaches**
o Anger **o Low backache** **o Vaginal discharge**
o Missed periods **o Over age 15 and have not begun menstruation**
o Unable to get pregnant **o Low abdominal pain** **o Increased urinary frequency**
o Dull ache radiating to low back or legs **o Pelvic soreness** **o Diarrhea**
o Abdominal bloating **o Have to lie down on first 1 or 2 days of period**
o Craving for sweets **o Insomnia** **o Light scanty blood flow**
o Pain during period is progressively getting worst **o Vaginal bumps & sores**
o Pain and cramps without blood flow **o Heavy menstrual bleeding** **o Pubic area sore**
o Breast lumps/breasts painful/sore to touch **o Ovarian cysts/uterine cysts**
o Pain in ovaries **o Water retention/swollen feeling**
o Premenstrual breast pain or discomfort **o Mother used D.E.S.(hormones) while pregnant**
o Recent Pap smear abnormal **o Family history of breast cancer** **o Hot flashes**
o Night sweats **o Hysterectomy** **o Sweating throughout day**
o Dryness of skin, hair and vagina **o Painful intercourse** **o Vaginal pain**

Form of birth control(if used) ____ none ___pill ___IUD ___sponge ___diaphragm ___foam ___condom
____ cervical ___mucous ___temperature ___other

Age of first menstruation?_____ Number of pregnancies? _____

Miscarriages? _____ Date of last menstrual period?_____

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MUSCULOSKELETAL

o Painful fingers, arms, hands	o Bones sore/painful	o Bone loss
o Calcium deposits	o Bone deformity	o Recent bone fracture
o Have osteoporosis/osteomalacia	o Muscle cramps	o Leg cramps at night
o Stiffness only in the morning	o Stiffness all over	o Unable to sit straight
o Pain in neck and /or shoulder	o Swollen knees/elbows	o Low back pain
o Athletic injury	o Bursitis/tendonitis	o Joint pain
o Slipped disc/herniated disc	o Loss in height	o Injure easily

NEUROLOGICAL

o Loss of balance	o Trembling hands	o Loss of grip strength
o Limbs feel too heavy to hold up	o Tingling pain sensation	o Convulsions
o In-coordination	o Nervousness	o Accident prone
o Need for 10-12hrs sleep per night	o Loss of muscle tone	o Nightmares
o Can't fall asleep/insomnia	o Leg cramps/restless legs at night	o Intense dreams
o Awake frequently throughout night	o Can't fall back to sleep after waking	o Restless/uneasy sleeper
o Are you considered nervous/jittery	o Sleep walk	o Shingles

SKIN

o Unexplained rashes	o Red colour flushes	o Excessive itching
o Rough skin	o Dry skin	o Acne(pimples)
o Hives from food or drugs	o Moist oily skin	o Dandruff

FOODS

o Gain weigh on low calorie diets	o Usually add salt to your meals	o Chew gum frequently
o Usually eat lite salt, a salt substitute	o Usually avoid butter/eat margarine	o Usually skip breakfast or lunch
o Are you on a special diet for any health problem		o Do you eat eggs
o Usually avoid raw vegetables	o Eat cheese regularly	o Avoid sugar
o Do you eat many soya products	o Are you vegetarian	o Snack on sweets
o Eat bakery goods daily (donuts, cakes, cookies)		o Often eat canned fruit/vegetables
o Often eat white flour foods (pasta/bread)		o Gain weight easily

Servings of fruit per day _____ Servings of vegetables per day _____

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Declaration and Consent to Treat

Name_____ Date_____

This is to acknowledge that I have been informed and I understand that:

OHIP does not cover Naturopathic services; therefore fees for Naturopathic services and all supplements are the responsibility of the patient, payable in full, at the time of the appointment.

We are required by our licensing board to perform a basic physical examination on each new client. This will be adhered to, unless this office accepts the examination of the referring practitioner who sends a full report and that report has a specific request(i.e.: if your dentist refers you for testing of dental materials, then a written request from the dentist must be forwarded)

With the number of clients we thoroughly interview, assess and treat, timing is crucial. For the convenience of our clients, and for the orderly and efficient operation of our clinic, we endeavor to keep scheduled appointments on time; however, complications and emergencies do arise and in these circumstances, we appreciate your patience and understanding.

1. I have read all the foregoing information and that I understand that the ultimate responsibility for my health is my own.
2. I will be seeing a Naturopathic Doctor not a Medical Doctor
3. The Naturopathic Doctor(s) at the Wellness Clinic work within the Naturopathic scope of practice.
4. Any treatment or advice given to me as a patient of the Naturopathic Wellness Clinic is not mutually exclusive from any treatment or advice that I may receive now, or in the future, from another licensed health care provider.
5. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider.
6. No employee, agent, or anyone else under the Naturopathic Wellness Clinic's direction or control is suggesting or recommending to me to refrain from seeking or following the advice of another health care provider.
7. The treatment and therapies rendered or recommended by the Naturopathic Wellness Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.
8. I agree to abide by the financial policies as outlined and I accept full responsibility for any fees incurred during care and treatment. I agree to fully discharge this responsibility at the time of the visit unless prior arrangements have been made.
9. I understand that my appointment time is reserved for me and the clinic requires a minimum of 24 hours notice for cancellation or change (72 hours for new patients and special appointments), otherwise I will be billed for the the full fee for missed appointments.

I declare that I have received a full and complete explanation of the treatment of services that I may receive at the Naturopathic Wellness Clinic and hereby authorize consent to treatment.

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Signature