Balance Point Health Centre Inc.

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NEW PATIENT QUESTIONNAIRE

Date: _____

Name: _____

Current Gender Identity: _____ **Birthdate:** _____ **Age:** _____

Address: _____ **City:** _____

Postal Code: _____

Home Phone #: _____ **Work #:** _____ **Cell #:** _____

Email address: _____

Occupation: Present: _____ **Past:** _____

Relationship Status: (please circle) married single divorced common law re-married

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How did you hear about our office? _____

Name of Family Doctor: _____ Phone #: _____

Primary reasons for coming to our clinic:
Please state the first time you noticed the condition and describe any factors that you suspect may have played a role in its onset and progression; Please list in order of importance to you.

1. _____
2. _____
3. _____

List any other health concerns:

_____

_____

_____

List any significant illnesses that you have had in the past including any hospitalizations:

_____

_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) **Y / N**

Medications/Supplements:

Please list all current and previous medications and supplements used (including antibiotics)

Medications/Supplements	Condition Prescribed For	Dose	Duration of Use	Side Effects/ Reactions

Family History:

Indicate where applicable if anyone in your family currently has or has had any of the following conditions:

Disease/Illness	Mother	Father	Sibling	Maternal Grandparents	Paternal Grandparents
Heart Disease (*ie. Heart Attack, Congestive Heart Failure)*					
Cancer **Type:**					
Stroke					
Hypercholesterolemia					
Hypertension					
Kidney Disease					
Tuberculosis					
Diabetes					
Osteoarthritis					
Rheumatoid Arthritis					
Epilepsy					
Mental Illness					
Depression					
Alcoholism					
Allergies **Type:**					
Age (at death)					
Cause of Death					

Do you have any allergies? (food, environmental, drug) _____

_____

_____

Have you done any home renovations recently? _____

_____

How would you describe the emotional climate of your home? _____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

_____

Context of Care

Why did you choose to come to this clinic? _____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

0 1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

_____

_____

_____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making? _____

What do you LOVE to do? _____

_____

INFORMED CONSENT TO TREATMENT

Dr. Jane Goehner ND Dr. Jennifer Kaster ND Dr. Janna Fung ND

Please initial on the line beside each of the following to acknowledge that you have been informed and understand that:

_____ ***Initial*** The ND keeps a record of services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate copy fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

_____ ***Initial*** I must pay for all test, in-office supplements and services when rendered. I understand that I am responsible for the total charges incurred for each visit to be paid at the time of the visit unless specific arrangements have been made **prior** to my scheduled appointment. I understand that if I have coverage for Naturopathic Medicine, I am responsible for billing by own insurance company. I understand that a fee will be charged for any missed appointments or late cancellations (less then 24 hours).

_____ ***Initial*** Any treatment or advice provided to me as a patient of the Naturopathic Doctor (ND) is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider; I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. The ND has not recommended for me to refrain from seeking or following the advice of another licensed health care provider;

_____ ***Initial*** There are some risks, however rare, to Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms,
- Reaction to supplements or herbs,
- Bruising from an acupuncture needle.

_____ ***Initial*** I intend for this consent form to cover the entire course of treatment presented for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures and treatments at any time in written or verbal format.

Naturopathic Doctors use a variety of therapeutic approaches, either alone, or in combination. These include **nutritional and lifestyle counselling, nutritional supplementation, Asian medicine and acupuncture, botanical medicine, homeopathy.**

_____ ***Initial*** I understand that my ND will answer my questions that I have to the best ability, in a manner which I can comprehend. I understand that the results are not guaranteed. I do not expect my ND to be able to anticipate and explain all risks and complications. I will rely on my ND to exercise the best judgement in my best interests, based on the facts and findings then known.

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for:

Please list any treatment exceptions: _____

Patient Name (please print): _____

_____ _____

Signature of Patient/Guardian *Date*

_____ _____

Signature of Naturopathic Doctor *Date*

Would you like to receive our newsletter? **Yes / No**

PERMISSION FOR TELE-HEALTH VISITS

What is telehealth?

- Telehealth is a way to visit with healthcare providers, such as your naturopathic doctor.
- You can talk to your provider from any place, including your home.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Please use the secure video link sent to you from your naturopathic doctor **via Doxyme** to use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic to see your provider.
- You won't risk getting sick from other people.

Are there any risks to telehealth?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may recommend an office visit at a later date if a physical examination is needed.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- We use telehealth technology (doxyme) that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can arrange an in-person office visit to follow-up on any conditions that may require physical examination or if you prefer in-person appointments in the future.

What does it mean if I sign this document?

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You consent to a telehealth visit.

Patient Name (please print): _____

_____ _____

Signature of Patient/Guardian *Date*