ND PATIENT REGISTRATION FORM

PATIENT INFORMATION			
Last Name:	First Name and Initial(s):	Gender: ❑ M ❑ F	Date of Birth (yyyy-mm-dd):
Street Address:			
City:	Province:	Postal Code:	
Email: *By providing your email, you are consenting to email communication from Rebalance Health Group such as appointment reminders, statements, invoices, Doctor's instructions & commercial electronic messages.*			
Marital Status:	Occupation:		
Phone (Home):	Phone (Work):	Phone (Mobile):	
Please indicate the best method of contact during the day:	❑ Home	❑ Work	❑ Mobile
Emergency Contact (Name and Phone):			

HOW DID YOU HEAR ABOUT DR. WINTON?			
❑ Website	❑ Street Signage	❑ Doctor's Referral	____________________
❑ Google	❑ Return Patient	❑ Family/Friend Referral	____________________
❑ Twitter	❑ Yelp	❑ Local Businesses	____________________
❑ Facebook	❑ Yellow Pages	❑ Other	____________________

Would you like to receive a copy of our Electronic Newsletter? ❑ Yes ❑ No

(Rebalance Health Group respects your privacy. We do not sell, rent, loan or transfer any personal information regarding our clients to any third parties.)

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CURRENT HEALTH INFORMATION

Names of Other Health Care Providers? ____

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Please list your health concerns that you would like to address, in order of importance:

1. ____
2. ____
3. ____
4. ____
5. ____

Please list any other health conditions that you have: ________________________________

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MEDICATIONS

How many courses of antibiotics have you had in the past 2 years? ______________________

Are you allergic or sensitive to any medications or other substances? ❑ Yes ❑ No

If so, please list (include medications, foods, environmental allergens, chemicals, etc.):

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Please list all medications, prescriptions, herbs, vitamins, and homeopathies that you are presently taking:

Name of Medication	Dosage	Frequency	Date Started

LIFESTYLE FACTORS

Do you drink alcohol? If so, how many drinks per week? ______________________________

Do you smoke? If so, how many packs per week? ___________________________________

Are you exposed to second hand smoke? If so, how often? ____________________________

Do you use recreational drugs? If so, how often? ____________________________________

Do you exercise? If so, how often? ____

Rate your stress level: ❑ Low ❑ Average ❑ High ❑ Very High ❑ Unbearable

What area of your life contributes most to your stress?

❑ Work ❑ Health ❑ Family ❑ Money ❑ Marriage ❑ Other _______________

PAST MEDICAL HISTORY

What hospitalizations or surgeries have you had and when did they occur?

____

____

Immunizations?

❑ Flu Shot ❑ Hepatitis B ❑ Measles/Mumps/Rubella ❑ Diptheria/Pertussis/Tetanus

❑ Polio ❑ Hepatitis A ❑ Chicken Pox

Childhood Illnesses?

❑ Chicken Pox ❑ Mumps ❑ Measles ❑ Whooping Cough ❑ Rheumatic Fever

❑ Eczema ❑ Polio ❑ Asthma ❑ Rubella ❑ Scarlet Fever

❑ Diptheria ❑ Frequent ear infections or colds ❑ Other ___________________________

FAMILY HISTORY

Please indicate if any of your family members have had any of the following:

Condition	Relative	Condition	Relative
Alcoholism		Heart Disease	
Allergies		High blood pressure	
Alzheimer’s		High cholesterol	
Arthritis		Infertility	
Asthma		Kidney disease	
Bleeding Disorder		Mental disease	
Cancer (indicate type)		Obesity	
Depression		Osteoporosis	
Diabetes		Thyroid Problem	
Drug Addiction		Stroke	

GOALS

What are your goals and expectations surrounding your care from the Naturopathic Doctor?

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ND PATIENT CONSENT FORM

NATUROPATHIC CLINIC POLICIES

Appointments: Appointment frequency and expected duration should be discussed with your Naturopathic Doctor and scheduled appropriately with the receptionist. Please check in at reception at each visit and sign at the front desk. It is important to arrive a few minutes before each treatment time, in order to prepare. If you do arrive late, you will be seen only for the remainder of your scheduled time.

Cancellations, Lateness, and No-Shows: If you need to cancel, informing us of your changed schedule as early as possible is appreciated. We require 24hrs notice for a cancellation. Late Cancellations and No-Shows will be charged the **full service fee** (which may not be covered by your extended health care plan). This is necessary to ensure proper respect for treatment times and difficulty in re-scheduling.

Payment: Naturopathic Medicine is not covered by OHIP. Extended health care benefits vary depending on the policy. It is the responsibility of the patient to verify the extent of insurance coverage per visit. Patients are responsible for full payment of their account at the end of each visit. Supplements prescribed can be bought at Rebalance or any other store of your choice.

Treatment Fees:
Initial Consult - $185.00
Follow Up Visits - $90.00
Acupuncture Only Follow Up - $69.00
Laboratory testing (e.g. blood glucose testing, urine dip stick) suggested by the Naturopathic Doctor will be provided at an extra charge to the patient and will be discussed at that time.

Personal Belongings: The clinic cannot be held responsible for loss or damage to personal belongings. Bring your belongings into the treatment room with you in order to avoid the risk of loss.

Thank you for your co-operation in the above matters.

NATUROPATHIC CONSENT TO TREAT

This is to acknowledge that I (or parent/legal guardian) have been informed and understand that:

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, and emotional aspects of an individual. A number of different approaches are used: diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counselling.

The Naturopathic Doctor will take a thorough case history, and perform a screening physical exam before developing an individualized treatment plan. If necessary, more specific physical examinations such as breast, gynaecological or genital exams, may be suggested and conducted. Certain laboratory assessments may also be suggested on a case specific basis.

Even the gentlest therapies can sometimes cause complications. Some therapies must be used with caution in conditions such as diabetes, heart, liver or kidney disease, during pregnancy and lactation, in children, and while taking other medications. It is very important therefore that you inform Morgan Winton, BSc, ND, of any health conditions you have, as well as any prescribed or over the counter medications or supplements you are taking. If you are pregnant, suspect you are pregnant, or are breastfeeding, please advise the Naturopathic Doctor immediately.

There are some slight health risks to naturopathic medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles

As a patient of Morgan Winton, ND, I am at liberty to seek or continue medical care from a medical doctor or other health care providers licensed to practice in Ontario. No employee, agent, board member, student, instructor or anyone else under the direction or control of Morgan Winton, ND, has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

As a patient of Morgan Winton, ND, I understand that results are not guaranteed.

I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during a clinic visit, as this is not safe medical practice.

This consent form is intended to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I fully understand the above and agree to abide by these policies:

____	______________	__________
Signature of Patient or Guardian/Parent (if under 18)	Name	Date

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Signature of Naturopathic Doctor