

# NEW PATIENT INTAKE FORM

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TODAY'S DATE \_\_\_\_\_

NAME \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

ADDRESS (FULL) \_\_\_\_\_

PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_

IN CASE OF EMERGENCY, IMMEDIATE CONTACT INFORMATION (Phone and Relation)

\_\_\_\_\_

MARITAL STATUS (circle one)    S    M    D    W    Sep    N<sup>o</sup> OF CHILDREN \_\_\_\_\_

OCCUPATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_

FOUND OUT ABOUT CLINIC THROUGH \_\_\_\_\_

**PLEASE LIST YOUR CONCERNS IN ORDER OF IMPORTANCE.**

CONCERN	SINCE	POSSIBLE CAUSE(S)

**WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?**

MEDICATION & WHY	SINCE	ADVERSE EFFECTS

**PLEASE LIST YOUR SUPPLEMENTS/VITAMINS WITH DOSAGES AND PROTOCOL**

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**WHAT OPERATIONS HAVE YOU HAD?**

OPERATION	WHEN	COMPLICATIONS?

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## WHAT MAJOR INJURIES HAVE YOU HAD?

INJURY	WHEN	LONG TERM EFFECTS?
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## WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD? (PLEASE CIRCLE)

Abscesses	Depression	Heart Disease	Mononucleosis	Rubella	Tonsillitis
Alcoholism	Diabetes	Hepatitis	Mumps	Scarlet Fever	Tuberculosis
Allergies	Emphysema	Herpes Genitalia	Parasites	Sexual Abuse	Typhoid
Amnesia	Epilepsy	Influenza	Pelvic Inflammatory Disease	Skin Disease	Venereal Disease
Arthritis	Gall Stones	Kidney Disease	Peritonitis	Strep Throat	Warts
Asthma	Goiter	Leukemia	Pleurisy	Sinusitis	Whooping Cough
Cancer	Gonorrhea	Malaria	Pneumonia	Sunstroke	Worms
Chicken Pox	Gout	Measles	Prostatitis	Stroke	Yellow Fever
Cold Sores	Hay Fever	Miscarriage	Rheumatic Fever	Syphilis	Tuberculosis

OTHER \_\_\_\_\_

## VACCINATIONS

Which vaccinations have you had?

Childhood DPT MMR    Hepatitis    HPV    Flu Shot    Other \_\_\_\_\_

Any adverse effects from them? \_\_\_\_\_

## ♀ WOMEN

Age of first menses \_\_\_\_\_ Describe history of your cycle \_\_\_\_\_

Last Menstrual Period \_\_\_\_\_ Describe your current cycle \_\_\_\_\_

Last Pap (date) \_\_\_\_\_ Last Breast Exam (date) \_\_\_\_\_

Bone Density (date) \_\_\_\_\_ Was any test abnormal? \_\_\_\_\_

## ♂ MEN

Difficulty maintaining/achieving an erection? \_\_\_\_\_

If you have had prostate exams, results? \_\_\_\_\_

PSA (blood test done) and results? \_\_\_\_\_

## COGNITIVE

Problems with memory, focus, or concentration? \_\_\_\_\_

Headaches? \_\_\_\_\_

## WEIGHT

Weight loss   Weight gain   How much over what duration? \_\_\_\_\_

Where have you noticed the weight gain? \_\_\_\_\_

## SLEEP

How many hours do you sleep each night? \_\_\_\_\_

What time do you usually go to sleep at and what time do you wake? \_\_\_\_\_

Do you have difficulty falling asleep? \_\_\_\_\_

Do you feel rested upon waking in the morning? \_\_\_\_\_

Do you have difficulty sleeping, what disturbs your sleep? \_\_\_\_\_

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## DIGESTION (Please Circle)

Heartburn/RefluxBurping      Passing Gas      Bloating      Cramping      Lack Appetite      Always Hungry

## BOWEL MOVEMENTS (Please Circle)

*1every other day*      *less than 1*      1-2      2-3      more than 4

Easy to pass      Well-formed      Loose or watery      Explosive diarrhea

Brown Stools      Grey Stools      Green Stools      Mucous in Stools

## URINATION (Please Circle)

Urination Problems      Burning Sensation      Urinary Tract Infections      Incomplete Emptying

Urgency to Urinate      Incontinence      Low Back Pain      Blood In Urine

## FAMILY HISTORY (DETAILS THAT YOU MAY RECALL OF BIOLOGICALLY RELATED FAMILY)

Maternal \_\_\_\_\_  
Paternal \_\_\_\_\_  
Your siblings \_\_\_\_\_  
Your children \_\_\_\_\_  
Other history \_\_\_\_\_

**DENTAL**      How many amalgam fillings do you have? \_\_\_\_\_      How many root canals? \_\_\_\_\_  
What other dental procedures? \_\_\_\_\_      Have you had any teeth extracted? \_\_\_\_\_  
Any problems with oral health? \_\_\_\_\_

## LIFESTYLE, ENVIRONMENT & HYGIENE

How old is your home? \_\_\_\_\_      How long have you been living here? \_\_\_\_\_      How is your home heated? \_\_\_\_\_

Work environment? \_\_\_\_\_      Chemical exposure? \_\_\_\_\_

Alcohol and how much? \_\_\_\_\_

Do you smoke and how much? \_\_\_\_\_

Do you microwave foods? \_\_\_\_\_      Do BBQ? \_\_\_\_\_      Do you fry? \_\_\_\_\_

What kind of deodorant do you use? \_\_\_\_\_

Do you use cosmetics and which kinds?

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## DIET & EXERCISE

How often do you exercise? \_\_\_\_\_ For how long? \_\_\_\_\_

What type of activities? \_\_\_\_\_

How much water each day? \_\_\_\_\_ Juices? \_\_\_\_\_ Coffee? \_\_\_\_\_ Other? \_\_\_\_\_

Please list the most common foods and snacks.

MEAL NUMBER					
TIME OF DAY					
FOODS					

## INSURANCE & FINANCIALS

Does your insurance plan cover naturopathic medicine, how much? \_\_\_\_\_

Do you have any financial restrictions? \_\_\_\_\_

*All naturopathic services are covered by most private insurance plans up to the designated limit of the plan.  
Products are usually NOT covered by these plans.*

**Sign the necessary pages below. There are 4 required signatures. (Sign at the X)**

1. STATEMENT OF ACKNOWLEDGEMENT AND CONSENT TO EXAMINATION AND TREATMENT
2. PRIVACY INFORMATION CONSENT FORM
3. INFORMED CONSENT TO NATUROPATHIC DIAGNOSTIC AND THERAPEUTIC PROCEDURES
4. CONSENT AND AUTHORIZATION FOR PARENTERAL THERAPY PROCEDURES

# CONSENT FORMS

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## STATEMENT OF ACKNOWLEDGEMENT AND CONSENT TO EXAMINATION AND TREATMENT

***N.B. This form must be signed before any treatment will be rendered.***

Naturopathic medicine uses non-invasive methods of assessing the bodily functions and natural therapeutics for treatment. The treatments include the use of electro-acupuncture feedback in the assessment of structural, nutritional, electromagnetic and lifestyle. In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your cooperation in signing this statement of acknowledgement, in so doing you understand & agree that:

1. I am a Naturopathic Doctor, and not a Medical Doctor; that I use non-invasive, natural methods of assessment and treatment. The treatments you receive are not mutually exclusive from any treatment or advise you may be receiving or may receive in the future from another licensed health care provider.
2. Methods that I may use have a proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.
3. I am required by my licensing board to perform a physical examination on each new patient if necessary. This will be adhered to unless a full report is sent by the referring practitioner and that report is deemed acceptable.
4. Treatment and/or referral to other health practitioners is based on the assessment of your health, through personal history, physical examination, laboratory testing and other methods of evaluation. You are free to seek or continue care from other health care provider qualified to practice in Ontario.
5. I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended. I reserve the right to discontinue my services where it is apparent that your expectations and what I can provide are not in agreement.
6. You are not an agent of any private or government agency attempting to gather information without so stating your intentions.
7. While changes in dietary habits are not an absolute prerequisite for treatment, that you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.
8. You are accepting or rejecting this care of your own free will and the ultimate responsibility for your health care is your own, and that I am here to support you in this.
9. That you understand that all fees for services and supplements are payable at the time of the appointment. Any special financial arrangements may be made clear in advance.
  - (i) The fee for an initial visit is \$200.00 (60 min) and follow up visit is \$100.00 (30 min).
  - (ii) That there is a fee for completing insurance forms & letters of \$50.00 minimum and telephone consultations of greater than 10 minutes at \$50.00 per 15 minutes.
  - (iii) Notice of 24 hours is required for appointment cancellation; otherwise you will be charged a cancellation fee of \$50.00.
  - (iv) There is a fee for copying of patient records of minimum \$35.00 for files of less than 20 pages. Larger files will be charged according to cost of materials and administration time.

I, \_\_\_\_\_ have read and understood the above statements.

**X**

\_\_\_\_\_  
Signature of patient or guardian

Date: \_\_\_\_\_

# CONSENT FORMS

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## PRIVACY INFORMATION CONSENT FORM

### For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

The Privacy Information Officer is: **Dr. Salvatore Arrigo, ND.**

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Do not hesitate to discuss our policies with me or any member of our office staff. Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

In this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protocols;
- Our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

### The Collection, Use and Disclosure of Patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care & to identify and ensure continuous high quality service
- To assess & provide your health needs
- To advise you of treatment options & to offer and provide treatment, care and services
- To enable us to contact you & to establish and maintain communication with you to distribute healthcare information and to book and confirm appointments
- To communicate with other treating health-care providers, including specialists and referring doctors
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- To comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the practice.
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages, if any.
- To prepare materials for the Health Professions Appeal and Review Board (HPARB).
- To invoice for goods and services

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- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirement
- To comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

## Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information. I know that your office has a Privacy Code, and I can ask to see the code at any time.

I agree that Dr. Sam Arrigo ND, can collect, use and disclose personal information about

\_\_\_\_\_ as set out above in the information of the office's privacy policies.  
(Patient's Name)

**X** \_\_\_\_\_ Date \_\_\_\_\_  
Patient Signature

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## PRIVACY INFORMATION

### How to Access the Privacy Process in Our Office

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your information.

### Our privacy information officer can be reached at:

#### Dr. Salvatore Arrigo, ND

Email: [Clinic.Info@DrArrigo.com](mailto:Clinic.Info@DrArrigo.com)

Oak Park Wellness Centre  
231 Oak Park Blvd, Oakville, ON, L6H 7S8  
Phone 905 901 3402  
Fax 905 901 3139

Pinewood Natural Health Centre  
489 Kingston Road West, Ajax, Ontario  
Phone 905 427 0057  
Fax 905 427 0054

Our privacy information officer will attempt to answer any questions or concerns that may arise. If you have a concern and/or wish to make a complaint to us about our privacy practices, including asking questions about the contents of your charts or records, you must make your request in writing. Please send it to our office's Privacy Information Officer by surface mail, fax, or email.

Our Privacy Information Officer will promptly acknowledge receipt of your complaint in writing, and will ensure that it is investigated thoroughly. You will be provided with a formal decision in writing, and the reason for the decision. If you are dissatisfied with the decision, you may seek further information from the Privacy Commissioner of Canada. We have included all the necessary contact information listed below.

Postal Address:  
Privacy Commissioner of Canada  
112 Kent Street  
Ottawa, ON K1A 1H3

General Inquiries:  
Phone: 613-995-8210  
Toll Free: 1-800-282-1376  
Fax: 613-947-6850

Our privacy policies and procedures comply with federal legislation called the Personal Information Protection and Electronic Documents Act (PIPEDA). This very complex law does provide some exceptions to the privacy principles that are too detailed to outline here. Our privacy code sets out this office's commitment to protecting your private health and personal information. It is available on request by asking any of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

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## INFORMED CONSENT TO NATUROPATHIC DIAGNOSTIC AND THERAPEUTIC PROCEDURES

RECOMMENDED DIAGNOSTIC PROCEDURE(S): (incl. those by referral to another practitioner)

- ElectroDermal Testing and/or BTA(Biological Terrain Assessment) and/or Microscopy and/or Thermography and/or Hair Analysis and/or Blood Testing and/or Heart Rate Variability

RECOMMENDED THERAPEUTIC PROCEDURE(S)/PLAN: (incl. those by referral to another practitioner)

- Nutritional/Botanical/Homeopathic supplementation and/or Diet and Lifestyle modification, Ion-cleanse, Sauna, Pressotherapy, Magnetic Field Therapy, Ionized Oxygen Therapy, Pulsation Therapy, and Acupuncture.

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/plan and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the diagnostic and therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily **consent** my informed consent for the recommended diagnostic and therapeutic procedure(s)/plan as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

**X** \_\_\_\_\_  
Patient or Lawful Representative Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness Signature\*  
*\*Witness signature is advised but not necessary*

\_\_\_\_\_  
Witness Relation to Patient

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

**Dr. Salvatore Arrigo, ND** Attending N.D./Assistant

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## WITHDRAWAL OF INFORMED CONSENT

I do hereby voluntarily **withdraw** my informed consent for the recommended therapeutic procedure(s)/plan as specified above. I understand that I may change informed consent at any time.

\_\_\_\_\_  
Patient or Lawful Representative Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness Signature\*  
*\*Witness signature is advised but not necessary*

\_\_\_\_\_  
Witness Relation to Patient

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

**Dr. Salvatore Arrigo, ND** Attending N.D./Assistant

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