purewellness group

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Weight Management Health Screening Form

All of your answers will be held ***absolutely confidential***. If you have any questions, please ask. Thank you!

GENERAL INFORMATION

Date:

Name:

Date of Birth: Gender:

Address:

Home Phone: Work Phone:

Cell Phone: E-mail Address:

Occupation:

How did you hear about us?

Family Physician: Phone:

Other Health Care Providers: Phone:

MEDICAL HISTORY

Please list current medications and/or supplements:

Type	Dose and Date Started	Taken for

Surgeries / Injuries:

Date:

Date:

MEDICAL TESTING

Please list any preventative or exploratory tests that have been completed in the last five years (colonoscopy, cardiac stress test, blood work, ultrasounds, etc):

Type of Test	Result

Please list ALL allergies / sensitivities (food, medical, environmental, etc):

CARDIOVASCULAR

- ( ) High Blood pressure *
- ( ) Congestive Heart Failure *
- ( ) Heart Attack *
- ( ) Arrythmia*
- ( ) Pacemaker or device *
- ( ) Heart Disease *
- ( ) Stroke *
- ( ) Bleeding disorder *
- ( ) _____

RESPIRATORY

- ( ) Chronic cough
- ( ) Shortness of Breath
- ( ) Bronchitis
- ( ) Asthma
- ( ) Emphysema *
- ( ) _____

ACHES AND PAINS

- ( ) Please describe

GASTROINTESTINAL

- ( ) Chronic Diarrhea
- ( ) Chronic Constipation
- ( ) Celiac Disease
- ( ) Inflammatory BowelDisease
- ( ) _____

OTHER CONDITIONS

- ( ) Mental Illness *
- ( ) Skin Conditions
- ( ) Cancer *
- ( ) Epilepsy *
- ( ) Eating Disorder
- ( ) Arthritis
- ( ) Diabetes *
- ( ) Low Blood Sugar
- ( ) Headaches
- ( ) Eye/Vision Problems
- ( ) Ear/Hearing Problems
- ( ) Osteoporosis / Osteopenia
- ( ) Joint replacement / pins / wires
- ( )

IMMUNE

- ( ) Autoimmune Disease
- ( ) Infectious / Contagious diseases: *
- ( )

RENAL AND UROLOGY CONCERNS

- ( ) Kidney Disease
- ( ) Kidney Stones
- ( ) Urinary/Bladder Infections
- ( ) Interstitial Cystitis
- ( )

FAMILY HISTORY

- ( ) Autoimmune Disease
- ( ) Cancer
- ( )

PREGNANCY

- ( ) Due Date:

* If you have any of these conditions currently or in the past, you may not be eligible to participate in any Weight Loss programs without further testing or a full initial consultation with one of our Naturopathic Doctors.

OBSTETRIC HISTORY

Check all that apply

( ) Pregnancies ____ ( ) Caesarean ____ ( ) Miscarriages ____ ( ) Abortions ____

( ) Vaginal Deliveries ____ ( ) Living Children ____ ( ) Post-Partum Depression ( ) Toxemia

( ) Gestational Diabetes ( ) Breastfeeding ____ *If so, for how long?* ____

MENSTRUAL HISTORY

Check all that apply

Age at first period: Frequency: Length: Pain: ( ) Yes ( ) No Clotting: ( ) Yes ( ) No

Have you ever skipped a cycle? *If so, for how long?* ____

First day of last menstrual period: Days between menses:

Do you use hormonal contraception? ( ) Yes ( ) No *If so what type?:* ____ *For how long?:* ____

Do you use contraception? ( ) Yes ( ) No *If so what type?:* ( ) Condom ( ) Diaphragm ( ) Partner Vasectomy

( ) IUD ( ) Tubal Ligation ( ) ____

FEMALE DISORDERS

Check all that apply

( ) Fibrocystic Breasts ( ) Endometriosis ( ) Fibroids ( ) Infertility ( ) Painful Periods ( ) Heavy Periods

( ) PMS ( ) Spotting ( ) Vaginal Discharge ( ) Low Sex Drive

Last Mammogram: Last Breast Biopsy: Last Self Breast Exam:

Last PAP Test: Results: ( ) Normal ( ) Abnormal

Last Bone Density Test: Results: ( ) High ( ) Low ( ) Within Normal Range

Describe any changes to body/psyche prior to menses:

Are you in menopause?: ( ) Yes ( ) No Age at menopause:

MALE DISORDERS

Check all that apply

( ) Prostate Cancer ( ) Enlarged Prostate ( ) Infertility ( ) PSA Testing

( ) Urinary urgency ( ) Urinating at Night ( ) Low Sex Drive ( ) Infertility

WEIGHT LOSS HISTORY

Please list any attempts at weight loss in the past and your level of success:

Description	Result and Duration (ie Weight Watchers and kept weight off for 1 year)

INFORMED CONSENT

We would like to take this opportunity to welcome you to Pure Wellness Group. This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's natural ability to heal and improve the quality of life and health through natural means.

Your Naturopathic Doctor (ND) will conduct a thorough case history. A screening physical exam, blood and/or urinary laboratory reports or other in house tests may be performed and may be used as part of the treatment work-up. Assessment of each patient's physical, mental and emotional well- being is required to facilitate this work.

If you have copies of lab tests or any other diagnostic tests done in the past 6-12 months please submit them with your forms. If you do not have copies, your Naturopathic Doctor may suggest a release of records with your Health Care Provider.

Additional or up-to-date diagnostic tests may be recommended as treatment guidelines are presented. Tests ordered by a Naturopathic Doctor are NOT covered under OHIP

Therapies used by a Naturopathic Doctor may include: Clinical Nutrition, Botanical Medicine, Homeopathy, Traditional Chinese Medicine, Acupuncture, Lifestyle Counseling & Stress Management, Hydrotherapy, Parenteral Therapies, Injection Therapies, and Physical medicine.

STATEMENT OF ACKNOWLEDGEMENT

I, (print your name) _____ , acknowledge that as a new patient of the clinic, have read the information included herein, and understand that the form of medical care is based on Naturopathic Medicine and other supportive principles and practices. I also recognize that even the gentlest therapies have potential complications in certain patients.

I therefore confirm that I have informed (and will continue to inform) my practitioner fully of my medical history, family history, medications and/or supplements I am currently taking (prescription and over the counter), or was previously taking. I have also advised my practitioner of the possibility that I may be pregnant and will continue to do so.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.

I understand that my practitioner will answer any questions I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the practitioner to anticipate and explain all risks and/or complications. With this knowledge I voluntarily agree to the diagnostic and therapeutic treatments outlined above except the following (list any therapies you do not wish to participate in): _____

FEE STRUCTURE FOR NATUROPATHIC VISITS

Full Initial visit:	**$300**
60 minute visit	**$230**
45 minute visit:	**$175**
30 minute visit:	**$125**
15 minute visit:	**$75**

*Note: **Telephone and email consults** are also available and are subject to a fee based on time or service provided.

I understand that charges are to be paid **at the time of the visit**. As the patient, I am responsible for the total charges incurred at each clinic visit, email/zoom and/or phone consultation and have been informed of the fee schedule and accepted methods of payment. Our methods of payment include VISA, MasterCard, Interact, cash (Canadian dollars only) E-Transfer or cheque. (NSF charge of $35.00 for a returned cheque/payment) Additionally, I am aware of the clinic's policy for missed or cancelled appointments.

Should I cancel or wish to change a previously scheduled appointment without providing a **MINIMUM of ONE weekday** advance notice, I authorize you to bill my credit card on file for 50% of the published costs for the previously scheduled appointment.

Should I NOT show up for an appointment without providing ANY advance notice, I authorize Pure Wellness Group to bill my credit card on file for 100% of the published costs for the previously scheduled appointment. Your credit card number will be collected at the time of scheduling the initial appointment and will ONLY be processed in the case of a missed appointment.

When you attend any scheduled appointment, you may pay with any form of payment of your choosing. Please be advised that the above fee schedule is subject to change.

Pure Wellness Group will advise patients of price changes if and when they occur.

I understand that Pure Wellness Group does not provide refunds for services, treatments or supplements. While our policy is firm, we will do everything we can to work with you to make your experience with us as positive as possible. I have read and understand all of the above-stated policies and information. I intend this consent form to cover the entire course of treatment I receive at **Pure Wellness Group**. I understand that I am free to withdraw my consent with written notice and to discontinue treatment at any time. I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating.

Patient's signature	Date
Witness's signature	Date

( ) I would like sign up for **Pure Wellness Group** newsletters and updates

E-mail address : _____

PATIENT INFORMATION AND PRIVACY FORM:

Privacy of your personal information is an important part of our office's pledge to provide 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.

Our Privacy Information Officer is Dr. Tara O'Brien ND. Tara will attempt to answer any questions or concerns that you might have. Tara can be reached at the address and phone number above, or by email at: **reception@purewg.ca**. If you do have a concern and/or wish to make a complaint to us about our privacy policies, you must make your request in writing. Our Privacy Officer will promptly acknowledge receipt of your complaint in writing, and will ensure it is investigated thoroughly. You will be provided with a formal response in writing indicating any decisions/actions, and the reason for such.

If you are dissatisfied with the actions or decisions, you may seek further information from the Privacy Commissioner of Canada. We have included all the necessary contact information below.

Privacy Commissioner of Canada
112 Kent St, Ottawa, ON K1A 1H3
Phone: 1-800-282-1376
Fax: 613-947-6850

Our privacy policies and procedures comply with the federal legislation called the Personal Information and Electronic Documents Act (PIPEDA). This very complex law does provide for some exceptions to the privacy principles that are too detailed to outline here.

Our Privacy Code sets out the offices' commitment to protecting your private health and personal information. It is available by request from any of our office staff.

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

We ask that you review our Privacy Code, for details on 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 protection protocols

Our privacy protocols comply with privacy legislation, standards of our regulatory body, the Board of Directors of Drugless Therapy-Naturopathy of Ontario, and the law.

Your information may be accessed by regulatory authorities under the terms of the Drugless Practitioners Act for the purpose of the Board of Directors of Drugless therapy-Naturopathy in Ontario fulfilling its mandate under the DPA, and for the defense of a legal issue.

Our office will not under any circumstance directly supply your insurer with your confidential medical history. In the event this kind of 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 to use or disclose your personal information by written notification, and we will explain the ramifications of that decision, and the process. If a new purpose arises for the use/or disclosure of your personal information, we will seek your approval in advance.

Statement of Consent to Collect Information:

I have read and understood the above information, and am fully aware of the privacy policies of **Pure Wellness Group** how your office will use, collect and disclose my personal information, and the steps your office is taking to protect my information. I agree that **Pure Wellness Group** can collect, use, and disclose personal information about myself, as set out above and according to the PIPEDA guidelines.

Patient's signature	Date
Witness's signature	Date

INFORMED CONSENT REGARDING EMAIL OR THE INTERNET USE OF PROTECTED PERSONAL INFORMATION

Pure Wellness Group offers patients the opportunity to communicate with their Naturopathic Doctor and administrative staff via email. Transmitting confidential health information by e-mail, however, has a number of risks, both general and specific, that should be considered before using email.

Among general e-mail risks are the following:

- E-mail can be immediately broadcast worldwide and be received by many intended and uintended recipients.
- Recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge.
- Users can easily misaddress e-mail.
- E-mail is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.

Among specific patient e-mail risks are the following:

- E-mail containing information pertaining to a patient(s) diagnosis and/or treatment must be included in the patient(s) medical records. Thus, all individuals who have access to the medical record will have access to the e-mail messages.
- Employees do not have an expectation of privacy in e-mail they send or receive at their place of employment. Thus, patients who send or receive e-mail from their place of employment risk having their employer read their e-mail.
- Patients have no way of anticipating how soon **Pure Wellness Group** and its employees will respond to a particular e-mail. Although **Pure Wellness Group** and its employees and agents will endeavor to read and respond to e-mail promptly, **Pure Wellness Group** cannot guarantee that any particular e-mail message will be read and responded to within any particular period of time **unless an email consult has been booked in the system**. Health care workers rarely have time during consultations, appointments, staff meetings, meetings away from the facility, and meetings with patients and their families to continually monitor whether they have received e-mail. Thus, patients should not use e-mail in a medical emergency.

It is policy of **Pure Wellness Group** that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be part of that patients protected personal health information and will treat each e-mail with the same degree of confidentiality as afforded other portions of the protected personal health information. Pure Wellness Group will use reasonable means to protect the security of e-mail or internet communication, but because of the risks outlined above, we cannot guarantee the security and confidentiality of e-mail internet communication.

Patients must consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mail to or from patients concerning diagnosis and/or treatment will be made part of their medical records.
b. We may forward email messages within the practice as necessary for diagnosis and treatment. We will not forward e-mail outside of the clinic without the consent of the patient as required by law.
c. We will endeavor to read e-mail promptly but can provide no assurance that the recipient of the e-mail will respond promptly, **unless an email consult has been booked in the system**. Therefore, e-mail must not be used in case of an emergency.
d. It is the responsibility of the sender to determine whether the recipient received the e-mail and when the recipient will respond.
e. We cannot guarantee that electronic communications will be private at this time. However, we will take reasonable steps to protect the confidentiality of the e-mail or Internet communication but **Pure Wellness Group** is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or misconduct.
f. If consent is given for the use of e-mail, it is the responsibility of the patient's to inform **Pure Wellness Group** of any types of information you do not want to be sent by e-mail.
g. It is the responsibility of the patient to protect their password or other means of access to e-mail sent or received from **Pure Wellness Group** to protect confidentiality. **Pure Wellness Group** is not liable for breaches of confidentiality caused by the patient.

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to **Pure Wellness Group**.

I have read this form carefully and understand the risks and responsibilities associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

Patient's signature	Date
Witness's signature	Date

PATIENT PLEDGE

Your health and healing depend on our commitment to doing the best that we can as your Naturopathic Doctor, in addition to YOUR commitment to the following:

- **A Partnership and a Process**
  Remember that your health concerns probably did not develop overnight. Most health concerns develop insidiously over months or years. In the same fashion, some chronic illness can take weeks, months, or even longer to improve with regular treatment. If you do not see immediate results, do not be discouraged, and most certainly do not give up. It takes time, patience and persistence to find and treat the root causes of your illness. You will be expected to put in as much effort as possible, and we will do the same.

- **Prescribed changes**
  Your compliance with prescribed dietary changes, supplements, botanicals, parenteral therapy, medications, as well as other treatment recommendations is really the key to healing. If you do not follow the recommended treatment plan with diligence and consistency, your journey towards optimal wellness will be slowed.

- **Patient/Physician Commitment**
  Establishing and maintaining a healthy and effective relationship with your physician at **Pure Wellness Group** is a key component to your success as a patient. Once a treatment plan is established, it is important that you remain in your Naturopathic Doctor's care and stay in regular communication.

- **Ongoing Support**
  Naturopathic Medicine is a unique approach from the existing health-care model in Canada. Chronic illness can contribute to significant changes in your activities of daily living, in your energy, mood, or focus. Some of the changes that your Naturopathic doctor suggests may be overwhelming at times. We suggest that patients find a source of support in their social network (family, friends, or colleagues). If you do not feel that you have this support in your immediate social group, we recommend that you find professional help in the form of a Counselor, Psychotherapist, or a Life Coach.

I have read and agree to the statements above.

Patient's signature	Date
Witness's signature	Date