DR. CHRISTINE MATHESON, ND

ChristineMathesonND.com Christine@ChristineMathesonND.com

NATUROPATHIC ADULT INTAKE FORM

CONTACT INFORMATION

Today's Date:_____

First Name:_____ Last Name: _____

Date of Birth (mm/dd/yy): _____ Age_____

Gender_____

Occupation:_____
Do you enjoy your work?_____

Full Mailing Address: _____

_____

_____

Email Address:_____
Home Telephone Number:_____
Other Telephone Number:_____
May I leave messages relating to your visits? _____

How did you hear about me? _____

Emergency Contact:

Name:_____ Relation:_____

Phone Number: _____

Other Healthcare Providers

Name: _____

Specialty:_____ Phone Number:_____

Name: _____

Specialty:_____ Phone Number:_____

Health History

What are your health concerns or goals, in order of importance to you:

1_____
2_____
3_____
4_____
5_____

If you are female, are you pregnant? Yes No Trying

Approx. Height:_____ Approx.Weight:_____

Have you had any unexplained weight changes recently? _____

Please list any previously diagnosed medical conditions /year diagnosed:_____

_____
_____
_____

Please list all of your allergies (medications, foods, pets, environmental, etc):_____
_____
_____

Please list all prescription drugs, over-the-counter medications:_____

_____
_____

Please list all natural supplements or herbal medicines:_____

_____
_____
_____

Vaccinations / Immunization Record (please check all that apply):

Routine Ontario Immunization Schedule

Polio
Hepatitis B
Varicella (Chicken Pox)

Haemophilus Influenza B
Human Papillomavirus (HPV)
MMR (Mumps, Measles, Rubella)
DPT (Diptheria, Pertussis, Tetanus)
Meningococcal C Conjugate (Meningitis)
Pneumococcal Conjugate (Meningitis, Pneumonia)

Additional Vaccines:
Flu Vaccine
Hepatitis A
Tetanus Booster
BCG (Tuberculosis) Other:

Other:

Did any of your vaccines cause adverse reactions? If yes, please describe:

_____

Family History

Please indicate if a parent, grandparent, child, or sibling has had any of the following health problems: allergies, arthritis, asthma, cancer, depression or other mental illness, diabetes, drug or alcohol abuse, headaches, heart disease, high blood pressure, kidney disease, thyroid disease, neurological conditions, or other genetic diseases:

Health Problem_____Family Member_____

Health Problem_____Family Member_____

Health Problem_____Family Member_____

Health Problem_____Family Member_____

Health Habits

Diet: Do you have any dietary restrictions?_____

_____

Exercise: How many times do you exercise per week?_____
What types of exercise?_____

Sleep: On average, how many hours of sleep do you get per night?_____
Do you have trouble falling asleep?_____
Do you wake up during the night?_____

Sex- Are you sexually active? Yes No

If yes, what form of contraception do you use?

_____

Energy: What is your average energy level from 1 (lowest) to 10 (highest)?_____

Stress: What is the biggest source of stress in your life?

_____

Hobbies: What are your hobbies?_____

Environment:Are you regularly exposed to toxins, smoke, animals, or other hazards? If yes, please describe:_____

Tobacco (amount per day):_____ Past tobacco (years used):_____

Alcohol (drinks per week) _____ Beer_____ Wine_____ Other_____

Caffeine (drinks per day) _____Coffe_____Tea_____Cola_____

Recreational Drugs What:_____Amount:_____

Is there anything else that you feel is important that you want me to know?

_____

_____

_____

_____

Example of 2 DAY EATING DIARY

Day 1

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Day 2

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

*Amount of Daily Water Intake:_____

Consent to Naturopathic Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person by taking into consideration the physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to promote healing. Your naturopathic doctor will take a thorough health history, perform a screening physical examination, and take laboratory samples when necessary. Depending on your case, the physical may include, with your consent, more specific examinations such as breast or external genital exams.

It is very important that you inform your naturopathic doctor of any disease you are suffering from, any allergies you have, and any medications or over the counter drugs that you are currently taking. Please advise your naturopathic doctor if you are pregnant, suspect you are pregnant, or if you are breastfeeding. As a patient, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the material effects, costs, expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to; some patients experience allergic reactions to some supplements and herbs; pain, bruising, or injury from taking blood tests or from acupuncture; fainting or small risk of puncturing an organ with acupuncture needles ; muscle strains, sprains, and disc injuries from spinal manipulation. There is a very small potential for stroke in neck manipulation. Patients are screened prior to manipulating the neck for potential contraindications. Your naturopathic doctor is trained to handle emergencies should the need arise.

I UNDERSTAND:

My naturopathic doctor does not guarantee treatment results. My naturopathic doctor will explain to me the exact details of any treatments provided and will answer any questions I may have.Costs above those included in the naturopathic visit fee will be explained prior to engaging in any treatment or diagnostic test that involves additional fees. I am free to withdraw my consent and to discontinue treatment at any time.

Print Name:_____

Signature:_____

Date (mm/dd/yy)_____

Consent for the Collection, Use, and Disclosure of Personal Information

I understand the importance of protecting the privacy of your personal information and we are committed to collecting, using, and disclosing your personal information responsibly. All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. As such, I strive 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.
- My privacy protocols comply with privacy legislation, the standards of our regulatory body, and the law.

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

- To assess your health needs and advise you of treatment options.
- To communicate with you and remind you of upcoming appointments.
- To communicate with all other health care providers in your health care team.

- To allow us to efficiently follow-up for treatment, care, and billing.
- To assist in complying with all regulatory requirements and the law, including requirements to advise authorities of child abuse and to report diseases and individuals who may be an imminent threat to themselves or others.
- To invoice for goods and services, process payments, and collect unpaid accounts.

If a new purpose arises, I will seek your written approval in advance. We will not, under any circumstances, supply your insurer with your confidential medical history. In the event that this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

PATIENT CONSENT:

I have reviewed the above information that explains how my naturopathic doctor will use my personal information. Should the need arise, I agree that my naturopathic doctor can email me and I understand that this is not considered a secure form of communication. I agree that my naturopathic doctor can collect, use, and disclose my personal information for the purposes listed above.

Print Name_____

Signature_____

Date (mm/dd/yy)_____

PATIENT HEALTH STATUS SCREENING POLICY AND PROCEDURE

For In-Office Visits with Christine Matheson, ND

It is of utmost importance that patients thoroughly read and sign this document with respect and sensitivity for the reasons it has been created.

Dr. Christine Matheson, ND has created the 'Patient Health Status Screening Policy and Procedure' for the purpose of **controlling and preventing the spread of contagious infections to her other patients and to herself and her family** therefore she appreciates your respect and compliance.

Because as part of her services, Dr. Matheson provides the Arvigo Techniques of Maya Abdominal Therapy with hands-on treatments through her 'Belly Be Well' Program, she wants to be particularly cautious about avoiding coming into contact with or spreading infection. Dr. Matheson also wants to remain well so she can continue to be in service to her patients and family and doesn't want to unnecessarily be exposed to contagious conditions.

Dr. Matheson has implemented this policy to clearly outline that **she will not see patients for in-office visits IF they have recently experienced or are experiencing the following signs or symptoms due to an acute, contagious and/or infectious cause, for example:**

- **Cough, cold, flu, fever, sore throat, respiratory infection, bronchitis, pneumonia, viral infection, sinus infection or nasal congestion caused by an acute infection**

This policy is to be respectfully implemented due to the serious health implications and inconvenience it can cause to Dr. Matheson's other patients, herself and her family, as well as other colleagues in the clinic. For this reason, no exceptions will be made.

Dr. Matheson will most certainly continue to see all patients when they are generally "well" and free of any acute, contagious and/or infectious symptoms.

In the event that a patient is experiencing or has recently experienced an acute, contagious and/or infectious illness, Dr. Matheson can offer the below options in an effort to assist you.

- A **phone consultation** in which it will be determined if a referral is warranted
- **Reschedule appointment** once patient is completely recovered and symptoms have subsided.
- A referral to the patient's family doctor if strongly suggested.

*If a patient is not sure if his/her symptoms are contagious and not sure whether or not he/she should attend an in-office visit, it is strongly advised to contact Dr. Matheson at **christine@christinemathesonND.com** to speak with Dr.Matheson to help assess patient health status and to ensure total clarity and complete safety.

I_____ (**print patient /or patient Guardian's name**) have read and understand the above 'Patient Health Status Screening Policy and Procedure' and will respectfully comply with this policy by not attending (or

having my child attend) any in-office visits with Christine Matheson, ND if I (or my child) have **recently experienced or am experiencing the following signs or symptoms due to an acute, contagious and/or infectious cause, for example:**

- **Cough, cold, flu, fever, sore throat, respiratory infection, bronchitis, pneumonia, viral infection, sinus infection or nasal congestion caused by an acute infection**

Patient Signature or Patient Guardian's Signature_____
Date_____

If signing as a Guardian, please indicate the name of the patient that you are Guardian for _____ (Print Patient Name)

Today's Date: _____

Please answer the following health status screening questions accurately and honestly;

1. Are you or have you (or your child) recently experienced signs or symptoms due to an acute, contagious and/or infectious cause, for example ; cough, cold, flu, fever, sore throat, sneezing, respiratory infection, bronchitis, pneumonia, viral infection, sinus infection or nasal congestion and sneezing caused by an acute infection?

YES or NO (Circle answer)

2. If you (or your child) have recently experienced signs or symptoms due to an acute, contagious and/or infectious cause, how many days have you (or your child) been completely symptom free? _____ days

3. If you (or your child) have recently experienced signs or symptoms due to an acute, contagious and/or infectious cause, did you seek medical attention for these symptoms? YES or NO (Circle answer)

If so, please explain further:

_____

_____

I respect the seriousness of this health status policy and have answered the above questions accurately and honestly.

Print PatientName_____

Guardian Name_____

Guardian Signature _____**Today's Date**_____

Thank you for your cooperation and for respecting the safety of my health and the health of my other patients and family.

THANK YOU FOR TAKING THE TIME TO COMPLETE THESE FORMS

Sincerely, Dr. Christine Matheson, ND