M. COLETTE HARMAN, N.D.

Doctor of Naturopathic Medicine

281 Durham Sreet, Kincardine, ON N2ZX 2X9

519-396-4018

Welcome to our office. We look forward to working with you.

Please fill out the following:

Patient Admittance Form *File No:*__________________

Name: ___________________________ ___________________ *Title:* _______________

*Address:*____

Phone: (home) (____) ________________ *(work) (____)*_________________________

Occupation: __________________________ *Employer:* ____________________________

Work Address: ____

Birthdate: ___/___/___ *Age:* ___ *Sex: M*___ *F*___ *Height:* ______ *Weight:* _____

*Marital Status: Single*___ *Married*____ *Separated*___ *Divorced*___ *Widowed*___ *Other*___

Number of Children: _____ *Ages & Sex:* _______________________________

*If patient is a child, give parents' names: Mother*______________________________

*Father*_______________________________________

How did you learn of our office? Friend ___ *Relative* ___ *Professional* ___

Name: __________________________________

Have you had previous naturopathic care? *Yes* ___ *No* ___

If yes, when? ____________________ *With whom?* ________________________

Are you familiar with the services we offer? Yes ___ *No* ___

Do you have extended health care coverage? Yes ___ *No* ___

Date: ____________________ *Signature:* ________________________________

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INFORMED CONSENT FOR NATUROPATHIC TREATMENT

I would like to take this opportunity to welcome you to the Kincardine Holistic Health Centre and the Naturopathic Practice of myself, M.Colette Harman, N.D. My practice utilizes the principles and practices of Naturopathic Medicine and other supportive therapies, to assist the body's own ability to heal and to improve the quality of life and health of individuals through natural means. A number of different approaches may used: diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, and lifestyle counselling.

A thorough case history will be conducted by myself. A physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up.

STATEMENT OF ACKNOWLEDGEMENT

As a patient of this clinic I understand that this form of medical care is based on Naturopathic principles and practices. I recognize that even the gentlest therapies may potentially have their complications 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 the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; and pain, fainting, bruising or injury from acupuncture.

As a patient of M. Colette Harman, N.D., I am at liberty to seek or continue medical care from any medical doctor or other health care provider licensed to practice in Ontario. 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 understand that results are not guaranteed. I understand that treatment advice will not be given over the phone or email unless directly relating to specifics discussed during a clinic visit. I accept full responsibility for any fees incurred during care and treatment. I also understand the Kincardine Holistic Health Centre's cancellation policy requires me to cancel a booked appointment 24 hours prior to that appointment. If I fail to do so, the fee for the missed appointment of $55.00 will be charged.

Patient's/Guardian's printed name: ______________________________

Patient's/Guardian's Signature: ______________________________

Witness Signature: ______________________________

Date: ____________________

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Patient Consent Form for Collection, Use and Disclosure of Personal Information

The privacy of your information is an important part of the Kincardine Holistic Health Centre, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this clinic, M. Colette Harman, N.D., is the only one who will come in contact with your personal information and is aware of the sensitive nature that you have disclosed to her. She is trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic 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; and our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy - Naturopathy.

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information. This clinic will collect, use and disclose information about you for the following purposes: to assess your health concerns; to provide health care; to advise you of treatment options; to establish and maintain contact with you; to send you newsletters and other information mailings; to remind you of upcoming appointments; to communicate with other treating health care providers; to allow us to efficiently follow-up for treatment, care and billing; to complete claims for insurance purposes; to comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy - Naturopathy acting under the authority of the *Drugless Practitioners Act ;* to invoice for goods and services; to collect unpaid accounts; to assist this clinic to comply with all regulatory requirements; to comply generally with the law; and to allow potential purchasers, practice brokers or advisers to conduct an audit in preparation for a practice sale.

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 as outlined above.

Patient Consent

I have reviewed the above information that explains how your clinic will use my personal information and the steps your clinic is taking to protect my information.
I agree that M. Colette Harman, N.D. can collect, use and disclose personal information

about_________________________________as set out above in the information about the clinic's privacy policies.
(patient name)

_________________________________ signature

_________________________________ print name

_________________________________ date

_________________________________ signature of witness

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OFFICE POLICIES: TO BE READ AND SIGNED BY PATIENT, PARENT OR GUARDIAN

To increase the efficiency of our office and to ensure that you will derive maximum benefit from the care offered, we have established the following office policies:

1. We reserve the right to reject any case presented to this clinic, on the basis of history and/or physical examination.

2. We reserve the right to discharge any case where:
   - we feel that the case is outside the scope of practice of this clinic;
   - the patient refuses to cooperate with the recommendations mutually agreed upon.

3. We are required by our regulatory board to perform a physical examination on each new patient. This policy will be adhered to unless a full report is sent by the referring practitioner (i.e. If your medical doctor or chiropractor refers you for a specific procedure only, then you must present a written referral request for that procedure from that practitioner to us.)

4. For the convenience of our patients and for the orderly and efficient operation of our clinic, we endeavour to keep scheduled appointments on time. However, complications and emergencies do arise and in these circumstances, we appreciate your patience and understanding. Please note that when you arrive late for your appointment, only the balance of the time that was reserved for you can be used.

5. We must respectfully request a minimum of **24 hours notice** in the event that you must change your appointment. **Failure to give this notice will result in the full fee being charged for the time and procedure missed.**

6. All fees for services are the responsibility of the patient and are payable at the time of the visit. Payment may be made by cash or cheque. Receipts are issued at the time of payment. Please save your receipts for your records and for insurance and income tax purposes. A charge will be made for issuing duplicate receipts.

7. Please note that if you need to contact Dr. Harman before your next appointment, please telephone the office leaving your name and phone number with a brief reason for your call. Dr. Harman will return the call as soon as possible. (If calling long distance, the call will be returned collect.) Should the telephone consultation be longer than five (5) minutes then a fee of $25.00 will apply.

Please note that naturopathic services are not covered by OHIP. However, many extended health care plans do cover a portion of naturopathic services. Check the specifics with your company. We are usually required to fill out forms for you to submit along with your receipts. The reimbursement returns directly to you.

I, ____, HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE POLICIES.

(Please print)

____ DATE: ______________________

(Signature)

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Please Note: Our ability to draw effective conclusions about your present state of health and how to improve it depends to a great extent on your ability to complete this questionnaire honestly and accurately. The Doctor is the only person who will review this survey and your confidentiality is strictly maintained. Please fill in forms as thoroughly as possible.

New Patient Questionnaire

1. Please state your primary reason for attending this office. If this involves a specific health condition, please describe it in detail. In your own words, list the very first time that you noticed the condition and describe carefully any factors that you suspect may have played a role in its onset and perpetuation. Please list every detail and give the Doctor the opportunity to distinguish what may or may not be relevant to your case. (Please attach a sheet if more space is required).

2. Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? If so, please indicate these clearly.

3. Are you currently working with a professional counsellor, psychologist, social worker, pastor or psychotherapist? Yes ☐ No ☐ Have you in the past? Yes ☐ No ☐
Do you have another doctor? Yes ☐ No ☐ Medical Doctor's Name:_______________
Do we have permission to contact your medical doctor about your case? Yes ☐ No ☐
Chiropractor's Name:__________________

4. Have you consulted a medical doctor or chiropractor regarding the aforementioned condition(s)? Please explain their therapy and the result.

5. Please list all of the secondary health conditions which you are aware of whether you feel they are related to the previously reported conditions or not.

6. Please list all drugs/medications which you presently use or have used in the past and why? Reflect carefully as your current health state may relate directly to the treatment of a past health problem.

7. Do you use any other type of non-prescription and/or recreational drug? Yes ☐ No ☐ Please list and indicate quantity and frequency of use.

8. Do you consume alcohol? Yes ☐ No ☐ What type? ______________________
Indicate approximate consumption per week.____________

9. Do you supplement your diet with vitamins or minerals? Yes ☐ No ☐ Please list the brand name, content and potencies of all products used and indicate the frequency with which they are taken.

Health History

Family Health History:

10. Please indicate whether there is any history of the following conditions in your family and give the details below. (Please be accurate). Heart Disease, Cancer, Osteoarthritis, Ankylosing-Spondilitis, Rheumatoid Arthritis, Multiple Sclerosis, Muscular Dystrophy, Mental Illness, Auto-Immune Disorders, Allergies, Alcoholism, Drug Abuse or any other conditions which might be pertinent to your present state of health. (Please attach sheet if space is required).

Personal Health History:

11. Was your mother's health good throughout her pregnancy when carrying you? (Please check if you can). Yes ☐ No ☐

12. Were you breast fed at all, and for how long?

13. Were you a colicy baby? Yes ☐ No ☐ Until what age? _____

14. Did you require any medical attention, hospitalization, or medication as a baby? Yes ☐ No ☐ As a child? Yes ☐ No ☐ Please explain if "Yes" answers.

15. Have you had any surgery? Yes ☐ No ☐ Please list all surgeries, their approximate dates, and why they were performed.

16. Have you had any illness other than the ordinary self-limiting childhood diseases of measles, mumps and chickenpox? Please explain.

17. Have you ever had worm or parasite infections? Yes ☐ No ☐

18. Have you ever had scarlet or rheumatic fever? Yes ☐ No ☐

19. Have you ever been diagnosed as having cancer, diabetes, M.S., M.D., arthritis, AIDS, hepatitis, Chronic Fatigue (Epstein Barr) or any heart conditions? Explain.

20. Have you ever had any disease condition involving the bones, muscles, ligaments or tendons? Please explain.

21. Have you had any bad sprains, strains or broken bones due to accidents or sports? Describe.

22. What X-rays have you had done in the past?

23. Have you had any recurring infections? i.e. tonsilitis, bladder or ear infection, vaginitis, colitis, sinusitis, yeast overgrowth, mastitis, dental abcesses, etc.? Please explain fully.

24. Have you had any respiratory disorders? i.e. pneumonia, bronchitis, asthma, etc.? Yes ☐ No ☐ How long do they last?

25. Do you take any medication for the above? If so, what kind?

26. Have you had any sexually transmitted disease or genital herpes? Yes ☐ No ☐

27. Have you ever fainted, blacked out or had a convulsion? Yes ☐ No ☐ Please describe.

28. Do you wear a medical alert bracelet or tag? Yes ☐ No ☐ For what condition?

29. Do you have any allergies to foods, drugs, or inhalants? Yes ☐ No ☐ How do you react? Please list and describe.

Elimination Assessment

A. COLON / BOWELS

1. Bowels move:_____ xday; _____ xweek (on average).

2. Laxative use:_____ xday; _____ xweek; _____ xmonthly; _____ never.
Type used:__________.

3. Have you had or do you have hemorrhoids or varicose veins? Explain.

4. Do you make a conscious effort to eat a high fibre diet? How?

5. Have you ever been diagnosed as having diverticulitis, anal fissures, colitis, Crohn's Disease, spastic or Irritable Bowel Syndrome? (Please underline which).

6. Do you usually pay attention when nature calls?

B. KIDNEY / BLADDER

7. Do you use bottled or purified water? Yes ☐ No ☐ (Please underline which).

8. Do you drink tap water, well water or Municipal? (Please underline which).

9. Do you make a conscious effort to drink 6 - 8 glasses of water daily? Yes ☐ No ☐

10. How many times do you urinate on average? _____ xdaily. Do you void small, medium or large quantities each time? (Please underline which).

11. Do you feel a sense of urgency (need to urinate), yet pass little urine when you try?

12. Do you feel satisfied that your bladder is completely empty after urinating?

13. Does your urine have a strong odour to it? Yes ☐ No ☐ Is it usually _____ Clear; _____Cloudy; _____ Bright Yellow; _____ Dark Yellow; _____ Orange.

14. Please list the number and nature of the beverages which you drink daily and regularly.

15. Do you have any burning or irritation during or after urination? Yes ☐ No ☐

16. Do you any difficulty starting or stopping when urinating? Yes ☐ No ☐ Do you get up in the middle of the night to urinate? Yes ☐ No ☐ How often? _____ xnight; _____ xweek.

C. EXERCISE

17. Do you exercise regularly? Yes ☐ No ☐ _____ xdaily; _____ xweekly; _____ xmonthly.

18. Please indicate the nature of the exercise and also the number of minutes per session.

19. Do you perspire with your exercise? _____ Lightly; _____ Moderately; _____ Heavily.

20. Do you perspire other than when exercising? Yes ☐ No ☐ When?

21. Do you have difficulty perspiring? Yes ☐ No ☐

22. Does your perspiration smell strong? Yes ☐ No ☐

23. Do you get short of breath with even slight exertion? Yes ☐ No ☐

D. FEMALE REPRODUCTIVE SYSTEM

24. Are you still having menstrual periods? Yes ☐ No ☐ If no, please explain.

25. Date of last menstrual period: ________________

26. Are your periods regular? Yes ☐ No ☐

27. Length of menstrual cycle? _______________

28. Length of menstrual flow? _______________

29. Have you ever been pregnant? Yes ☐ No ☐ How often? ___________________

30. a) Did the pregnancy result in live birth? Yes ☐ No ☐ When? _____

b) Did the pregnancy result in still birth? Yes ☐ No ☐ When? _____

c) Did the pregnancy result in miscarriage? Yes ☐ No ☐ When? _____

d) Did the pregnancy result in a therapeutic abortion? Yes ☐ No ☐ When? _____

31. Are you using any form of contraception or birth control? Yes ☐ No ☐ If yes, what type? _______________

E. DETOXIFICATION

32. Have you ever done a detoxification program? Yes ☐ No ☐ Please explain.

33. Do you fast? Yes ☐ No ☐ How often and for how long?

34. Are you on a special diet? Yes ☐ No ☐

35. If you avoid any foods or follow a special dietary program, please explain.

F. OCCUPATIONAL / LIFESTYLE

36. What is your occupation? Please describe the nature of your work.

37. Do you work in an office building? Yes ☐ No ☐ How many hours per week? _____ Do the windows open? Yes ☐ No ☐

38. Do you work in the presence of toxic fumes or chemicals? Yes ☐ No ☐
Have your ever? Yes ☐ No ☐

39. a) Do you chew tobacco, smoke cigarettes, cigars, pipe, hashish or marijuana? Please underline which. (How much? How often? For how long? ______ years).

    b) Have you done any of the above in the past 12 months? When? _____

40. Do any of your hobbies involve toxic materials? Yes ☐ No ☐ If so, what kind? (i.e. paints, plastics, gases, etc.)

41. Do you do any type of relaxation or meditation regularly? Yes ☐ No ☐ What kind?
_______________ How often? _____ xday; _____ xweek; _____ xmonthly.

Please note: This questionnaire is strictly confidential between you and your Doctor. Your accurate responses are vital to provide effective health care at this office. Please go back over your responses and consider their accuracy. Thank you!

Signature: ___________________________________

Date: ____

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Thank you for taking the time and effort to fill out this form for your child. This information is very important in the assessment of your childs case. *Please state the primary reason for attending this office*: (Please attatch sheet if more space is required)

Medical History

Please check the boxes that best describe your child:

Past	Present		Past	Present		Past	Present	
❑	❑	Colic	❑	❑	Burning of urine	❑	❑	Nervous child
❑	❑	Hives	❑	❑	Frequent urination	❑	❑	Sleep problems
❑	❑	Eczema	❑	❑	Heart murmur	❑	❑	Bedwetting
❑	❑	Bleeding Gums	❑	❑	Vomiting spells	❑	❑	Night sweats
❑	❑	Nose Bleeds	❑	❑	Anemia	❑	❑	Sensitive to light
❑	❑	Acne	❑	❑	Stomach aches	❑	❑	Body/breath odor
❑	❑	High Fevers	❑	❑	Digestive upsets	❑	❑	Motion/car sickness
❑	❑	Chronic rash	❑	❑	Jaundice	❑	❑	No appetite
❑	❑	Ear infections	❑	❑	Easy bruising	❑	❑	Nightmares
❑	❑	Hearing loss /problems	❑	❑	Flat feet	❑	❑	Canker sores
			❑	❑	Constipation	❑	❑	Unusual fears
❑	❑	Diarrhea	❑	❑	Gas	❑	❑	Excessive fatigue
❑	❑	Sore throats	❑	❑	Bleeding tendency	❑	❑	Hair loss
❑	❑	Frequent headaches	❑	❑	Joint pains	❑	❑	Hyperactivity
			❑	❑	Dizzy spells	❑	❑	Lack of energy
❑	❑	Frequent colds	❑	❑	Vision problems	❑	❑	Learning problems
❑	❑	Breathing problems	❑	❑	Speech problems	❑	❑	Tantrums
❑	❑	Wheezing	❑	❑	Dental problems	❑	❑	Difficult to please
❑	❑	Cough	❑	❑	Bloody urine	❑	❑	"Problem child"
❑	❑	Convulsions	❑	❑	Cries easily			

Bowel movements per day: ______________________ Colour: ____________________

Medical History (cont'd)

Childhood Illnesses:

❑ Chicken Pox	❑ Pneumonia #____	❑ Ear Infection #______
❑ Measles	❑ Frequent Colds	❑ Whooping cough
❑ Mumps	❑ Rheumatic Fever	❑ Roseola
❑ Rubella	❑ Tonsilitis	❑ Bronchitis #_____
❑ Scarlet Fever	approx. #______	❑ Asthma

Medications:

Past	Present	Past	Present	Past	Present
❑	❑ Aspirin	❑	❑ Ibuprofin	❑	❑ Anti-histamine
❑	❑ Tylenol	❑	❑ Antibiotics	❑	❑ others
❑	❑ Decongestant				
❑	❑ Tempra				

Has your child had any of the following tests:

	When?	Where?
Electroencephalogram		
Psychological evaluation		
Hearing		
Speech/Language		

Injuries/Surgeries/Hospitalizations (please list):

Immunizations:

❑ Measles	❑ DPT	❑ Smallpox
❑ Mumps	❑ MMR	❑ Influenza
❑ Polio	❑ Tetanus	❑ Diphtheria
❑ Other (please list):		

Any adverse reactions (eg. Fever, seizures, pain/sweling at injection site, persistent crying, rashes, hives, vomiting/diarrhea, meningitis, encephalitis, prolonged sleeping etc.

Birth History:

Term: ❑ Full ❑ Premature ❑ Late

Weight at Birty:_____________ Rh blood problem? ❑ Yes ❑ No

Birth complidcations (during or after delivery) please explain:

Delivery was:

- ❑ Normal
- ❑ Premature
- ❑ Caesarean
- ❑ Forceps aided
- ❑ At home
- ❑ In a hospital
- ❑ Difficult (# hrs. labour ______)
- ❑ Drug aided (please list):

Feeding:

- ❑ Breast How many months?:
- ❑ Bottle Type of formula?:

Has your child had any of the following problems?

- ❑ Jaundice
- ❑ Colic
- ❑ Blue Baby
- ❑ Diarrhea
- ❑ Fever
- ❑ Seizures
- ❑ Birth defects
- ❑ Birth injuries
- ❑ Cerebral Palsy
- ❑ Rashes
- ❑ Allergies

Other (please explain):

Child's sleep patterns (first year):

Food intolerances (if any):

Age child began solid foods: ________ What food introduced first?: ____________________________

Age child began:

- Sitting __________
- Crawling __________
- Walking __________
- Talking __________

Mothers Pregnancy History:

Mother's age at child's birth: _________ How many lbs./kg. did you gain? __________

Difficulties in becoming pregnant?:

Was the pregnancy stressful for you?:

Did you experience any of the following:

- ❑ Nausea
- ❑ Shocks/Traumas
- ❑ Bleeding
- ❑ Diabetes
- ❑ Vomiting
- ❑ Hospitalizations
- ❑ Thyroid problems
- ❑ Illnesses
- ❑ Anemia
- ❑ Extreme tiredness
- ❑ Hypertension

Were any of the following used/given during pregnancy?

- ❑ Cigarettes
- ❑ X-rays
- ❑ Sleeping pills
- ❑ Alcohol
- ❑ Ultrasound
- ❑ Antibiotics
- ❑ Recreational Drugs
- ❑ Sedatives
- ❑ Iron supplements

Were you on a special diet? ❑ Yes ❑ No

If yes, please explain:

Previous pregnancies by natural mother, miscarriages or complications (please list):

Family History:

❑ Heart disease	❑ Diabetes	❑ Birth defects
❑ Hypertension	❑ Arthritis	❑ Tuberculosis
❑ Cancer	❑ Allergies	❑ Mental illness

Diet:

Please describe your child's typical 'daily diet':

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DIET DIARY

Please record your daily food and liquid intake for one week. Also include quantities of food eaten and how it is cooked.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Morning (Breakfast)							
Noon (Lunch)							
Evening (Dinner)							