

**MacDonald Naturopathic Medical Clinic**  
**Crista MacDonald, BHSc., ND – Doctor of Naturopathic Medicine**  
29 Wellington Street North, Woodstock, Ontario N4S 6P4  
Tel: (519) 539-7000

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Dear Patient,

Thank you for booking an appointment at the MacDonald Naturopathic Medical Clinic. As discussed, I have included a detailed health intake questionnaire and consent forms. Please bring the completed questionnaire and forms to your appointment, as well as any supplements you are currently taking, and a copy of any lab or blood work that has been performed within the past year (your medical doctor/specialist can supply you with a copy of your lab results if you ask him/her).

Your appointment information is as follows (*please fill in the following*):

**Date:**

**Time:**

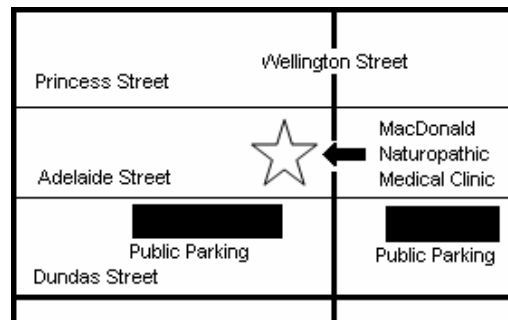
The MacDonald Naturopathic Medical Clinic is located at 29 Wellington Street North. There is plenty of free parking in the public parking lots along Adelaide Street.

Your initial appointment will be 1 ½ hours (90 minutes) in length and will consist of a thorough health intake and a complaint oriented physical examination. Follow-up visits are generally 30 minutes in length. The cost of the initial appointment is \$125 (plus GST). The follow-up appointments are \$65 (plus GST). Payment is made on receipt of treatment. ***We accept cash and check only.*** Naturopathic medical services are covered by most extended health insurance plans. Please check with your provider for more information.

If you have any questions please feel free to contact me at (519) 539-7000. I look forward to working with you in achieving your health goals.

Wishing you good health,

Crista MacDonald-Werby, BHSc., ND  
Doctor of Naturopathic Medicine



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**PEDIATRIC INTAKE FORM (8-12 YEARS OF AGE)**

Patient's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_  
 Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Guardian Contacts:

Name	Relation	Home Phone	Work Phone

Food or Drug Allergies: \_\_\_\_\_  
 Environmental Allergies: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Name of Medical Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about us?

Newspaper  Website  Friends  Family  Other: \_\_\_\_\_

**This is a confidential record of your child's medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.**

**Health Concerns**

What are your and your child's main health concerns in order of importance?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Vitamins and Supplements**

Is your child taking any vitamin/mineral/herbal supplements?    Y    N

If yes, please list the supplement(s) and the dosage:

Supplement/Vitamin	Reason for taking	Dosage

## Prescription Drugs

List all prescription drugs that your child is currently taking. Indicate present dose and how long she/he has been on each medication.

Prescription Drug	Dosage	When did she/he begin the medication?

What over-the-counter medications does your child take? \_\_\_\_\_

How many times has your child taken antibiotics? \_\_\_\_\_

## Medical History

List any major surgery or injury and when it happened:

\_\_\_\_\_

List any major illnesses or diseases that your child has/had:

\_\_\_\_\_

## Vaccinations (please check)

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Flu Shot    |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella)        | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Chicken Pox                          | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Polio                                | <input type="checkbox"/> Other _____ |

Did your child experience a reaction to any of these vaccinations?

\_\_\_\_\_

## Present and Past Health Symptoms

Please check “√” if your child is currently experiencing the following symptom or write ‘P’ beside the box if she/he has experienced the symptom in the past.

### General

- Change in appetite
- Weight gain
- Weight loss
- Cancer
- Diabetes
- Poor sleep
- Nightmares
- Sleep walking
- Fatigue
- Allergies
- Chills and fevers

- Night sweats
- Heavy perspiration
- Cravings
- Strong thirst

### Eyes Ears Nose Throat

- Ear aches
- Ear infections
- Ringing in ears
- Sinus infections
- Enlarged glands
- Recurrent sore throat
- Nasal obstruction

- Runny nose
- Post nasal drip
- Nosebleeds
- Headaches
- Loss of taste/smell
- Eye pain
- Eye strain
- Dizziness
- Impaired vision
- Facial pain/tics
- Mercury fillings
- Sores in mouth

**Skin and Hair**

- Rash
- Itching
- Eczema
- Acne
- Cold sores
- Warts
- Hair loss
- Excess hair
- Dandruff
- Change in mole(s)
- Dryness
- Hives
- Boils
- Bruising/bleeding

**Cardiovascular**

- Irregular heartbeat
- Heart problems
- Fainting
- Cold hands or feet
- Blue skin

**Respiratory**

- Difficulty breathing
- Chronic cough
- Asthma
- Shortness of breath
- Throat phlegm
- Wheezing

**Muscle, Bone & Joints**

- Muscle pain
- Muscle weakness
- Arthritis
- Other pain

**Gastrointestinal**

- Abdominal pain
- Nausea
- Vomiting
- Bloating
- Burping
- Bad breath
- Jaundice
- Constipation
- Diarrhea
- Incomplete bowel movements

- Chronic laxative use
- Rectal pain
- Blood in stool
- Excess gas
- Intestinal worms

**Infections**

- Rubella (German measles)
- Measles
- Mumps
- Chicken pox
- Scarlet fever
- Mononucleosis
- Rheumatic fever
- Whooping cough
- Hepatitis
- Tuberculosis
- HIV/AIDS

**Neurological**

- Loss of balance
- Poor memory
- Dizziness
- Lack of coordination
- Seizures/Epilepsy
- Concussion
- Loss of sensation
- Muscle weakness

**Kidney and Bladder**

- Frequent urination
- Urgency to urinate
- Pain on urination
- Wetting the bed
- Incontinence
- Kidney stones
- Bladder infection
- Blood in urine

**Female Health**

- Vaginal discharge
- Vaginal pain
- Vaginal sores

**Male Health**

- Testicular swelling
- Undescended testicles
- Testicular pain

- Genital sores

**Emotional**

- Irritability
- Anxiety
- Nervousness
- Depression
- Anger
- Aggressive
- Hyperactive
- Inattentive
- Unusual fears
- Other \_\_\_\_\_

Please have your child rate their level of stress from 1 (low stress) to 10 (high stress):

1 2 3 4 5 6 7 8 9 10

Who does your child live with?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What does your child enjoy doing in her/his spare time (hobbies, activities, etc)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does she/he enjoy going to school?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Family History

Please indicate if the child's family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis.

Relationship	Diseases Suffered/Cause of Death
Father	
Mother	
Brother(s)	
Sister(s)	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	
Uncles	
Aunts	

### Chemical, Heavy Metal and Toxin Exposure

Please circle the chemicals, toxins and/or heavy metals that your child has been exposed to:

Second Hand Smoke	Cleaning Products	Mercury
Pesticides	Asbestos	Aluminum
Herbicides	Radiation	Lead

### Birth Health

Was the birth mother exposed to toxic chemicals, smoke, alcohol or recreational drugs during the pregnancy?    Yes    No

Were there any complications during the pregnancy?

\_\_\_\_\_

Weight of the child at birth: \_\_\_\_\_ Height of the child at birth: \_\_\_\_\_

Please list any abnormalities, treatments or surgeries your child received following the birth:

\_\_\_\_\_

### Diet

How many cups/bottles/glasses does your child drink on average per day?

Milk		Soft Drinks (regular)		Fruit Juice	
Water		Soft Drinks (diet)		Herbal Tea	
Coffee		Black Tea		Other: _____	

Diet: Non-Vegetarian  Vegetarian  Vegan  For how long? \_\_\_\_\_

Does your child consume (circle):  
Aspartame    Colours/dyes    MSG    Trans-fats/Hydrogenated oils    BBQ-ed foods

Known Food Allergies/Food Sensitivities: \_\_\_\_\_  
\_\_\_\_\_

Please describe a typical day's diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

**Personal Habits and Lifestyle**

Number of bowel movements per day or week? \_\_\_\_\_

How many hours of sleep does your child get on average per night? \_\_\_\_\_

Does he/she feel refreshed upon waking in the morning?    Y            N

Does your child exercise?    Y            N    If yes, how often? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**General:**

Is there anything else that I should know about your child?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE**

I attest that the information provided is true and accurate to the best of my knowledge.

Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Thank you for taking the time to fill out this questionnaire. It will allow us to assess your child's past and current state of health and it will help us to better understand your and your child's health goals.**

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## Health Consent Form

NOTE TO PATIENT: We want your *informed consent*. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have a question about any of this, please ask.

### CONSENT TO EXAMINATION AND TREATMENT

I would like to take this opportunity to welcome you to the MacDonald Naturopathic Medical Clinic. Naturopathic Medicine is a distinct primary health care system that blends modern scientific knowledge with traditional and natural forms of medicine.

*At the MacDonald Naturopathic Medical Clinic, treatment approaches can include any combination of: Clinical nutrition, Botanical (herbal) medicine, Acupuncture, Asian Medicine, Homeopathic medicine, Physical therapeutics, Hydrotherapy, and Life-style counseling.*

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 informed consent. In so doing you understand that:

1. I, Crista MacDonald, ND, am a Naturopathic Doctor, and not a conventional medical doctor. Naturopathic Medicine is the art and science of disease diagnosis, treatment and prevention using non-invasive natural therapies tailored to each patient and their individual health concerns.
2. The methods I use may have a proven clinical foundation and/or a proven scientific 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. A physical examination will allow me to better understand your unique state of health.
4. Referral to other health professionals will be made as necessary. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider while under care at the MacDonald Naturopathic Medical Clinic.
5. While changes in dietary habits are not an absolute prerequisite for treatment, you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.
6. You are accepting or rejecting this care of your own free will.
7. All fees for services and supplements are to be paid at the time of the appointment by the patient or the guardian. **There is a fee for completing insurance forms, letter writing and telephone consultations of greater than 10 minutes. Notice of 24 hours (in person or by telephone – NO emails please) is required for appointment cancellation, otherwise you will be charged an administrative fee of \$25.00.**

**CONSENT FOR THE COST OF OUR SERVICES**

Initial appointment (1 ½ hours) \$ 125 (plus GST)  
Second appointment (45 minutes) \$ 65 (plus GST)  
Follow-up appointments (30 minutes) \$ 65 (plus GST)  
Home visits (30 minutes) \$ 85 (plus GST)  
Health products (if needed) are in addition to the cost of the visit (prices vary).  
Laboratory test fees (if needed) are in addition to the cost of the visit (prices vary).

I, \_\_\_\_\_ have read and understood the above statements regarding *Consent to Examination and Treatment* and *Consent for the Cost of our Services*.

SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_  
(Patient or guardian)

**CONSENT FOR PERSONAL INFORMATION**

I understand that to provide me with naturopathic services, the MacDonald Naturopathic Medical Clinic will collect some personal information about me (e.g., home telephone number, address, past and present health history, etc.).

The MacDonald Naturopathic Medical Clinic’s Privacy Policy is several pages long. A copy of the Privacy Policy is always available at the clinic’s reception desk. Do not hesitate to discuss our policies with the clinic owner, Crista MacDonald, ND.

I have reviewed the MacDonald Naturopathic Medical Clinic’s Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask questions about the Privacy Policy and they have been answered to my satisfaction.

I understand that **only if I check off** the following boxes will I receive the following:

- I would like to receive notice when it is time to review whether I need another appointment.
- I would like to receive newsletters and other informational mailings or emails from the MacDonald Naturopathic Medical Clinic.
- I would like to receive notice of promotions and/or seminars or workshops offered by the MacDonald Naturopathic Medical Clinic

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments. I agree to the MacDonald Naturopathic Medical Clinic collecting, using and disclosing personal information about me as set out above and in the MacDonald Naturopathic Medical Clinic’s Privacy Policy.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

NATUROPATHIC DOCTOR: \_\_\_\_\_