

**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:**

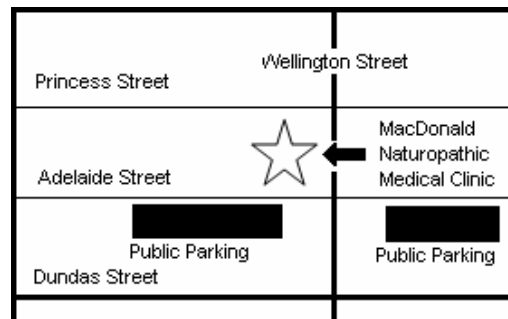
The MacDonald Naturopathic Medical Clinic is located at 29 Wellington Street North. There is plenty of free parking in the public parking lots along Adelaide Street.

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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**TEEN INTAKE FORM (13-18 YEARS OF AGE)**

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 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 main health concerns in order of importance to you?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Vitamins and Supplements**

Are you 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 you are currently taking. Indicate present dose and how long you have been on each medication.

Prescription Drug	Dosage	When did you begin the medication?

What over-the-counter medications do you take? \_\_\_\_\_

\_\_\_\_\_

How many times have you taken antibiotics? \_\_\_\_\_

## Medical History

List any major surgery or injury and when it happened:

\_\_\_\_\_

\_\_\_\_\_

List any major illnesses or diseases that you have 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 you experience a reaction to any of these vaccinations?

\_\_\_\_\_

\_\_\_\_\_

## Family History

Please indicate if your 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)	
Grandfather	
Grandmother	



**Male**

- Testicular swelling
- Undescended testicles
- Testicular pain
- Sores on genitals
- Pain or difficulty with erection
- Pain on ejaculation
- Sexually transmitted infection
- Hernia
- Do you perform regular testicular exams?    Y    N

Age of first menstrual period? \_\_\_\_\_

Date of last Pap \_\_\_\_\_

Pregnant?    Y    N

Number of:

- pregnancies \_\_\_\_\_
- births \_\_\_\_\_
- abortions \_\_\_\_\_
- miscarriages \_\_\_\_\_

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

1 2 3 4 5 6 7 8 9 10

Who do you live with?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you enjoy school?

\_\_\_\_\_

\_\_\_\_\_

**Female**

- Irregular periods
- Heavy periods
- Light periods
- Clotting
- Painful period
- PMS
- Vaginal discharge
- Vaginal sores
- Breast pain
- Breast lump
- Sexually transmitted infection

**Emotional**

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

What do you enjoy doing in your spare time (hobbies, activities, etc)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Chemical, Heavy Metal and Toxin Exposure**

Please circle the chemicals, toxins and/or heavy metals that you have been exposed to:

Second Hand Smoke

Pesticides

Herbicides

Cleaning Products

Asbestos

Radiation

Mercury

Aluminum

Lead

**Diet**

How many cups/bottles/glasses do you drink on average per day?

Milk		Soft Drinks (regular)		Fruit Juice	
Water		Soft Drinks (diet)		Herbal Tea	
Coffee		Black Tea		Alcohol	

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

Do you consume (circle):    Aspartame    MSG    Trans-fats/Hydrogenated oils

Please describe a typical day's diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

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

### Personal Habits and Lifestyle

Do you smoke? Y N If yes, how many cigarettes per day? \_\_\_\_\_

Do you use recreational drugs? Y N If yes, type of drug: \_\_\_\_\_

How frequently do you move your bowels? \_\_\_\_\_ (# of movements per day or week)

Do you use laxatives? Y N If yes, how often? \_\_\_\_\_

How many hours of sleep do you get on average per night? \_\_\_\_\_

Do you feel refreshed upon waking in the morning? Y N

Do you exercise? Y N If yes, how often? \_\_\_\_\_

What do you do for exercise? \_\_\_\_\_

\_\_\_\_\_

### General:

Is there anything else that I should know about you?

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

### 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 past and current state of health and it will help us to better understand your 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: \_\_\_\_\_