



Name: _____ Age: _____ Date of Birth: _____

Address: _____ Postal Code: _____

Telephone #: Home (____) _____ Work (____) _____

E-mail address (optional – if you would like to receive newsletters, etc.): _____

Marital Status: S M D W Sep. # of Children: _____ Names/Ages: _____

Occupation: _____ Employer: _____

How did you learn about this clinic? _____

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 me to do so.

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE	SINCE	CAUSE
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHAT TREATMENTS OR REGIMES ARE YOU FOLLOWING?	SINCE	RESULTS
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHICH OF THE FOLLOWING CONDITIONS HAVE YOU HAD?

abscesses, allergies, amnesia, arthritis, asthma, cancer, chicken pox, cold sores, depression, diabetes, emphysema, epilepsy, gall stones, goiter, gonorrhea, gout, hay fever, heart disease, hepatitis, oral herpes, influenza, kidney disease, leukemia, malaria, German measles, red measles, mononucleosis, mumps, parasites, peritonitis, pleurisy, pneumonia, rheumatic fever, scarlet fever, sexual abuse, skin disease, strep throat, sinusitis, sunstroke, stroke, syphilis, tonsillitis, tuberculosis, typhoid fever, warts, whooping cough, worms

ANY OTHER MAJOR CONDITIONS? _____

ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH YOU HAVE NEVER BEEN TOTALLY WELL AGAIN, OR WHICH HAVE BEEN MORE SEVERE THAN USUAL? WHICH ONES?



WHAT OPERATIONS HAVE YOU HAD?	WHEN?	COMPLICATIONS, IF ANY?
_____	_____	_____
_____	_____	_____

WHAT MAJOR INJURIES HAVE YOU HAD?	WHEN?	LONG TERM EFFECTS?
_____	_____	_____
_____	_____	_____

ALLERGIES? _____

Age at first menses? _____ Number of pregnancies _____

What vaccinations have you had? _____

Have you lost or gained any weight lately? How much? _____

What exercise do you do now and how much? _____

How often do you have a full and complete bowel movement? _____

Do you have to get up at night to urinate? How often? _____

How often do you get headaches? _____ What triggers them? _____

FAMILY HISTORY:

RELATIVE	AGE IF ALIVE	AGE AT DEATH	AILMENTS
Mother			
Father			
Sisters			
Brothers			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

PLEASE LIST THE NAME OF YOUR FAMILY DOCTOR AND/OR OTHER MEDICAL SPECIALISTS:

PHYSICIAN	FOR WHAT CONDITIONS	TREATMENT

HAVE YOU BEEN TREATED BY A NATUROPATH BEFORE? (please circle) Yes No



Informed Consent

Nicole Meier, N.D.

We want your informed consent for the services we are to provide. This means that we want you to understand the services we provide, the cost involved, and what we do with the personal information we obtain about you. If you have any questions about this, please ask.

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. The following outlines the therapies we may utilize:

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health.

Botanical medicine is a plant-based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations for the treatment of illness and disease.

Homeopathy is a form of medicine based on the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal, or mineral origins are used to stimulate the body's ability to heal itself.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally.

Physical medicine refers to the use of hands-on techniques such as soft tissue work and spinal manipulation.

Hydrotherapy refers to the use of hot/cold water applications to improve circulation and stimulate the immune system.

Lifestyle counseling involves identifying risk factors and making recommendations to help optimize one's physical, mental and emotional environment.

**Cornerstone Health Centre
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Georgetown, ON
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(905) 702-1944
(289) 428-1366
www.cornerstonehealth.ca**



During your initial visits, your Naturopathic Doctor will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take blood and urine samples.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. It is very important, therefore, that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

Health risks associated with Naturopathic Medicine include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process.
- Allergic reactions to supplements or herbs.
- Pain, bruising or injury from venipuncture or acupuncture.
- Fainting or puncturing of an organ with acupuncture needles.
- Muscle strains and sprains or disc injuries from spinal manipulation.

_____ **Initials** 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 can request a copy, by paying the appropriate fee. I have read and understand the privacy policy of Cornerstone Health Centre.

_____ **Initials** I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I voluntarily consent to the diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

_____ **Initials** I understand that any treatment or advice provided to me by any of the above Naturopathic Doctors is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from another licensed health care provider.

_____ **Initials** I understand the fee schedule as stated below.

_____ **Initials** I understand that I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. N. Meier, N.D. has not suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

_____ **Initials** I understand that I may purchase any recommended medicines or supplements from the dispensary of Cornerstone Health Centre OR any pharmacy/retail store of my choice.

As the patient, you are responsible for the total charges incurred (visit fees plus any supplements, tests or medicinal substances) for each visit. If you have private health coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. Most insurance companies do not cover the supplements that we prescribe and dispense.

Consultation fees are based on the amount of time spent with the Naturopathic Doctor and are typically scheduled as an initial visit, a second visit and repeat visits as required. The length of the second visit can vary if the doctor feels more time is required to review lab results, food testing results or for other reasons. Additional time is also scheduled after a long absence from the clinic (1 year or more).



Naturopathic Consultations	Initial Visit (75min adult/60min child)	Second Visit (45min or 60min)	Repeat Visits (30min)	Half Visit (15min)
Adult	\$175	\$115 (45min) \$150 (60min)	\$75	\$40
Child (up to 16)	\$150	\$115 (45min)	\$75	\$40
Acupuncture	\$175	\$75 (45min)	\$75	n/a
Phone	n/a	n/a	\$75	\$40

*Seniors (65+) and college/university students (full time) get a 10% discount on naturopathic consultations

*Medical letters are subject to a \$30 fee. File copying is also subject to a \$30 fee.

Koru Food Testing	Initial Testing	Follow-up (candida, virus etc)
Adult and child	\$150 to \$190	\$25 plus \$10 for each additional retest
Functional Testing and Injections		
B12 and folic acid	\$15	
B complex	\$12	
Urinalysis	\$5	
Functional medicine tests vary greatly in cost and are always discussed with the patient in advance.		

We require a minimum of 24hrs notice to cancel or reschedule an appointment. Missed appointments are subject to a \$50 fee if less than 24hrs notice is given. Initial visits require 48hrs notice for cancellation or rebooking.

I have read and understand the above-stated policies and information. I intend this consent form 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.

Patient Name (please print): _____ Date: _____

Signature of Patient (or Parent/Guardian): _____

Signature of Naturopathic Doctor: _____



Consent for Personal Information

I understand that to provide me with Naturopathic services, Nicole Meier, N.D. will collect some personal information about me. For example; address, phone number and health history.

I have reviewed Nicole Meier, N.D.'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 any questions I have about the Privacy Policy, and they have been answered to my satisfaction.

I understand that I will be contacted 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 new goods or services
- I would like to receive newsletters and other informational mailings from Nicole Meier, N.D. and Cornerstone Health Centre.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Nicole Meier, N.D. using and disclosing personal information about me as set out above and in the above Privacy Policy.

Signature: _____ Date: _____

Printed Name: _____

Notes made by Nicole Meier, N.D.