Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

Holistic Nutrition Informed Consent

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

We would like to take this opportunity to welcome you to Lakeside Natural Health Centre. This clinic utilizes the principles and practices of Holistic Nutrition to educate individuals about the benefits and health impact of optimal nutrition. Holistic Nutritionists maintain an interest in the well-being of all individuals. They respect the rights of each client's personal tastes, morals and social values in order to achieve their goals. Holistic Nutritionists recognize the need to work co-operatively with other disciplines, holistic or allopathic to best serve their client's needs.

Privacy of your personal information is an important part of providing you with quality care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. Our privacy protocol complies with privacy legislation and standards of the Canadian School of Natural Nutrition.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my Holistic Nutritionist may discuss my case with other healthcare providers. I understand that I may look at my file at any time and can request a copy of my file with a fee of $0.10 per page. I understand that information from my file may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily. I understand that I am free to withdraw my consent at any time.

Client Name (Please print name): _____

Signature of Client or Guardian: _____ Date: _____

Holistic Nutritionist Name: _____ Holist Nutritionist Signature: _____

The vision of Lakeside Natural Health Centre is to provide true integrative health care. Given our commitment to this best-patient practice, we will communicate with your other practitioners at our clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.
I welcome professional dialogue regarding my case between members of my health care team at Lakeside Natural Health Centre (please circle): Yes / No
Signature: _____

Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

Billing Authorization Form

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Credit Card on File:

Client's Name: _____

Name as it appears on the credit card: _____

Type of credit card (please circle): MasterCard / Visa

Card Number: _____

Expiration Date (month/year): _____

Cancellation Policy:

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours' notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with our clinic policy.

I, _____, authorize Lakeside Natural Health Centre to process the above credit card as "Signature on File" for any balance due on my account past 30 days and for any appointments not cancelled in accordance with Lakeside Natural Health Centre's cancellation policy. I understand that a receipt will be promptly sent to me upon any charges.

Patient / Cardholder's Signature: _____ Date: _____

Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

Holistic Nutrition Intake Form

Please complete the following form to provide us with the background information we require to ensure you receive comprehensive care. It should take 15 - 20 minutes.

Contact Information:

Name _____
Date of Birth M_____D_____Y_____
Gender (circle) ____Male / Female_____ Age_____
Home # _____
Address _____
_____
Email _____

Occupation _____
Work # _____
Cell # _____
Emergency Contact _____
Emergency Contact # _____
Parent or Guardian Name
(If under 16 years) _____

YES / NO Can we send you our monthly newsletter and new event listings via email? Your email address will not be shared.

How did you hear about Lakeside Natural Health Centre? _____

Health Care Providers:

Medical Doctor _____
Phone # _____

Naturopathic Doctor _____
Phone # _____

Other Health Care Providers:

Type of Provider _____
Name _____
Phone # _____

Type of Provider _____
Name _____
Phone # _____

Health Concerns (List in order of importance):

1. _____
2. _____
3. _____
4. _____

Medical and Lifestyle Information:

What are your goals in consulting a holistic nutritionist? _____
_____

Please circle the number that indicates your level of stress: (0 – no stress, 5 – moderate stress, 10 – extremely stressful)

Family members	0	1	2	3	4	5	6	7	8	9	10
Financial	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10
Job Related	0	1	2	3	4	5	6	7	8	9	10
Spiritual	0	1	2	3	4	5	6	7	8	9	10
Relationship	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

Do you use strategies to cope with stress and/or anxiety? (circle one): YES / NO
If so, please explain: _____

General state of health (circle one): excellent good fair poor Energy level: _____ / 10 (0 – no energy, 10 – abundance of energy)
Do you experience any lulls or highs in your energy level during the day? (circle one): YES / NO
If yes, please explain: _____

How many hours of sleep do you get per night? _____ Do you wake feeling rested? YES / NO
Do you wake up during the night? (circle one): YES / NO If so, how often? _____ Reason for waking? _____

Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

Please circle which conditions you have experienced: (C = Current; P = Past)

General			**Gastrointestinal**			**Ears, Eyes, Nose, and Throat**		
Chronic Headaches	C	P	Constipation	C	P	Ear infections	C	P
Migraines	C	P	Diarrhea	C	P	Ringing in the ears	C	P
Fatigue	C	P	Abdominal bloating	C	P	Frequent colds/flus	C	P
Insomnia	C	P	Gas	C	P	Recurrent sore throat	C	P
Canker Sores	C	P	Heartburn	C	P	Sinus infections	C	P
Herpes	C	P	Undigested food in stool	C	P	Hoarseness	C	P
Dizziness	C	P	Blood in stool	C	P	Sore throat	C	P
Numbness/tingling in arms/hands/legs	C	P	Belching	C	P	Cold sores	C	P
Allergies	C	P	Colitis/Crohn's	C	P			
Heart Disease	C	P	IBS	C	P	**Musculoskeletal**		
High/low blood pressure	C	P	Hemorrhoids	C	P	Jaw pain	C	P
Diabetes	C	P	Hernia	C	P	Arthritis	C	P
Depression/Anxiety	C	P	Ulcers	C	P	Osteoporosis	C	P
Elevated Cholesterol	C	P				Gout	C	P
Adema (swelling of hands, feet)	C	P	**Skin**			Muscle spasms/cramps	C	P
PMS	C	P	Acne	C	P			
Menopausal symptoms	C	P	Eczema/psoriasis	C	P			
Irregular menses	C	P	Varicose veins	C	P	**Respiratory**		
Low libido	C	P	Fungal infections	C	P	Asthma	C	P
Cold hands and/or feet	C	P	Warts	C	P	Bronchitis	C	P
Anemia (low iron)	C	P	Hives	C	P	Lung disease	C	P

Have you sought treatment from a Physician or been hospitalized due to the above concerns? If so please describe the treatment and results:

_____

_____

Have you sought treatment from a Naturopathic Doctor or other complimentary health practitioner due to the above concerns? If so please describe the treatment and results:

_____

_____

Please list any other aliments that you have been diagnosed with: _____

_____

How often do you exercise? _____ / wk
What is your exercise routine? _____

How many hours do you work per week? _____ What times do you start and end each day? _____

When was your last vacation and for how long?_____
Do you vacation regularly? (circle one): YES / NO

Do you smoke? (circle one): YES / NO
If so, for how long and how often do you? _____

Do you drink alcohol? (circle one): YES / NO
If so, how frequently and what quantity? _____

Do you use recreational drugs? (circle one): YES / NO
If so, how frequently and what quantity? _____

Lakeside Natural Health CENTRE
HEAL · GROW · THRIVE

Do you actively participate in religious or spiritual activities? Please describe: _____

Have you experienced any major trauma or loss in your life? _____

Women Only – Do you experience any PMS or Menopausal symptoms? (circle one): YES / NO
If so, please explain: _____

Do you follow a specific way of eating (e.g. vegetarian, paleo, Kosher)? (circle one): YES / NO
If so, please explain: _____

Do you wish to (circle one): Gain weight? Lose weight? How much? _____ When do you wish to reach your goal? _____
What is your motivation to change your weight? _____

Describe what you eat in a typical day (please indicate at what time of day):
Breakfast: _____ Lunch: _____
Dinner: _____ Snacks: _____

How much fluid do you consume on a daily basis, and what types? _____
_____

Do you crave certain foods? (circle one): YES / NO
If so, which foods?: _____

Do you avoid certain foods? (circle one): YES / NO
If so, please explain: _____

Do you experience any symptoms immediately after a meal, 1-2 hours after a meal, or after skipping a meal? (circle one): YES / NO
If so, please explain: _____

How often do you have a bowel movement? Please explain: _____
Do you ever have loose bowel movements? (circle one): YES / NO
If so, how often and what do they seem triggered by? _____
Do you ever strain with bowel movements? (circle one): YES / NO
If so, how often and what do they seem triggered by? _____
Do you ever have undigested food in your stool? (circle one): YES / NO If so, how often? _____

Allergies or Food sensitivities: Please indicate any allergies and/or serious food sensitivities

Allergy / Sensitivity	Severity of reactions

Medications: Please list all medications and over-the-counter medications taken in the past 6 months

Medication/Supplement	Dose/Length of use	Condition it is treating

Supplements or Natural remedies: Please list all supplements/homeopathics taken in the past 6 months

Supplement/Natural Remedy	Dose/Length of use	Condition it is treating

Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

Do you eat or use any of the following? (please indicate 1 = rarely; 2 = regularly; 3 = often)

_____ Aluminum pans _____ Margarine _____ Candy _____ Microwave _____ Fried foods _____ Fast foods
_____ Lucheon meats _____ Cigarettes _____ Artificial Sweetners (Splenda, etc.) _____ Refind foods (pastries, white bread, etc.)

Please circle which of the following symptoms you have experienced: (O = Occasional; F = Frequent)

Liver

Yellow or pale fingernails	O	F	Excess body odour	O	F	Yellow palms	O	F
Skin oily on nose and forehead	O	F	Migraine headaches	O	F	Jaundice	O	F
Fars/greasy foods cause nausea, headaches	O	F	High cholesterol/high cholesterol diet	O	F	Weight gain around the abdomen	O	F
Vertical white streaks on fingernails	O	F	Constipation	O	F	Poor concentration	O	F
Onions, cabbage, radishes, cucumbers cause bloating/gas	O	F	Discomfort underneath right ribcage	O	F	Acne, boils, rashes, psoriasis or eczema	O	F
Bad breath; bad taste in mouth	O	F	Irritable, easily angered	O	F	Difficulty losing weight	O	F

Dysglycemia

Hungry up to 3 hours after eating	O	F	Frequent “midnight snacks”	O	F	Fainting spells	O	F
Irritable if late for, or ship a meal	O	F	Family history of diabetes	O		Depression	O	F
Strong, sudden cravings for sweets, starches, coffee or alcohol	O	F	Addicted to coffee with sugar and/or colas	O	F	Nervous/anxious feelings relieved by eating	O	F
Overweight	O	F	Fatigue	O	F	Loose temper easily	O	F
Frequent Headaches	O	F						

Thyroid

Distinct, lethargic, tiredness or sluggishness	O	F	Gain weight easily, fail to lose on diets	O	F	Constipation, less than one bowel movement a day	O	F
Cold hands or feet	O	F	Low body temperature, especially at bed rest	O		Feel stiff after sitting still for some time	O	F
Mercury amalgams (filings)	O	F	Hair dry, brittle dull, lifeless	O	F	Unusually square and wide fingernails	O	F
Low energy in the morning	O	F	Flaky, dry rough skin	O	F	High cholesterol	O	F
Low pulse rate	O	F	Mood swings	O	F	Diminished sex drive	O	F

Candidiasis

Extreme fatigue	O	F	Poor bowel movement	O	F	Anxiety/panic attacks	O	F
Recurrent vaginal infections	O	F	F: PMS	O		Canker sores	O	F
Frequent use of antibiotics	O	F	Pain in pelvic area	O	F	Jock itch	O	F
White coated tongue, oral thrush	O	F	Cystitis, repeated bladder infection	O	F	Athlete’s foot, finger/toenail fungus, ringworm	O	F
Crave sugars, bread, alcohol	O	F	Increasing food and chemical sensitivities; severe reaction to tobacco, perfume, etc.	O	F	Unexpected/unexplained weight gain	O	F
Headaches	O	F	F: endometriosis/ovary problems	O	F	Irritability	O	F
Tonsillitis, recurrent strep throat	O	F	Hives, psoriasis, acne, rashes	O	F	Brain fog or memory loss	O	F
Skin flushes	O	F	Rectal itching	O	F	Mood swings	O	F
Always cold, especially in extremities	O	F	Excessive wax in ears	O	F	Itchy ears, nose, eyes	O	F
Chronic indigestion, frequently use antacids	O	F	Abnormal muscle aches from exercise	O	F	Depression or anger for no reason	O	F