Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416 597 1640
1002 King St. West, Toronto Ontario M6K 3N2 www.kingwestchiro.com

ADULT PATIENT INTAKE FORM

We are aware of the time it takes to fill out such a lengthy intake form, however, your cooperation in completing it is essential to providing the highest standard of care. All your information is kept strictly confidential. PLEASE PRINT.

Registration Information

Name: _____ **Today's Date**: _____
(First) (Middle) (Last) dd / mm / yy

Date of Birth: ___/___/___ **Age**: _____ **Gender**: _____
dd/ mm / yy

Home Address:

_____

Town/ City: _____ **Postal Code:** _____

Home Telephone: ( ) _____ **Work:** ( ) _____

May we leave messages on your home phone relating to your visits? Y N

Email address: _____

Emergency contact Name: _____ **Phone:** ( )_____

How did you find out about our clinic?

Referral- Whom may we thank?_____
OAND or APND Website (please circle)
Newspaper/ magazine / flyer / Signage
Google Search
Yellow pages
Other _____

Family Physician: _____ **Phone:** ( ) _____

Other Health Care Provider(s): _____ **Phone:** ( ) _____
_____ **Phone:** ( ) _____

Do you have extended medical coverage, if so, what services are covered?

_____
_____

This is a confidential record of your medical history and will be kept in this office. The information it contains will not be released to any person without your authorization.

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Health Concerns

What are your primary health concerns, in order of importance to you:

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

List any other concerns you may want to discuss:

_____
_____

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please list any recent or past serious conditions, illnesses, injuries, and/or hospitalizations with approximate dates:

_____
_____
_____

Do you have any allergies (medicines, environmental, foods)?

_____
_____

Please indicate what immunizations you have had:

DPT (diphtheria, pertussis, tetanus)	Haemophilus influenza B
Hepatitis A	Tetanus booster
"Flu"	Hepatitis B
MMR (measles, mumps, rubella)	Polio
Smallpox	

Please indicate any adverse reactions you may have had to past immunizations:

_____
_____

Approximately how many times have you been treated with antibiotics in the past 5 years? _____

Do you get regular screening tests done by another doctor? (Pap, Prostate, blood tests, etc.) Yes No

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Do you frequently use any of the following?

Laxatives Antacids
Diet pills Aspirin/Tylenol/Advil
Caffeine - form and amount/day_____
Artificial Sweeteners- how much/day or week_____
Alcohol - how much/day or week_____
Recreational drugs - what and how much_____

Family Health History (√ - present or 'P' - past):

Indicate if a close relative (parent, grandparent, sibling, aunt, uncle) has, or has had any of the following:

Allergies	Endometriosis	Osteoporosis
Artificial Heart Valve	Gallstones	PMS
Arthritis	Heart Disease	Rubella
Asthma	High Blood Pressure	Rheumatic Fever
Cancer (type_____)	Kidney Disease	Skin Disease
Diabetes	Mental Illness	Stroke
Eczema	Multiple Sclerosis	Tuberculosis

Any other familial medical conditions?

_____

_____

Vitamins and Supplements

Please list all current vitamins/minerals/herbal/homeopathic supplements that you are currently taking (if you need more room please use the back of the page):

Supplement (**including brand**)	Dosage	When did you begin this supplement?

Medications

Please list all prescription and non-prescription medications that you are currently taking (if you need more room please use the back of the page):

Medication	Dosage	When did you begin taking this medication?

Please list any past prescription medications:

_____

King West Village Chiropractic Clinic

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Environment

Occupation(s):

_____

_____

Hobbies: _____

_____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe:

_____

_____

Personal Habits and Lifestyle

How frequently do you have bowel movements? _____ (# movements) per day or week (circle)?

How many hours of sleep do you get on average? _____
Do you feel refreshed in the morning? Yes No

How often do you exercise? _____

What type of exercise, how long is each session?

_____

_____

_____

Do you smoke? Yes No **If yes, how many per day?**
Do you use recreational drugs? Yes No **If yes, which one(s)** _____

Rate your average daily energy level between: (low) 1 2 3 4 5 6 7 8 9 10 **(high)**
What time of day is your energy the best? _____ **worst?** _____

How many glasses of each of the following drinks do you have on average per day?

Water	Fruit Juice	Beer
Milk	Vegetable Juice	Wine
Coffee	Diet soft drinks	Liquor
Tea	Regular Soft drinks	Mixed drinks
Herbal Tea		

What is the source of the majority of your drinking water?

Tap (city) Filtered Reverse Osmosis Bottled Well

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Female Reproductive

Age of your first menses _____ When was your last menstrual period? _____
How many days do you bleed? _____ How long is your typical menstrual cycle? ___
Do you experience: Heavy flow? Yes No Light flow? Yes No
Clotting? Yes No Bleeding between periods? Yes No
Do you suffer from pre-menstrual symptoms? Yes No
If yes, which ones? ☐Pain or cramping ☐Mood Swings
☐Bloating and/or water retention ☐Headaches
☐Breast tenderness ☐Cravings
Are you sexually active? Yes No Current form of contraception: _____
Are you pregnant? Yes No Are you currently trying to conceive? _____
Number of pregnancies _____ Number of miscarriages _____
Have you had a hysterectomy? Yes No
Have you ever used birth control? Yes No What type? _____
Are you menopausal? Yes No Age of last menses _____

Please indicate if any of the following applies to you:
☐Vaginal Discharge ☐Abnormal pap tests
☐Pain during intercourse ☐Low libido
☐Vaginal Itching ☐Vaginal dryness
☐Vaginal Odour ☐Sexually transmitted disease/infection: _____
When was your last pap test? _____ Results: _____
Have you ever had an abnormal pap? Yes No If yes, explain: _____
_____

Breast Health
When was your last breast exam? _____
Do you perform monthly self breast exams? Yes No
Do you have regular mammograms? Yes No
Do you experience: ☐Lumps ☐Tenderness ☐Nipple discharge

Male Reproductive

Please indicate if any of the following applies to you:
☐Impotence ☐Sexually transmitted disease
☐Sores on genitals ☐Discharge
☐Testicular Mass ☐Testicular pain
☐Infertility/low sperm count ☐Hernia
☐Prostate condition Year of last prostate exam?
Are you sexually active? Yes No Current form of contraception:

Is there anything that you feel that is important that hasn't been covered?

_____
_____

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FINANCIAL POLICY AND BILLING PROCEDURES

Our Naturopathic Visit Billing Procedures Are As Follows:

Initial Consultation: 90 minutes - $175.00 + HST
2nd Follow-up visit: 60 minutes- $140.00 + HST
Follow-up visits: 45 minutes- $95.00 + HST
30 minutes- $70.00 + HST
15 minutes- $35.00 + HST
Home Visits: Please Contact Dr. Sloan
Initial Acupuncture Treatment (without prior ND visit) $125.00 + HST
Acupuncture Treatments: $60.00 + HST
Phone Consultations (10 min-15min) - $35 + HST. Phone consultations lasting longer than 15 minutes will be billed at $70 + HST (equivalent to a 30 min appointment).

Please be advised that all missed appointments, without a 24-hour cancellation notice, will be applied to your account. Thank you for respecting our time.

INFORMED CONSENT TO TREATMENT

1. I understand that Tara Sloan, B.Kin. (Hons), ND is a Naturopathic Physician, and will use only natural, non-invasive methods of assessment and treatment.

2. I understand that any advice given to me as a patient at King West Village Chiropractic Clinic, is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.

3. I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in Ontario.

4. I understand that the Naturopathic Physician reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.

5. I understand that I am accepting or rejecting this care by my own free will.

6. I understand that no employee or physician at King West Village Chiropractic Clinic, is suggesting that I refrain from seeking the advice of another health care provider.

7. I understand that the services offered by Tara Sloan, ND are not covered by OHIP, and that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.

8. **I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the appointment fee.**

9. I understand that any therapies recommended will be explained to me in full by the naturopathic physician, and that I will give consent to treatment based on informed consent.

I _____ have read, understood and agree to the above statements.

Signature_____ Date_____

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PATIENT CONSENT FORM
FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic, 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.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are 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.
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy– Naturopathy.

HOW OUR CLINIC COLLECTS, USES, AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Our clinic understands the importance of protecting your personal information. Outlined below is how our clinic is using and disclosing your personal 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 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 comply with legal and regulatory requirements or 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 process credit card payments
- To collect unpaid accounts
- To assist this clinic with all regulatory requirements
- To comply generally with the law

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 you personal information as outlined above.

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 King West Village Chiropractic Clinic can collect, use and disclose personal information about (**patient name**)

_____ as set out above in the information about the clinic's privacy policies.

_____ _____
Signature Print Name

_____ _____
Date Signature of Witness