PRIVACY POLICY FORM

Privacy of your personal information is an important part of our Health Centre, while providing you with quality care. We understand the importance of protection your personal information. We are committed to collecting, using, and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

Consent Declaration

Dr Andréa Proulx ND understands the importance of protecting your personal information. To demonstrate our commitment to you, please find below an outline of how the office is using and disclosing your information.
This office will collect, use and disclose only necessary information about you for the following purposes:

- To collect information for all services offered by Dr Andréa Proulx ND.
- To collect fees relating to the services offered by Dr Andréa Proulx ND.
- To provide a means of communication between Dr Andréa Proulx ND and the Patient (via email or Canada Post mail) regarding services being offered at that time.
- To provide information on seminars and workshops offered by Dr Andréa Proulx ND via email or Canada Post mail.
- To provide handouts and additional relevant health information via email or Canada Post mail.
- To establish and maintain contact with you, including reminders of upcoming appointments.
- To assist this Health Centre to comply with all regulatory requirements and comply generally with the law.
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for practice sale.

DISCLOSURE:

1. to the Patient's/Client's doctor/health practitioner(s).
2. to colleagues of Andréa Proulx ND for the purposes of supporting Patient/Client health (all Patient/Client confidentiality is maintained).

We will only share your information with your consent. Storage, retention and destruction of your personal information complies with existing legislation and privacy protocols.
The privacy officer of this office is Dr Andréa Proulx ND. A copy of the privacy policy is available on request.

Patient/Client Consent

I have reviewed the above information that explains how your Health Centre will use my personal information, and the steps your Health Centre is taking to protect my information.

_____ _____
(Signature) (Print Name)

_____ _____
(Date) (Signature of Witness)

ACTIVE HEALTH INSTITUTE
Dr Andréa Proulx *ND*

CONSENT TO TREATMENT FORM

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Your Naturopathic Doctor will take a thorough case history, do a complete physical examination as indicated, and may take blood and urine samples. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles

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 unless so directed by myself unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee.
I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications.

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)

_____

Signature of Patient (or Guardian):

_____

Date:

_____

Naturopathic Doctor: _
Dr Andréa Proulx, ND. #1575

_____

ACTIVE HEALTH INSTITUTE

Dr Andréa Proulx *ND*

Welcome to your initial naturopathic consultation. Please take the time to fill out this form in order to give me background information needed to fully address all of your concerns. This will take approximately 20 minutes.

Name: _____

Date of Birth: _____ (d/m/y)

Gender: ___FEMALE___MALE ___OTHER_

Address:_____
_____
_____
_____

Tel #: _(____)_____ Home
_(____)_____ Cell

Email: _____

Occupation: _____

Employer: _____

Work tel #: _(____)_____

Emergency Contact:_____

Emergency Contact Tel #:_(___)_____

Contact relationship: _____

EMAIL	TEL	Preferred method of communication
YES	NO	May the clinic leave messages relating to your visits?
YES	NO	Can we send you my quarterly newsletter via email? (Your contact information will not be shared.)
YES	NO	Are you currently seeing another member of the Active Health Institute team? If so, whom: _____

How did you hear about Dr Andréa Proulx ND?: _____

Members of your ***Current*** Health Care Team:

Medical Doctor

Name: _Dr._____

Tel #: _(_____)_____

Address: _____

_____

Fax #: (_____)_____

Circle all that apply

Dentist Periodontist Other Dental

Massage therapist Physiotherapist

Personal trainer Coach Kinesiologist

Chiropractor Osteopath Pedorthist

Internist Rheumatologist Endocrinologist

ObGyn Midwife Doula Fertility Clinic

ACTIVE HEALTH INSTITUTE

Dr Andréa Proulx *ND*

Your Health Concerns

What are your health concerns, or reasons for coming to the clinic, in order of importance to you. Give a brief description of each of these concerns.

1)
2)
3)
4)

Personal Profile

Marital Status: □ single □ married/common law □ divorced/separated □ widowed □ same sex

Live with: □ spouse □ partner □ children (how many? ____) □ roommate □ parents □ alone

What 3 expectations do you have from THIS VISIT to our clinic?

_____

_____

_____

What LONG TERM expectations do you have from working with our clinic?

_____

_____

_____

What is your present level of commitment to address any underlying causes of your symptoms that relate to your lifestyle? (Please rate from 1 to 10, 10 being 100 % committed).

1 2 3 4 5 6 7 8 9 10

What behaviours or lifestyle habits do you currently engage in regularly that will support your health? (Please list): _____

_____

ACTIVE HEALTH INSTITUTE

Dr Andréa Proulx *ND*

What behaviours or lifestyle habits do you currently engage in regularly that you believe are not supportive for your optimal health? (Please list): _____

_____

Who do you know that will sincerely support you with the potential lifestyle changes you will be making? _____

Personal Medical History

CURRENT Medication / Supplement	*Dosage/Brand*	*Prescribing Physician*	*Condition Treated*	*Start date*

Are there any medications that you have used for more than 5 years which you have not already mentioned? _____

Approximately how many times have you been treated with antibiotics? _____

Do you receive regular screening tests by another doctor (pap, blood tests, etc.)? Yes No

Are there any traumatic events (surgeries, drug reactions, life trauma etc.) that you can identify as having caused or clearly aggravated your health problems?

_____

_____

Describe your general health during childhood? □ Excellent □ Good □ Poor □ Very Poor

Which childhood illnesses have you had?

□ Asthma □ Chicken Pox □ Mumps □ Polio
□ Rheumatic Fever □ Scarlet Fever □ Roseola □ Other: _____
□ Rubella (German Measles) □ Whooping Cough □ Measles

Please check the appropriate boxes for conditions you suffer from currently (C) or in the past (P))

Condition	*C*	*P*	*Condition*	*C*	*P*	*Condition*	*C*	*P*	*Condition*	*C*	*P*
Acne, Boils, Impetigo			Sinusitis			Prostate Problems			Anemia		
Shingles			Allergies (Environmental)			Erectile Dysfunction			Raynaud's Disease		
Eczema			Hay Fever			Diabetes			Bleeding problems		
Keloids			Bronchitis			Gall Bladder Disease			Gestational Diabetes		
Psoriasis			Pneumonia, Pleurisy			Eye Problems			Uterine Prolapse		
Warts			Asthma			Kidney Problems			Pre-eclampsia		

Herpes (cold sores)			Tuberculosis			Cushing's Disease			Pregnancy Problems		
Urticaria - hives			Malnutrition			Addison's Disease			Fibrocystic Breast		
Ulcers			Obesity			Thyroid: overactive			PMS		
Skin Cancer			Rickets			Thyroid: underactive			Uterine Fibroids		
Candida (yeast)			Osteoporosis			Eating Disorder			Endometriosis		
Iritable bowel syndrome			Wilson's Disease			Schizophrenia			Ovarian Cysts		
Colitis (inflamed bowel)			Chronic fatigue syndrome			Bipolar Disease			Vaginitis (recurrent)		
Diverticulitis			Environmental Illness			Clinical Depression			Migraine Headaches		
Constipation			HPV			Suicidal Tendencies			Dizziness		
Food Poisoning			Chlamydia			Multiple Sclerosis			Numbness		
Diarrhea			Syphilis			Lupus			Cramps		
Parasites/Worms			HIV			Myasthenia Gravis			Epilepsy		
Stomach Ulcers			Genital Herpes			Heart Problems			Meningitis		
Appendicitis			Genital Warts			Heart attack, angina			Lupus		
Rheumatoid Arthritis			Gonorrhea			Palpitation			Strep Throat		
Osteoarthritis			Spleen Disease			Circulation Problems			Bladder Problems		
Backpain/Sciatica			Jaundice			Pancreatic Problems			Liver Disease		
Fibromylagia			Hepatitis			Cancer (specify):					
Gout			Alcoholism								

Past Surgeries and Tests (Please check all that apply)

Surgery or Test	*Year*	*Surgery or Test*	*Year*	*Surgery or Test*	*Year*
Abdominal/Gastrointestinal		Chest x-ray		Sigmoid or colonoscopy	
Appendix		Abdominal x-ray		CT scan	
Brain		Kidney x-ray		MRI	
Caesarean Section		Echocardiogram		Ultrasound	
Gallbladder		ECG or EKG		Tubes in ears – 1st set	
Heart		Cancer (type?)		Vasectomy	

Please list any hospitalizations and major injuries/traumas and the year in which they occurred:

_____

_____

_____

Approximately how many times each year do you get colds or the flu? _____

Family Medical History

Illness	*Circle*		*Family member*	*Comments (if needed)*
Alcoholism	Yes	No		
Anemia	Yes	No		
Arthritis	Yes	No		
Asthma	Yes	No		
Cancer	Yes	No		
Depression	Yes	No		
Drug abuse	Yes	No		

Diabetes	Yes	No		
Food allergies	Yes	No		
Digestive problems	Yes	No		
Heart disease / Stroke	Yes	No		
High blood pressure	Yes	No		
Mental illness	Yes	No		
Osteoporosis/penia	Yes	No		
Seizure / epilepsy	Yes	No		
Thyroid disorders	Yes	No		
Other / Family history unknow	Yes	No		

Diet and Lifestyle

Please indicate the number of times per week that you eat or drink the following:

Food	# /wk	Food	# /wk	Food	# /wk
Fruits/Fruit juices		Soy products (tofu, soy milk, etc.)		Fast food (MacDonalds, etc.)	
Vegetables/Vegetable juices		Soft drinks (regular)		Coffee	
Luncheon meat/smoked meat		Soft drinks (diet)		Regular Tea	
White flour/white rice products		Salty snack foods (chips, etc.)		Herbal tea/Green tea	
Margerine		Sweets (candies, cookies, etc.)		Wine	
Milk/Cheese Products		Artificial sweeteners		Other alcoholic drinks	
Microwaved foods		Meal replacement bars/drinks		Glasses of water per day:	

What is the main source of drinking water? □ Tap □ Well □ Bottled (spring) □ Filtered □ Distilled

Is there anything about your diet you would like to change? _____
_____

Number of meals per day? 1 2 3 4 5 >5 Which is usually largest? _____

List any foods that you crave regularly:_____

List any foods you exclude from your diet: _____

Do you follow a specific diet regime? □ Vegetarian □ Vegan □ Other _____

Do you consume organic foods? □ Never □ 1-3x/wk □ 3-5x/wk □ 5-7x/wk □ Daily

EXERCISE: How many times per week? □ Never □ < 1/wk □ 1-3/wk □ 3-5/wk □ >5/wk

What types of exercise do you do & duration of session? _____
_____

Please indicate the amount of time you spend doing the following activities on a typical day:

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Dr Andréa Proulx *ND*

Activity	Times (hrs)	Activity	Time (hrs)
Computer Related Work		Relaxing / Reading / Listening to music	
Time spent inside a building		Sleeping	
Time spent outdoors		Eating	
Exercising		Watching Television / Gaming	
Working		Socializing	

Hours of direct sunlight per week: Summer? _____Winter? _____ Sunscreen regularly □ Yes □ No

Do you smoke? □ Yes (# packs/day _____ , #of years ___) □ Never smoked □ Smoked in the past
□ Regularly exposed to second hand smoke □ Use chewing tobacco

Any recreational/street drugs? □ Yes □ No □ In the past: which ones/how long_____

Frequently use? □Aspirin □Diet Pills □Antacids □Sleeping Pills □Laxatives □Pain pills

Environmental Exposures

Which of the following are you routinely exposed to?

□ Air Pollution	□ Heated Waterbed	□ Nail Polish	□ Oil Heat	□ BBQ cooked foods
□ Makeup	□ Hydro Towers	□ Electric Blanket	□ Gas Fumes	□ Microwave
□ Cleaning Products	□ Air fresheners	□ Computer Screen	□ Factory Fumes	□ Mould/mildew
□ Chemical Spray	□ Paint fumes	□ Pesticides	□ Other (Specify) _____	

Do you have pets in your home? □ Yes □ No Type of pets? _____

Is your home or work environment excessively □ Damp □ Dry □ Hot □ Cold

Do perfumes or strong odours irritate you? □Yes □ No □ Maybe/sometimes

Review of Systems

Height: _____ Weight:_____ Weight 1 year ago: _____ Desired weight: ____

Any <u>unexplained</u> change of weight of 10 lbs or more in the past 6 months? □ Yes □ No

Your energy level: (Low) 1 2 3 4 5 (High) Time of day of high?: _____ low? _____

Rate your stress level: (Low) 1 2 3 4 5 6 7 8 9 10 (High)

How many hours of sleep do you get per night? _____ Do you awake feeling rested? □ Yes □ No

Please indicate if you are currently experiencing or have experienced any of the following:

Endocrine:

□ 20 lbs change in weight in the last year □ Sluggish after eating □ Poor concentration □ Generally feel hot

□ Hypoglycemia (low blood sugar) □ Sluggish after coffee □ Generally feel cold

Immune:

□ Chronic infections □ Shingles □ Cold sores □ Frequent sore throats
□ Frequent antibiotics □ Frequent colds/flus □ Swollen glands/nodes □ Slow wound healing

Neurological:

□ Paralysis □ Muscle weakness □ Vertigo □ Loss of balance
□ Numbness □ Tingling □ Loss of memory □ Lack of coordination
□ Seizures/Epilepsy □ Concussion □ Loss of sensation

Skin, Hair and Nails:

□ Rashes □ Itching □ Hair loss □ Night sweats
□ Lumps/Abscesses □ Strong body odour □ Acne □ Brittle nails
□ Excessive perspiration □ Dry skin □ Warts
□ Eczema/psoriasis □ Thinning hair □Change in the size, shape, colour of a mole or freckle

Head, Eyes, Ears, Nose and Throat:

□ Headaches □ Poor night vision □ Earaches □ Teeth grinding
□ Migraine headaches □ Dry eyes □ Impaired hearing □ Gum problems
□ Visual disturbances □ Excessive tearing □ Ringing in ears □ Cavities
□ Colour blindness □ Nose bleeds □ Loss of hearing □ Throat hoarseness
□ Eye pain/strain □ Poor sense of smell □ Itchy ear canal □ Mercury fillings
□ Blurry vision □ Loss of taste/smell □ Excessive ear wax □ Sinus infections
□ Post nasal drip □ Facial pain/tics □ Sores in mouth

Respiratory System:

□ Difficulty breathing □ Bronchitis □ Emphysema □ Coughing blood
□ Chronic cough □ Asthma □ Shortness of breath □ Throat phlegm
□ Wheezing □ Pain while breathing

Cardiovascular System:

□ High blood pressure □ Phlebitis □ Pacemaker/Valves □ Fainting
□ Low blood pressure □ Chest pain □ Varicose veins □ Cold hands or feet
□ Irregular heartbeat □ Dizziness □ Heart murmurs □ Swelling of limbs

Gastrointestinal System:

□ Indigestion □ Vomiting □ Mucous in stool □ Incomplete bowel movement
□ Gas or burping □ Heartburn □ Black stool □ Undigested food in stool
□ Nausea □ Constipation □ Blood in stool □ Hemorrhoids
□ Bloating □ Chronic laxative use □ Rectal pain □ Itching around rectum
□ Colon trouble □ Known parasites □ Gallbladder problems □ Jaundice

How often do you have a bowel movement? _____

Genito-urinary System:

□ Frequent urination □ Blood in urine □ Awaken to urinate □ Kidney stones
□ Urgency on urination □ Mucus in urine □ Strong urine odour □ Kidney infection
□ Pain on urination □ Incontinence □ Bladder infections □ Strain to urinate

Muscle, Bones and Joints:

□ Neck pain	□ Muscle pain	□ Arthritis	□ Artificial joint
□ Back pain	□ Muscle weakness	□ Bursitis	□ Other pain

Male Sexual Health: How do you describe your sexual orientation? _____Sexually active? □Yes □ No

□ Hernia	□ Testicular mass/pain	□ STD	□ Low sexual drive
□ Discharges or sores	□ Sexual difficulties	□ Impotence	□ Prostate condition

When was your last prostate exam? _____

Female Sexual Health: How do you describe your sexual orientation? _____Sexually active? □Yes □ No

□ Vaginal discharge	□ Irregular periods	□ PMS symptoms:	BREAST HEALTH:
□ Vaginal dryness	□ Heavy periods	□ Cravings	□ Fibrocystic breasts
□ Vaginal itching	□ Clots during period	□ Sore breasts	□ Sore breasts
□ Abnormal PAP tests	□ Light periods	□ Cramps	□ Nipple discharge
□ Sores, growths, lumps	□ Heavy periods	□ Mood swings	□ Skin puckering
□ Odour to discharge	□ Bleeding between periods	□ Low back ache	□ Lump
□ Low sex drive	□ Fertility concerns	□ Bloating	□ Dry skin on nipple
		□ Diarrhea	
□ Pain during intercourse	□ Missed periods	□ Water retention	□ STD _____

Length of cycle (days): _____ (if applicable)

Do you practice birth control? □Yes □ No What type? _____ Date of last PAP: _____

Are you trying to conceive? □Yes □ No Live births: _____ Abortions: _____ Miscarriages: ____

Mental/Emotional:

□ Prolonged sadness/grief	□ Easily angered	□ Mental illness	□ Panic attacks
□ Anxiety/Nervousness	□ Indecision	□ Mood swings	□ Memory problems
□ Depression	□ Irritability	□ Phobia	

What were the major stresses in your life? Are any of these still affecting you?

1._____

2._____

3._____

Has there been an event or illness from which you have never fully recovered from?

_____

_____

Thank you for your time.