Dr. Pamela Frank, BSc (Hons), ND
FORCES OF NATURE WELLNESS CLINIC
2447 Yonge St – 2nd Floor
Toronto ON M4P 2E7
www.ForcesofNature.ca
416.481.0222
Naturopathic . Chiropractic . Massage Therapy
Psychotherapy . Doula . Yoga

ADULT INTAKE FORM

Name _____ Date of first visit_____
Address _____ Apt #_____City_____
Postal Code_____ Phone: Home_____ Work _____
Cellphone_____ Email:_____
Date of Birth (dd/mm/yy) _____ Age_____ Height(feet/inches)_____ Weight(lbs)_____
Occupation_____
May we email you our newsletter & special offers?(your email will remain private) ___Yes ___No
Would you like the option to order our supplements on-line? (we will need your email to set up your account) ___Yes ___No
Family Physician_____Phone_____Address_____
May we contact your physician(s) about your condition/treatment? ___Yes ___No
Whom may we thank for telling you about our clinic? _____

Chief Complaint(s) or Concerns

_____

_____

Other problems or symptoms

_____

Have you been treated by anyone else for these? __ Yes ___No If yes, when, how & did it help?

_____

Have you had any diagnostic tests (x-rays, blood tests) done for this condition? If so, please list. Bring copies with you if possible.

_____

_____

Are you currently taking any medications, including vitamins and supplements? If so, please list.

_____

Have you *ever* had any of the following conditions (please circle all that apply):

Abortion	Diabetes	Leukemia	Tinnitus
AIDS	Eczema	Lupus	Tuberculosis
Allergies	Emphysema	Measles	Ulcerative colitis
Anemia	Gallstones	Menstrual disorders/PMS	Ulcers
Angina	Glaucoma	Mononucleosis	Urinary tract/bladder infections
Arthritis	Gonorrhea	Mumps	Whooping cough
Asthma	Hearing Loss	Parasites	Yeast infections
Abuse(sexual/physical)	Heart Disease	Pneumonia	Other:
Bronchitis	Hepatitis	Pregnancy	
Cancer	Hernia	Psoriasis	
Cataracts	Herpes	Scarlet fever	
Chicken Pox	High Blood Pressure	Strep throat	
Crohn's	Irritable bowel syndrome (IBS)	Surgery	
Cirrhosis	Jaundice	Syphilis	
Deafness	Kidney disease	Thyroid problems	

DECLARATION AND CONSENT TO TREATMENT

Patient Name: _____ Date Of Treatment _____
(First and last name)

I. This is to acknowledge that I have been informed and I understand that:

a) Any treatment or advice provided to me as a patient of Pamela Frank, ND is not mutually exclusive from any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider.
b) I am at liberty to seek or continue medical care from a medical physician or surgeon or other health care provider.
c) No employee, agent or anyone else under Naturopathic Doctor Pamela Frank's direction or control is suggesting or recommending to me to refrain from seeking or following the advice of another licensed health care provider.
d) The treatment or therapies rendered or recommended by this clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

II. I understand that my first visit includes a full, non-invasive physical examination and that my treatment program may include dietary changes, vitamins/supplements, herbs, homeopathy, acupuncture and/or lifestyle changes. I declare that I have received a full and complete explanation of the treatment or services that I may receive from Naturopathic Doctor Pamela Frank or staff under her direct supervision and hereby authorize and consent to such treatment.

III. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements, cost of laboratory tests and other fees.

IV. **I understand that if I fail to provide 48 hours notice of cancellation or I miss my appointment that I may be charged a cancellation fee of half the cost of the full visit.**
(Please initial that you have read and understood:_____)

V. I understand that some of the treatments recommended for me may be harmful if I am pregnant/breastfeeding or planning to become pregnant. I understand that it is my obligation to inform the naturopathic doctor if I may be or may become pregnant and if this status changes to notify Pamela of such immediately.

VI. I understand that I may purchase my vitamins/supplements/herbs here at Forces of Nature but I am under no obligation to do so and that I may purchase the above at the health food store of my choosing. I am also aware that if I choose to use products other than the specific ones recommended for me by Naturopathic Doctor Pamela Frank that these products may be ineffective or harmful and I assume full and complete responsibility for using them.

_____
Patient's signature

PRIVACY POLICY 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 massage therapy. We understand the importance of protecting 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.

In this Clinic, Pamela Frank BSc, N.D. acts as the Privacy Information Officer.

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. To help you understand how we are doing that, we have outlined here how our Clinic is using and disclosing your 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 send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers, with your express written consent
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of 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 to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a

practice sale

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 your personal information as outlined above.

Patient Consent

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 Forces of Nature Wellness Clinic can collect, use and disclose personal information about *(Patient's Name)* _ as set out above in the information about the Clinic's privacy

_____ _____

Signature Print Name

_____ _____

Date Signature of Witness