Shelby Worts, BSc, ND **Doctor of Naturopathic Medicine**
115 Hurontario St., Suite 200 Collingwood, ON L9Y 2L9 ∞ t: 705-444-8300 www.shelbyworts.com

Welcome!

Congratulations on taking this first step to more optimal health and wellness. Naturopathic medicine is about you feeling comfortable and energetic in the present and then achieving your vision of health to carry you well into the future. Naturopathic medicine does not simply mask symptoms in order for you to feel better; rather, it addresses the cause of your symptoms, disease or feelings of unrest.

As a naturopathic doctor, my medical training includes a focus in *preventive medicine* as well as using safe and effective techniques to *restore health* to your body.

The body is an incredible healer when given the correct environment (dietary, lifestyle, spiritual habits) to do so. Lao Tzu said 'The journey of a thousand miles begins with a single step.' The healing path that you embark upon at your first visit with me will be the first step in a very therapeutic journey. Our goal is not a temporary quick-fix… it is vibrant, sustainable health!

Are you ready to take the first step?

I look forward to being your guide, educator and coach.

Please bring your completed intake package, and any additional questions you may have, to our first meeting so that we may begin your journey.

Namaste,

Shelby

Taking the first step…

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CONFIDENTIAL PATIENT HEALTH HISTORY

Date:_____

Name:_____ Sex: M F O Birthdate:_____ Age:_____

How would you prefer to be addressed in our office?_____

Home address:_____ City:_____Postal code:_____

Home phone:_____ Day phone:_____ Cell:_____*optional*

Email:_____ □check here if you would like to receive our e-newsletter

Occupation:_____ □full-time □part-time

Place of employment:_____ Position:_____

Status: Married___ Single___ Widowed___ Divorced___ Separated___ Common law__ Same sex__

Number and ages of children:_____ Name of your MD:_____

Person to notify in an emergency:_____ Relationship:_____
Address:_____ Phone:_____

How did you hear about our clinic? □ Friend or family Who?:_____
Advertisement: □ Collingwood *Life* □ On The Bay □ Escarpment □ body magazine □ Yellow Pages
Other: _____

If you are under 18, what is the name and relationship of the person(s) legally responsible for you?
_____

☼ ---------- ☼

CURRENT HEALTH CONDITION:

What health concerns / problems brought you to this office?_____
_____
_____
_____

Has anything recently changed or become worse?_____
_____
_____

Are you currently being treated for a condition by a physician? □ Yes □ No

If 'yes', please specify:_____
Name of physician:_____ City:_____

What are the most significant measures you have taken to date to improve your state of health?
_____
_____
_____

Please list the 5 most significant stressful events in your life, from the most recent to the most distant:

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

CONTEXT OF CARE OVERVIEW

Why did you choose to come to this clinic? _____
_____
_____
_____

What do you know about our approach?_____
_____
_____
_____

What three expectations do you have from this first visit to our clinic?

1. _____
2. _____
3. _____

What long term expectations do you have from working with our clinic? _____
_____
_____
_____

What expectations do you have of me personally as your physician? _____
_____
_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 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 you believe support your health? (please list) _____
_____
_____

What behaviours or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list) _____
_____
_____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which I will be sharing with you?
_____
_____
_____

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

What do you LOVE to do? _____
_____
_____

PERSONAL HEALTH HABITS

Height:_____ **Current weight**:_____ 1year ago:_____ Maximum weight:_____ Year:_____
Smoker: □ No □ Yes Smoked_____year(s) Amount/day:_____ Year stopped:_____
Alcohol use: □ No □ Yes Type:_____ Frequency:_____
Recreational drug use: □ No □ Yes Type:_____ Frequency:_____
Coffee: □ No □ Yes cups/day:_____ **Tea**: □ No □ Yes cups/day_____ Type:_____
Water: Bottled:___ Home-purification system:___ Tap:___ Cups/day_____
Diet: Any food groups that you avoid? □ No □ Yes _____
Are there any food groups that you tend to eat frequently? □ No □ Yes _____
Stress: Please indicate your current stress level ((10 is highest)): 1 - - - 5 - - - - 10
Energy: Please indicate your current energy level ((10 is highest)): 1 - - - 5 - - - - 10
Sleep: How many hours of sleep do you get each night?___ Do you wake feeling rested? □ No □ Yes

Regular exercise: □ No □ Yes Type:_____ Duration:_____ Frequency:_____

Vitamins or minerals Are you currently taking any? □ No □ Yes

Women: Are you currently pregnant? □ No □ Yes □ Not sure Date of last period:_____

Birth control: Type used:_____
Women: If history of birth control pill use, how many years?_____

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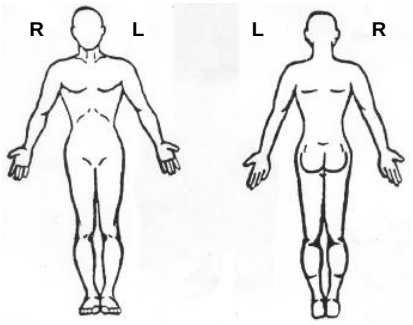
MEDICAL HISTORY: Please check only those that pertain to YOU personally.

□ Alcohol or Drug Abuse
□ Allergies
□ Anemia
□ Anxiety
□ Arthritis
□ Asthma
□ Autoimmune condition
□ Bladder/Urinary Problems
□ Blood Sugar Problems
□ Bleeding Problems
□ Blood Pressure Problems
□ Breast Pain or Lumps
□ Cancer
□ Colitis
□ Cold / Flu / Sore Throat; frequently
□ Diabetes
□ Digestive Disturbances; bloating, flatulence, etc.
□ Ear Problems
□ Eating Disorder(s)
□ Edema
□ Epilepsy
□ Eye Problems
□ Fatigue, chronic
□ Female Gynecological Problems
□ Fever
□ Gall Bladder / Liver Problems
□ Gum / Teeth Problems
□ Hair Loss
□ Hayfever
□ Headaches
□ Heart Problems
□ Jaundice
□ Joint Problems
□ Lung Problems
□ Kidney Problems
□ Osteoporosis
□ Parasites
□ Sexual Abuse
□ Sexually-Transmitted Disease(s)
□ Skin Problems
□ Stroke
□ Suicidal Tendencies
□ Thyroid Problems
□ Toxic Substances Exposure
□ Ulcer
□ Weight Issues
□ Yeast Infections



Please indicate your area(s) of discomfort

Blood Type: □ A □ B □ AB □ O

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Family Medical History: Please check areas pertaining to blood relatives ***NOT*** including yourself.

□ Asthma
□ Arthritis
□ Bleeding Problems
□ Cancer
□ Diabetes
□ Eating Disorder(s)
□ Epilepsy
□ Gout
□ Hayfever, Allergies
□ Heart Problems
□ High Blood Pressure
□ Kidney Problems
□ Mental Disorders
□ Obesity
□ Osteoporosis
□ Stroke
□ Substance Abuse
□ Tuberculosis
□ Thyroid Problems
□ _____
□ _____

CURRENT HEALTHCARE OVERVIEW

Have you consulted your MD regarding your chief complaints today? what therapies were prescribed? what was the result? _____

_____

_____

_____

Are you currently attending a chiropractor? for any specific complaint(s)?_____

_____

_____

Do you attend other health care professionals such as dentist, optometrist, acupuncturist, massage therapist, physiotherapist, etc? please explain the complaints: _____

_____

_____

_____

Please list all of your health concerns whether you feel they are related to your primary concern or not: _____

_____

_____

_____

Please list all of your **current** prescription medications, the reason and their effect(s) *((incl. Birth Control Pill, Steroids, Laxatives, Pain-killers, etc.)):*

Medication	Potency & Dose	Reason for Taking	Duration	Effects

Please list all of your **past** prescription medications, the reason and their effect(s) *((incl. Birth Control Pill, Steroids, Laxatives, Pain-killers, etc.)):*

Medication	Potency & Dose	Reason for Taking	Duration	Effects

Please list all of your **non-prescription** medications, the reason and their effect(s) *((incl. Painkillers, Laxatives, Antihistamines, etc.)):*

Medication	Potency & Dose	Reason for Taking	Duration	Effects

Other **supplements** *((including Vitamins, Herbs, Minerals, etc.)):*

Supplement	Brand	Potency & Dose	Reason for Taking	Effects

Do you have any known allergies such as medications, pollens, animals, foods:_____

_____

_____

PERSONAL HEALTH HISTORY

Were you breast fed? for how long? _____

Were you a colic-y baby? _____

What was your mother's health like during her pregnancy with you? _____

Please list all traumatic events, physical and emotional, that you have experienced during these age spans in your life ((ie. accidents, injuries, hospitalizations, job loss, divorce, deaths, etc.))

Year	Event
0-12 mo	
1-5	
6-10	
11-15	
16-20	
21-30	
31-40	
41-50	
51-60	
61-70	
71-80	
81-90+	

Have you ever had parasites, that you know of? when? _____

Have you ever traveled to a third-world country? for how long? _____

What do you feel your weakest organ system is? _____

_____

How many times each year do you get a cold, flu or bronchitis? How many days are you sick with it? Do you miss work because of it? _____

_____

How many times have you had antibiotics in your life? _____

Describe your bowel function; frequency, size, colour, odour, presence of undigested food, blood or mucous. Is it loose, formed or unformed? _____

_____

Dental health: How many silver fillings do you think you have? Root canals? _____

_____

Have you experienced any change in your health since the dental work? _____

_____

Has there ever been a trauma or sickness that you felt you have never recovered from and you have not been well since? please explain: _____

_____

_____

What questions do **you** have that you would like to have answered?_____

_____

_____

_____

REVIEW of SYSTEMS

Please check (√) whether you experience the symptom **N**ow or in the **P**ast

General:	**N**	**P**
Fatigue		
Poor / disturbed sleep		
Recent weight change		
Fevers, chills or sweats		
Poor appetite		
Excessive appetite		
Excessive thirst		
Heat or cold intolerance		
Must eat frequently to avoid becoming dizzy		
Other		

Head & Neck:	**N**	**P**
Eye pain		
Recurrent eye infections		
Glaucoma		
Cataracts		
Use of contact lenses		
Use of glasses		
prescription:		
date prescription was last checked:		
Other 'eye' issue:		
Recurrent nasal infections		
Nasal discharge		
Hay fever		
Disturbed sense of smell		
Ear pain		
Recurrent ear infections		
Discharge from ear(s)		
Excessive ear wax		
Impaired hearing		
Other 'ear' issue		
Difficulty swallowing		
Difficulty speaking		
Neck mass or swelling		
Swollen glands		
Thyroid problems		
Neck injury		
Neck discomfort		
Recurrent throat infections		
Other 'neck/throat' issue		
Migraine headaches		
Tension headaches		
Head injury		
Dizziness		
Other 'head' issue		

Circulatory:	**N**	**P**
Varicose veins		
Leg cramping		
Hemorrhoids		
Cold hands &/or feet		
Easy bleeding / bruising		
Other		

Cardiovascular:	**N**	**P**
High or Low blood pressure		
Cholesterol problems		
Murmurs		
Palpitations or fluttering		
Chest pain / Angina		
Out-of-breath climbing stairs		
Last electrocardiogram (ECG)		
Pace maker		
Previous heart attack		
Other		

Respiratory:	**N**	**P**
Wheezing		
Asthma		
Emphysema		
Persistent cough		
Tuberculosis / Pneumonia		
Chronic bronchitis		
Excessive phlegm production		
Smoker		
Spitting up blood		
Shortness of breath (SOB)		
SOB at night		
SOB when lying		
Last chest xray		
Other		

Digestive:	**N**	**P**
Heartburn		
Indigestion		
Burping		
Passing gas		
Feeling as if abdomen is Bloated		
Abdominal pain		
Crohn's		
Colitis		
IBS		
Blood in vomit or stool		
Nausea / vomiting		
Diarrhea		
Constipation		
Liver disease		
Gallbladder disease		
Black tarry or Pale stools		
Hiatal hernia		
Sleepy after eating		
Change in appetite		
Other		

Female Reproductive:	**N**	**P**
Ovarian cysts		
Endometriosis		
Date of last pelvic exam		
Date of last pap smear		
Irregular pap findings		
Sexually-transmitted disease		
Age of first menses		
Number of days of bleeding		
Number of days of full cycle		
Bleeding between periods		
Irregular cycles		
Painful menses		
Excessive flow		
PMS		
Number of pregnancies		
Number of live births		
Number of miscarriages		
Number of abortions		
Difficulty conceiving		
Pain during intercourse		
Sexual difficulties		
Vaginal discharge		
Vaginal itching		
Sexually active		
Please indicate sexual preference		
Heterosexual		
Homosexual		
Bisexual		
Menopause		
Age of onset		
Hormone therapy		
Other		

Male Reproductive:	**N**	**P**
Testicular or scrotal lumps		
Testicular or scrotal pain		
Date of last prostate exam		
Date of last PSA test		
Sexually-transmitted disease		
Impotence		
Premature ejaculation		
Discharge of sores		
Sexually active		
Hernia		
Please indicate sexual preference		
Heterosexual		
Homosexual		
Bisexual		
Groin injury		
Other		

Urinary:	N	P
Blood in urine		
Mucus in urine		
Pain on urination		
Increased frequency		
Inability to hold urine		
Frequent infections		
Kidney stones		
Reduced urine flow		
Number of times you wake at night to urinate		
Other		

Musculo-skeletal:	N	P
Muscle pain or weakness		
Arthritis		
Loss of mobility		
Physical trauma		
Osteoporosis		
Gout		
Other		

Immune:	N	P
Autoimmune condition		
Many colds / flus each year		
AIDS / HIV		
Allergies		
Other		

Breast:	N	P
Mammogram; screening		
Lumps / swelling		
Tenderness		
Regular self-examination		
Nipple discharge		
Other		

Neurological:	N	P
Loss of consciousness		
Paralysis / weakness		
Involuntary movements		
Loss of balance		
Head trauma		
Loss of coordination		
Loss of memory		
Vertigo		
Other		

Skin:	N	P
Psoriasis		
Eczema		
Lumps / bumps		
Moles; change in appearance		
Itchiness		
Dry skin		
Wounds that heal poorly		
Rashes; local or systemic		
Acne		
Hives		
Other		

Emotional:	N	P
Anxiety episodes		
Mood swings		
Anger		
Hallucinations / delusions		
Insomnia		
Eating disorder(s)		
Phobias		
Psychiatric issues		
Depression / boredom ϖ life		
Sexual difficulties		
Drug abuse		
Thoughts of suicide		
Psychological counselling		
Other		

If you have any questions please do not hesitate to contact our clinic.

I look forward to our first meeting together.
Shelby

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DECLARATION AND CONSENT TO TREAT

This is to acknowledge that I (or parent/legal guardian) have been informed and understand that:

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental emotional and spiritual aspects of the individual. A number of different approaches are used: Diet and nutritional supplements, botanical medicine, homeopathy, Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counselling.

Shelby Worts, BSc, ND, will take a thorough case history, do a screening physical exam and if your case requires, do more specific physical examinations including breast exams, gynecological exams and genital exams. Certain laboratory assessments may also be required on a case specific basis.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those on multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform Shelby Worts, BSc, ND, of any disease process that you are suffering from or 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 Shelby Worts, BSc, ND immediately.

There is 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, accidental burning of skin from the use of moxa.
- Muscle strains and sprains, disc injuries from spinal manipulation

As a patient of Shelby Worts, BSc, ND, I am at liberty to seek or continue medical care from a medical doctor or other care providers licensed to practice in Ontario. No employee, agent, board member, student, instructor or anyone else under the direction or control of Shelby Worts, BSc, ND, has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

The Treatment and therapies rendered or recommended by Shelby Worts, BSc, ND, may be different that those usually offered by a medical doctor or other licensed health care providers.

As a patient of Shelby Worts, BSc, ND, I understand that results are not guaranteed.

I agree to pay my full account at the time of each visit or treatment, including fee for services, cost of supplements and remedies, cost of laboratory tests and other fees unless otherwise discussed with Shelby Worts, BSc, ND. Payment can be made in cash, personal cheque, Debit Card, Visa or MasterCard.

I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during intake of my case.

I understand that a 24-hour cancellation policy is in effect. To avoid a visit charge I will notify the office of Shelby Worts, BSc., ND, 24-hours before a scheduled appointment.

I will be given a full and complete explanation of the present and future treatments and/or services that I will receive.

OVER →

Privacy of your personal information is an important part of our practice, 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. We will try to be as open and transparent as possible about the way we handle your personal information. For more detailed information ask the Privacy Information Officer for a copy of our privacy policy.

In this office Shelby Worts acts as the Privacy Information Officer.

This consent form is intended to cover the entire course of treatments in this office. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Date _____

Patient's printed name _____

Patient's signature _____

Parent's/legal guardian's signature (if under 18 years) _____

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PROFESSIONAL FEES FOR NATUROPATHIC SERVICES

Naturopathic services are not covered by OHIP. However, extended health care benefits on various group insurance plans do have some coverage depending on the package. Check your insurance coverage.

Fees are due at time that service is rendered.

All naturopathic services are subject to HST.

Services	**Investment In Your Health**
Initial visit for Consultation and Initial Examination – Adult (60min)	$165.00
Initial visit for Consultation and Initial Examination – Child (45-60min)	110.00
Follow-up Visit – Adult (30minutes)	$85.00
Follow-up Visit – Adult short (15minutes)	55.00
Follow-up Visit – Adult long (45minutes)	120.00
Follow-up Visit – Child (30minutes)	$60.00
Follow-up Visit – Child (15minutes)	35.00

The service fees for follow-up visits listed above are for in-office and phone consultations.

Forms & Reports	**Investment In Your Health**
Filling out Insurance forms	$25.00
Narrative reports for Legal Purposes – per page	100.00

Home Visits	**Investment In Your Health**
Within Collingwood – Initial visit	$225.00
Within Collingwood – Follow-up visit	165.00
Outside Collingwood; add driving time – per hour	165.00

Fee schedule is subject to change.

I have read the above and fully understand the contents

Name: _____ Signed: _____

Date: _____

Naturopathic medical services are covered by most extended medical plans.