Dr. Patricia J. Wales ND & Dr. Jennifer Bunzenmeyer ND

Naturopathic Medicine at the Acadia Wellness Centre *# 2 - 430 Acadia Dr. SE, Calgary, AB T2J 0B2*

(403) 301- 0123 **Fax (403) 301-0105** **www.ndclinic.com**

Welcome to our Naturopathic Office

We want you to enjoy and benefit from your visits with us.

Your first visit will consist of **consultation, detailed history, a general physical exam and a more specific naturopathic examination**. Based on this information, initial recommendations for your treatment protocol will be made on your first visit. If we feel it is necessary for a more complete analysis of your health status, you may be asked to have further laboratory tests through your medical doctor, or additional testing through our office lab facilities. Through this healthcare assessment, we are able to establish a baseline measure of health that we can then use to monitor your progress.

On your second visit, **a detailed report of findings and an in-depth treatment plan** will be explained to you. Programs often include **dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy and traditional Chinese medicine**. Your program will also involve lifestyle recommendations that are logical and sensible. (We encourage you to have a support team as you make these changes. Often having someone else, be it a partner, family member or friend who is undergoing naturopathic care at the same time will help to ease you both toward better health.) This return visit is also a good time to ask any questions that you may have had after your initial visit. If you need immediate clarification on remedies, dietary recommendations or have a concern over any unfamiliar symptoms that may arise, please call our office.

On your following visits your progress will be monitored and treatments will be modified accordingly. The second visit is usually three to five weeks after your initial visit. If you are receiving acupressure treatments visits will be more frequent, either once or twice weekly for 6-10 sessions. As you start to experience a new level of wellness, we suggest an office visit every three to four months for general disease prevention and health maintenance. If an acute, non-emergency condition occurs, please give us a call as we may be able to help with a naturopathic treatment.

Many of our patients have allergies and are environmentally sensitive. We ask that on the day of your visit to our office you do not wear any scented products (perfumes, shaving lotions, hairsprays, etc.).

We request that if you are unable to keep a scheduled appointment, you give our office 2 business days notice. As we are closed on Mondays, this means notice early on Friday for appointments the following Tuesday. We are then able to provide that appointment time to someone on our waiting list. If we do not receive sufficient notice, you will be charged for the missed visit and you will be asked for your credit card information to pay for the missed visit.

Naturopathic coverage is available through many extended healthcare plans; please inquire with your HR department. Payments for visits are due at the time of the appointment.

Effective Aug. 1, 2010, the fees (plus 5% GST) are:

Dr. Patricia J. Wales ND

Initial visit	1 hour	$ 160
Report visit	45 min	$ 135
Regular visit	30 min	$ 90

Dr. Jennifer Bunzenmeyer ND

Initial visit	1 hour	$ 160
Report visit	45 min	$ 135
Regular visit	30 min	$ 90

We maintain a dispensary of professional quality supplements, botanicals and homeopathics for the treatment of our patients. Items are individually priced and GST is added.

We accept the following methods of payment:
Visa, Mastercard, Debit Card, Cheque or Cash

If you have any concerns, please contact our front desk staff and they will be happy to pass your message on to your naturopathic doctor.

Please fill out the following forms and bring to your child's first appointment.

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Pediatric Patient Intake Form

Our professional association requires us to maintain contact information for our patient records.
No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to remind you of your upcoming visit and inform you of our office events and news and will not be distributed for any other use.

First Name ______________________________ Last Name ___________________________________

Address ____

City __________________________ Province ________________ Postal Code _________________

Parent/Guardian's Names____

Telephone (H) ____________________ (W) ______________________ (F) ____________________

E-mail ____ Cell ___________________

I have read Welcome to our Naturopathic Office provided with this form.
I am aware of the type of treatments offered and I agree to abide by the office policies.

Guardian's Signature _________________________________ **Date** ______________________

Type of school & / or child care____

Performance (circle one): **Academics**: Excellent/Moderate/**Weak** **Concentration**: Excellent/Moderate/Weak

Social interaction: Excellent / Moderate / Weak **Overall Health**: Excellent / Moderate / Weak

Date of Birth ________________ Age ______ Sex M F Parent's Marital Status __________

Other Siblings & their ages ____

Blood Type ___________ Height ____________ Weight ____________ Ideal Weight __________

Religion or personal philosophy____

Name of Medical Doctor __________________________ Date of last physical _________________

Phone (____) ____________ Fax (_____) ____________ Date last lab tests ___________________

Has your child been treated by a Naturopathic Doctor? ________ Other health practitioners? __________

Name ___________________________ Name ________________________________

When?___________________________ When? ________________________________

Please tell us how you heard of our clinic. Family _____ Friend _____ Ad _____Yellow Pages.ca _______

Internet ____ Health Professional ___ Who recommended our clinic to you? ____________________

Please list (in order of importance) the **primary health concerns** / **reasons** for his visit for your child.	Please indicate any **treatments** that you have tried previously to address your child's health issues and **how effective** you found these treatments.

Please list all **pharmaceutical medications, herbals, vitamins and supplements** (& dosages, if known)

Now	In the Past

Please list any **allergies** your child has and what kind of **reaction** occurs.

Please list all **hospitalizations, fractures or major illnesses** that your child has had.

Type of illness, operation / procedure	Date	Any ongoing concerns?

How would you rate your child's **energy level**? ____ (from 1-10, **10 being highest**) Do they wake-up feeling refreshed? Y___ N___ What time do they go to sleep from and wake up at? ________________________

How many glasses of **water** & of what **kind** does your child drink per day? Please indicate numbers below.

Tap________ Filtered________ Distilled_________ Reverse Osmosis__________ Spring_________

How many **cups / day** does your child drink of each of the following?

Juice ____ Pop _____ Milk _ ___ Chocolate milk ____ Rice /soy/almond milk ____ / ____ / ____

Is your child exposed to cigarette **smoke**? N __ Y ___ How many years? ____ In the past? Y ___

Does your child **exercise**? N__ Y___ Hours per week _____ Type of exercise ________________________

Does your child watch **TV**? N__ Y___ # of hours per week __________

Please check **childhood illnesses** your child has had.

☐ Measles ☐ Rubella ☐ Whooping Cough ☐ Rheumatic Fever ☐ Allergies
☐ Mumps ☐ Chicken pox ☐ Scarlet Fever ☐ Polio ☐ Asthma

Please check any **vaccinations** your child has had.

☐ Hep B ☐ DtaP or DTP ☐ MMR ☐ Gardasil ☐ Hib ☐ Polio ☐ Varicella

Did they have any **adverse reactions** (eg. rash, flu, extreme upset, vomiting, neurological)?

____

What vaccines have they had recently? ____

Please check all of the following **conditions** that are applicable to **your child & their family** and note who.

	Alcoholism			Gout	
	Allergies			Heart disease	
	Arthritis			Heart murmurs	
	Asthma			High blood pressure	
	Auto Immune			Hypo / hyper thyroid	
	Cancer			Irritable bowel	
	Crohn's or Colitis			Kidney disease	
	Depression			Liver disease	
	Diabetes			Mental illness	
	Eczema			Osteoporosis	
	Gallbladder			Stroke or aneurysm	
	GERD/hiatal hernia			Ulcers	
	Glaucoma / Cataracts			Other	

On a separate sheet of paper, please record everything that your child ate yesterday for breakfast, lunch, dinner, snacks and beverages in as much detail as possible.

Please do not write in this space. It will be cut off.

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INFORMED CONSENT (MINOR)

Naturopathic doctors assess the whole person, taking into consideration the physical, mental, emotional and energetic aspects of an individual. Your naturopathic doctor will conduct a thorough case history, physical exam and may request specific blood and/or urinary laboratory reports to be used as part of the treatment work-up.

It is very important that you inform your naturopathic doctor immediately of all disease process that your child may be experiencing, and of any medication, over-the-counter drugs or supplements s/he is taking.

Statement of Acknowledgement

As the guardian of a patient of this office who is below the age of majority, I have read the information about the health care to be provided and understand it is based on naturopathic and other supportive principles and practices.

I understand that a record will be kept of the health services provided to my child. This record will be kept confidential and will not be released to anyone other than Dr. Bunzenmeyer, Dr. Wales and other Acadia Wellness Centre practitioners that I consult unless so directed by myself or law requires it. By signing below, I acknowledge that Dr. Wales and Dr. Bunzenmeyer may enhance my child's care periodically by discussing her/his case with each other. I will inform my naturopathic doctor if I have any concerns about these methods of enhancing my child's care. I understand that I may look at my child's medical records at any time and can request a copy of these by paying the appropriate fee.

I also recognize that even the gentlest therapies can have complications in certain physiological conditions, in very young children, or for those on multiple medications. The information I have provided about my child is complete and inclusive of all health concerns including risk of pregnancy, and all medications including over-the-counter drugs and supplements.

The slight health risks of some naturopathic treatments include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture or intramuscular vitamin injections
- muscle strains and sprains from physical treatments & muscle testing.

I understand that results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications of treatment. With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above for my child.

I intend this consent form to cover the entire course of my child's naturopathic treatment at this office. I also confirm that my child and I have the ability to accept or reject this care of our own free will and choice, and to discontinue participation in these procedures at any time.

I accept full responsibility for all fees incurred during care and treatment and acknowledge that payment is due on the day of service.

NAME of PATIENT (Please Print) ____

NAME of GUARDIAN (Please Print) ____

SIGNATURE of GUARDIAN____

DATE _______________________

Please leave this space blank. It will be cut off.