DR. KRYSTEN DESOUZA
naturopathic doctor

krystendesouzand@gmail.com
www.desouzanaturopathic.com

ADULT NATUROPATHIC INTAKE FORM

Name _____ Date _____

Date of birth_____/_____/_____ (M/D/Y) Sex M F (please circle)

Address (city, province, postal code)_____

E-mail Address _____

Home telephone number (_____) _____-_____Work/Mobile (_____) _____-_____

May we leave messages relating to your visits? Y / N Preferred Number: Home/Work/Mobile/Any

Emergency contact: _____ Phone number (_____) _____-_____

How did you hear about our Clinic? _____

Primary Health Concerns: Please list in order of importance to you

_____

_____

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 visit to our clinic?

_____

_____

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 behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

_____

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

_____

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

_____

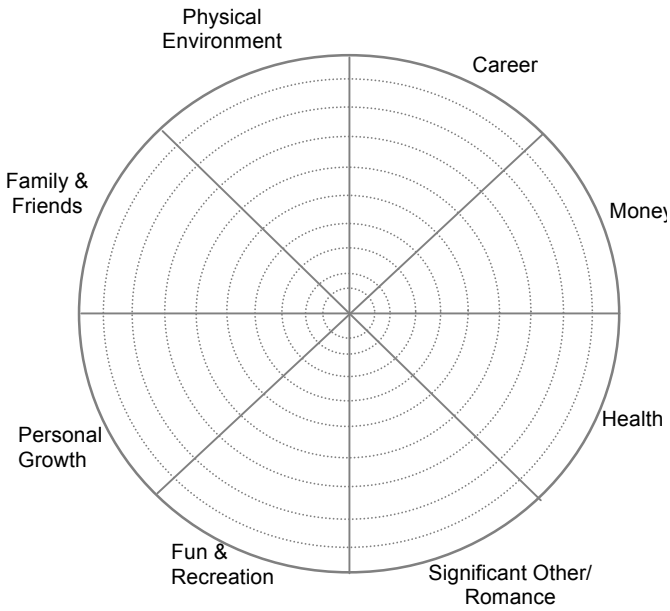
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

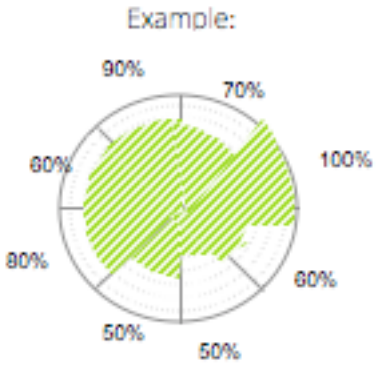
_____

What do you LOVE to do?

_____

WHEEL OF BALANCE





Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

MEDICAL HISTORY

If you are female, are you currently pregnant? Yes No (Please circle one)

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

_____

_____

Do you have any allergies (medicines, environmental, etc.)?_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

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

We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will be as open and transparent as possible about the way we handle your personal information.

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 that we 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, College of Naturopathic Doctors of Ontario.

How our Clinic Collects, Uses and Discloses Patients' Personal Information

We understand the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how we are using and disclosing your information. The 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
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse and reporting diseases and individuals who may be an imminent threat to harm themselves or others

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Patient Consent for Fee-for-Service

I understand that I am responsible to pay for the services provided to me by Dr. Krysten DeSouza, ND at the time I receive the services or prepaid in advance of the service to be provided unless other provisions for payment have been arranged with the clinic manager.

I understand that upon request, Dr. Krysten DeSouza, ND will provide me with an estimate of the fee-for-service prior to any patient service I accept.

Many extended healthcare benefits cover naturopathic services, and to a lesser extent lab services and supplements/herbal treatments. I understand that I will check with my individual or family benefit plan to see what is covered and Dr. Krysten DeSouza, ND will provide me with a detailed invoice that can be submitted for reimbursement. Dr. Krysten DeSouza, ND may direct bill select extended health care providers at the discretion of the clinic manager.

I am also aware of Dr. Krysten DeSouza, ND's cancellation policy which states I may be charged a fee equivalent to 50% of any visit I cancel with less than 24 hours' notice.

Patient Consent for Diagnosis and Treatment

All procedures, both diagnostic and therapeutic, will be discussed with me and I will be asked for my consent prior to the procedure. I further acknowledge that I will become informed of the procedures and plans with respect to financial costs, expected benefits, potential risks and side effects, the likely consequences of not following the procedure/plan and alternative courses of action. I also understand that I may stop treatment or change the status of this informed consent at any time.

Diagnostic procedures include but are not limited to: intake and history, laboratory evaluation, Traditional Chinese Medicine (TCM) diagnostic techniques, and standard physical examinations. Therapeutic procedures include but are not limited to acupuncture, TCM, botanical medicine, clinical nutrition and supplementation, homeopathy, hydrotherapy, and intramuscular vitamin injection.

I have reviewed the above information that explains how Dr. Krysten DeSouza, ND will use my personal information and the steps that are taken to protect my information. I agree that Dr. Krysten DeSouza, ND can collect, use and disclose personal information about me as set out above in the privacy policy. I have also reviewed the fee-for-service policy and consent for diagnosis and treatment.

_____	_____	_____
Signature	Printed Name	Date