2794 Lake Shore Blvd West
Etobicoke, ON M8V 1H5
647-748-2917 | PHYSIOINTHESIX.COM

All information will be held in strict confidence,

Last Name________________________ First Name________________________ Initial ______

Date of Birth (*dd/mm/yyyy*) ______/____/_______ Occupation________________________

Address________________________ City________________ Postal Code ______________

Email________________________ Preferred Pronouns ______________

Home Phone________________ Work Phone________________ Cell Phone ________________

Direct Billing Information: Insurance Company________________________

Policy Holder Last Name________________________ Policy No.________________________

Policy Holder First Name________________________ ID/Certificate No.________________________

Policy Holder Date of Birth (*dd/mm/yyyy*) ______/____/______________

For WSIB Claims Only: OHIP No. ________________ WSIB Claim No.________________________

For Auto Insurance Claims Only: Auto Insurance Company________________________

Address________________________ Phone/Fax ________________________

Claim No. ________________________ Policy No.________________________

Date of Accident (*dd/mm/yyyy*) ______/____/______________ Adjustor Name ________________________

Family Physician

Name________________________

Address________________________

Phone________________________

Fax ________________________

How did you hear about us?

Doctor_____ Friend_____ Media_____Walk-In__________

Insurance Company_____Family Member_____Other_____

Referral Source's Name (*Optional*)

____

Contact in case of Emergency

Name________________________ Relationship________________________

Home Phone________________________
Work Phone________________________

SERVICE	TOTAL FEE
Naturopathic Assessment	**$250.00**
Naturopathic Treatment -30mins/45mins/60mins	**$95.00/$125.00/$160.00**
Naturopathic Re-assessment ***greater than six months since last assessment or new complaint**	**$ 180.00**

N.B. Fees are subject to change.

****Our cancellation policy requires 24 hours notice or you will be charged 50% of the fee****

This signed form and photocopies of this signed form will serve as authorization to the Physio In The Six Inc. Clinic to obtain/release medical information pertaining to myself from/to my family physician and to other Physio In The Six Inc. Clinic practitioners. It also serves as an agreement to provide payment to Physio In The Six Inc. Clinic, at the time of each visit, and later claim through any extended health benefits plan, as appropriate. The undersigned has read and understands the cancellation policy.

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PHYSIOINTHESIX.COM **Signature** ______ **Date (*dd/mm/yyyy*)** ____/____/______

Health Profile and Medical History (Part 1)

Child's Current Medical Conditions

1) ____

2) ____

3) ____

Major Surgical Operations *(If possible please provide location & date)*

1) ____

2) ____

3) ____

Medications *(List all prescription, over the counter and supplements you are currently taking)*

Medication/Supplement /Vitamins/Health Foods	Strength (i.e. 400 mg)	Amount Per Day (i.e. one)	Time (AM/PM)	Since how long? (i.e. starting 1 yr ago)

Allergies:

Drugs:	Food:	Environmental:
______________	______________	______________
______________	______________	______________
______________	______________	______________

**Patient's Name: ________________________
**Date of Birth: (*dd/mm/yyyy*) ____/____/_______

Health Profile and Medical History (Part 2)

What are you most concerned about regarding your child's health?

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____

____

How did you hear about naturopathic medicine?

____

____

Birth History

Term length: _________________ Please circle: Full / Premature

If Premature: _______ weeks If Late: _______ weeks

Length of Labour: _____________________ Complications? ____________________

Describe Birth Experience (i.e. vaginal, induced, joyous, anesthesia, etc.)

____

____

Prenatal Health

Mother's diet during pregnancy (circle): Poor / Fair / Good / Excellent / Unknown

Did mother experience any of the following during pregnancy (circle):

Bleeding High BP Nausea/vomiting

Diabetes Thyroid Trauma

Mother's age at child's birth ____________ Hospital Birth or Home Birth? ________________

Birth was attended by (circle): OBGYN / MD / Midwife

**Patient's Name: ________________________________
**Date of Birth: (*dd/mm/yyyy*) ____/____/_______

Health Profile and Medical History (Part 3)

Family History *(Please complete to the best of your ability)*

Relation	Age (if alive)	State of Health	Age at Death & Cause	Check and Designate if They Had
Mother				

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Father				❒ Tuberculosis
Maternal Grandmother				❒ High Blood Pressure
Maternal Grandfather				❒ Heart Disease
Paternal Grandmother				❒ Migraine
Paternal Grandfather				❒ Strokes
Sibling (M / F)				❒ Cancer
Sibling (M / F)				❒ Allergies/Asthma
Sibling (M / F)				❒ Arthritis
Sibling (M / F)				❒ Kidney Disease ❒ Diabetes ❒ Nervous Troubles

If your child has or <u>has had</u> any of the following, please complete by checking the boxes that apply to you

Scarlet Fever ❒ Hearing Loss/Ringing ❒ Trouble Swallowing ❒
Measles ❒ Sinusitis ❒ Abdominal Pain ❒
Rubella ❒ Tonsillitis ❒ Diarrhea ❒
Mumps ❒ Eye Infections ❒ Constipation ❒
Chicken Pox/Shingles ❒ Rheumatic Fever ❒ Bladder/Kidney Problem❒
Infectious Mono ❒ Shortness of Breath ❒ Anemia/Blood Disease ❒
Whopping Cough ❒ Chest Pain/Pressure ❒ Moles ❒
Colic ❒ Excess Sweating ❒ Warts ❒
Psoriasis ❒ Goiter/Thyroid Diseases ❒ Athlete's Foot ❒
Eczema ❒ Cough or Sputum ❒ Liver Disease ❒
Rash ❒ Asthma or Wheezing ❒ Jaundice ❒
Swollen Glands ❒ Pneumonia or Pleurisy ❒ Hepatitis ❒
Night Sweats ❒ Blood in Sputum ❒ Diabetes ❒
Frequent Colds/Flus ❒ Hoarseness ❒ Sports Injury ❒
Ear Infections ❒ Indigestion ❒ Car Accident ❒
Knee Trouble ❒ Joint Disease ❒ Headache ❒
Numbness/Tingling ❒ Tremors ❒ Insomnia ❒ Nightmares ❒ Worries/Stress ❒ Problems Concentrating ❒
Depression ❒ Anxiety ❒ Phobia(s) ❒
Acting Out ❒ Temper Tantrums ❒ Heart Problems ❒
Nasal Congestion ❒ Other Nasal Problems ❒ Weight Loss-unexplained❒

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**Patient's Name: ______________________________
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Health Profile and Medical History (Part 4)

Dietary Assessment

How was your infant fed (circle)? Breastfed / Formula

If breastfed, how long? ____________ If Formula please indicate (circle) Milk / Soy / Other_____

What foods were introduced before 6 months? (please list approximately at what month)

____

____

____

What foods were introduced between 6-12 months?

____

____

____

Is your child sensitive to any foods (circle)? YES / NO If yes, please indicate:

____

____

How many times does your family eat at fast food restaurants, per week? _____________

Describe a typical day's diet:

Breakfast:

____

Lunch:

____

Dinner:

____

Snacks:

____

Liquids (list quantity)

____

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**Patient's Name: ___________________________

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Health Profile and Medical History (Part 5)

Health and Development

How was your child's health in the first year (circle)? Poor / Fair / Good / Excellent / Unknown
At what age did your child begin to:
Sit up __________ Crawl __________ Walk ___________ Talk ____________

Describe your child's mood and behavior at home:
____

How is your child's behavior and performance at school?
____

Is your child in (circle): School / Daycare / Homecare / Other________

What are you child's favourite activities?

____

Does your child exercise regularly (circle)? YES / NO
How much, how often?

____

How much television does your child watch? __________ hours a (circle) DAY / WEEK

How much computer time? __________ hours a (circle) DAY / WEEK

Does anyone in the child's household smoke (circle)? YES / NO
Are there animals in the house (circle)? YES / NO
How is the family home heated? ___________________

Do you know of any toxins or other hazards the child is regularly exposed to (home, hobbies, school etc.)? Please describe.
____

Describe the emotional climate of the child's home:

____

Anything else of importance you would like to add?
____

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**Date of Birth: (*dd/mm/yyyy*) ___/____/_______

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NATUROPATHIC MEDICINE - CONSENT TO TREATMENT AND PRIVACY POLICY

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. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent capacity/

I hereby consent to the assessment and treatment performed by the Registered Naturopathic Doctor named below.

I understand that treatment may include treatments for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purposes. Treatment modalities include dietary modification and nutritional supplementation, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counseling. Bowen therapy may also be used, as well as bio-identical hormones.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or in those with 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 your Naturopath immediately 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 that you are pregnant or are breast-feeding, please advise your Naturopath immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These can include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture

Supplements may be prescribed by your Naturopathic Doctor, these can be purchased at the clinic or at other local health stores. Please note: extended health insurance companies may not cover the supplements prescribed to you.

I understand that I may rescind or amend this consent in writing.

I further understand that the clinical, psychological and any other information which is gathered during the course of my treatment is confidential, but may be shared with my insuring agents, third party payers and/or physician(s) upon request.

Privacy and protecting your personal information is something we take very seriously. All personal information gathered adheres to the privacy legislation and standards of the College of Naturopaths of Ontario (CONO).

I consent to contact me by phone/text/email and/or leave a message when required for the purpose of appointment reminders, invoices, exercise sheets, communication by my health practitioner

I have read the above consent, and I have had the opportunity to ask questions about its content. This consent will cover the naturopathic assessment and entire course of treatment.

Patient Name ___________________________________
(*Please print*)

____
Patient Signature

____
Date Signed

Date of Birth: (*dd/mm/yyyy*) ____/____/________

MARY GALIC_____________________________
Doctors's Name (*Please print*)