CHOICE NUTRITION

Naturopathic Health Care & Microscopy

105 MACLEOD AVENUE EAST
MELFORT, SK S0E 1A0
TEL: (306) 752-9277
FAX: (306) 752-3757
WEB: WWW.CHOICENUTRITION.CA

109-701 CYNTHIA STREET
SASKATOON, SK S7L 6B7
TEL: (306) 249-6700
FAX: (306) 249-6706
WEB: WWW.CHOICENUTRITION.CA

Thank you and welcome to Choice Nutrition Centres Inc. This is a centre for integrative medicine. It is important for us to obtain an accurate history of your health to provide the best possible care. In order to provide our services we ask that you please take a few minutes to complete this form prior to your initial appointment with any practitioner. If your health status changes in the future please let us know. All information gathered is treated on a strictly confidential basis, as required or allowed by law and our privacy policy. Please feel free to ask us any questions.

CLIENT PERSONAL INFORMATION (please print legibly in pen)

FULL LEGAL NAME: _____

DATE OF BIRTH (DD/MM/YYYY): _____

GENDER: _____

MAILING ADDRESS: _____

CITY/TOWN: _____

PROVINCE/STATE: _____

POSTAL CODE/ZIP CODE: _____

HOME PHONE NUMBER: _____

WORK PHONE NUMBER: _____

CELL PHONE NUMBER: _____

EMERGENCY CONTACT PERSON: _____

EMERGENCY CONTACT PHONE NUMBER: _____

NAME OF FAMILY DOCTOR (IF ANY): _____

REFFERD TO THIS CLINIC BY (IF ANYONE): _____

DO YOU CONSENT TO ALLOW CHOICE NUTRITION CENTRES TO SEND COMMERCIAL ELECTRONIC MESSAGES (CEM'S) TO YOUR EMAIL, CONCERNING OUR BUSINESS, PRODUCTS, SERVICES AND PROMOTIONAL SALES? (PLEASE CIRCLE) YES NO

IF YES, PLEASE PRINT EMAIL ADDRESS: _____

OFFICE POLICY

Patients are responsible for the total charges incurred (visit fees plus any natural health products) for each visit. Services at Choice Nutrition Centres Inc. are not covered by the Saskatchewan Provincial Health Plan but may be covered by your extended health insurance plan. If you have coverage for naturopathic medicine through your extended health insurance plan, you are responsible for billing your own insurance company. Due to waiting lists other clients may be on and the time it takes to reschedule clients, we ask that you please be on time for any scheduled appointment. Any scheduled appointment that is cancelled with less than 24 hours notice may be charged for half the cost of the visit.
Your account will be charged $30.00 for any non-sufficient fund (NSF) cheques.
The practitioners at Choice Nutrition Centres Inc. may recommend or suggest natural health products that may be purchased onsite at this centre or at any other local option (i.e. health food stores).

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Client Name:_____ DOB:_____ Date: (dd/mm/yyyy):_____

Informed Consent And Acknowledgement

I, the undersigned hereby state that I understand and acknowledge that:

(A) Consent protects the right of informed choice and must be obtained for diagnostic procedures and/or treatments which are controlled acts under the RHPA, and Board of Directors of Drugless Therapy – Naturopathy, and The Naturopathy Act of Saskatchewan. Anything that is done for therapeutic, preventative, palliative, diagnostic, cosmetic, or health related purposes including course of treatment or plan of treatment requires consent. Exceptions are taking a health history, routine physical exams, communication of an assessment for diagnosis, emergency care including restraint or confining persons to prevent injury to self or others, routine vital signs, first aid, and treatment that in the circumstances poses little or no risk of harm. Choice Nutrition Centres Inc. and any practitioner thereof, obtain informed consent to make sure I am aware of the possible side effects/risks associated with Applied Integrative Microscopy and Naturopathic Medicine. These include, but are not limited to: aggravation of pre-existing symptoms, allergic reactions to natural health products or botanical herbs, pain, bruising or injury from the use of a lancet, venipuncture, acupuncture, mesotherapy, or parenteral therapy (intravenous infusion therapy and injection therapy). Fainting or puncture of body tissue such as an organ, blood vessel or nerve may occur from insertion of acupuncture needles, venipuncture needles, mesotherapy needles, parenteral therapy butterfly and angiocatheter needles as well as hypodermic needles used in injection therapies. Muscle strains and ligament sprains or disc injuries may occur from naturopathic spinal manipulation and other treatments to the soft tissue although these are rare.

(B) Naturopathic medicine is the treatment and prevention of disease by natural means, naturopathic doctors assess the whole person, taking into consideration physical, mental and spiritual aspects of the individual. Gentle, noninvasive techniques are generally used in order to stimulate the body's inherent healing capacity. Naturopathic doctors may use the following modalities in their practice: diet and nutritional counseling, lifestyle counseling, preventative medicine, botanical medicine, homeopathy, parenteral therapy (intravenous infusion therapy and injection therapy), mesotherapy, acupuncture, hydrotherapy, traditional Chinese medicine, natural health product supplementation, physical medicine, spinal manipulation, and applied integrative microscopy (including peripheral coagulation studies and live blood analysis to obtain useful information about your health status).

(C) Even the gentlest of therapies have their complications in certain physiological conditions such as: pregnancy and lactation, in very young children, or those taking multiple medications. Some therapies must be used with caution in certain diseases including but not limited to: diabetes, heart disease, kidney disease, and abnormal blood coagulation, use of blood thinning medication, presence of a cardiac pacemaker, high blood pressure, epilepsy, cold sore eruption, and allergic reactions, and as such must notify Choice Nutrition Centres Inc. or any practitioner thereof of any of the previously mentioned health ailments. Any tape recording / videotaping without express written consent of Choice Nutrition Centres Inc. or any practitioner thereof is strictly prohibited.

(D Choice Nutrition Centres Inc. or any practitioner thereof, including an attending Naturopathic Doctor, is not a medical doctor and does not hold himself/herself out as being able to diagnose, treat, operate/perform surgery or prescribe drugs for any human disease, pain injury, disability or physical condition.

(E) All information from, or communications with, Choice Nutrition Centres Inc. or any practitioner thereof, including an attending Naturopathic Doctor, are at my own request, with full knowledge of the above particulars.

(F) No guarantees have been made to me concerning the results that may be obtained as a result of my consultation with Choice Nutrition Centres Inc. or any practitioner thereof, including an attending Naturopathic Doctor.

I, the undersigned, acknowledge that I have read the above consent and have had opportunity to ask questions about its content. With this knowledge, I voluntarily consent to diagnostic & therapeutic procedures and/or recommendations given to me by Choice Nutrition Centres Inc. or any practitioner thereof, including an attending Naturopathic Doctor. I intend this consent to apply to all present and future consultations, suggestions, recommendations and treatment plans. I understand and acknowledge that I am free to withdraw my consent at any time.

_____	_____	_____
Name of Client (please print)	Signature of Client or Guardian (if a minor)	Date (dd/mm/yyyy)
_____	_____	_____
Name of Witness (please print)	Signature of Witness	Date (dd/mm/yyyy)

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Client **N**ame:_____ **DOB:**_____ **D**ate: **(**dd/mm/yyyy**):**_____

Privacy Policy for Collection, Use and Disclosure of Personal Information

Privacy of your personal information is important to Choice Nutrition Centres Inc. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. 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. Your medical records are stored securely onsite. The information caretaker officer for this office is Bartley Quibell.

Our privacy policy outlines what Choice Nutrition Centres Inc. is doing to ensure that:

- Only necessary information is collected about you, and 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 the regulatory body for naturopathic medicine in Saskatchewan (The Saskatchewan Association of Naturopathic Practitioners and the Board of Directors of Drugless Therapy – Naturopathy) Our privacy protocols also comply with those set forth by The Health Information Protection Act of Saskatchewan and the Personal Health and Information Protection Act

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

Choice Nutrition Centres Inc. understands 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. Choice Nutrition Centres Inc. will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient client care and to identity and to ensure continuous high quality care
- To assess your health needs and to provide health care and to collect unpaid accounts
- To advise you of your treatment options and to enable us to contact you and to process credit card payments
- To offer and provide treatment, care, and services in relationship to preventative medicine, acute and chronic naturopathic health care generally
- To communicate with other treating health-care providers, including specialists, family practitioners, referring physicians, and any other provider involved in the care of a client
- To allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments and to allow us to efficiently follow-up for treatment, care, and billing
- For teaching and demonstrating purposes on an anonymous basis
- To comply with legal and regulatory requirements including court orders, statutory requirements to advise authorities of child abuse, reporting communicable disease to public health or reporting those individuals who may be an imminent threat to harming themselves or others, including the delivery of client's charts and records to the Saskatchewan Association of Naturopathic Practitioners.
  To deliver your charts and records to the naturopathic doctor's insurance carrier to enable the insurance company to assess liability and quantify damages, if any, and to comply generally with the law
- To prepare materials for the Board of Directors of Drugless Therapy- Naturopathy complaints committee

Consent And Acknowledgement

I, the undersigned, hereby state that I understand and acknowledge that by signing this consent form, I voluntarily agree to the collection, use and/or disclosure of my personal health information or that of my child (if under the age of 18) by Choice Nutrition Centres Inc. or any practitioner thereof for the purposes listed above but only with proper obtained written and oral consent. I have reviewed the above information that explains how Choice Nutrition Centres Inc. will use my personal health information and the steps that are being taken to protect my information.

_____	_____	_____
Name of Client (please print)	Signature of Client or Guardian (if a minor)	Date (dd/mm/yyyy)
_____	_____	_____
Name of Witness (please print)	Signature of Witness	Date (dd/mm/yyyy)

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Authorization to Use or Disclose Protected Health Information

Client Name:_____

Address:_____

Date of Birth:(DD/MM/YYY)_____**Phone Number:**_____

As required by the Privacy Regulations, *Choice Nutrition Centres* may not use or disclose your protected health information.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of: **Interpretation of said images**

Effective date for this authorization is: _____/_____/_____. This authorization will apply for any additional thermal imaging appointments. DD MM YYYY

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____

Signature of Client or Client's Authorized Representative **Date (DD/MM/YYYY)**

_____ _____

Authorized Signature of Facility **Date (DD/MM/YYYY)**

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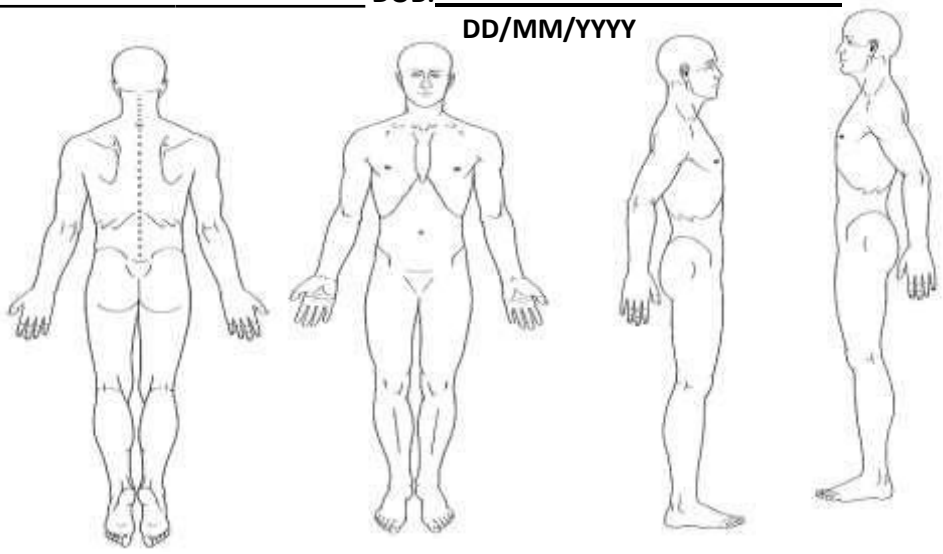
Half and Full Body Questionnaire

All information given in the questionnaire will remain strictly confidential and will only be released to the reporting thermologist and any other practitioner that you specify.

Name:_____ **DOB:**_____
DD/MM/YYYY

Please show areas of:

Main Pain *
Secondary Pain **O**
Numbness ///////
Pins and Needles :::::::
Skin lesions / Scarring ↑



Do you know what triggered the pain?

Does anything relieve it?

Does anything aggravate it?

Has it changed since it began?

Have you had any treatment?

PATIENT DISCLOSURE

I understand that the Report generated from my images in intended for use by trained health care providers to assist in evaluation, diagnosis and treatment. I further understand that the Report is not intended to be used by individuals for self-evaluation or self-diagnosis.
I understand that the Report will not tell me whether I have any illness, disease, or other condition but will be an analysis of the images with respect only to the thermographic findings of the areas discussed in the Report.
By signing below, I certify that I have read and understand the statements above and consent to the examination.

Client Signature_____**Date**_____
DD/MM/YYYY

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Breast Health Questionnaire

Name:_____ **DOB:**_____
(DD/MM/YYYY)

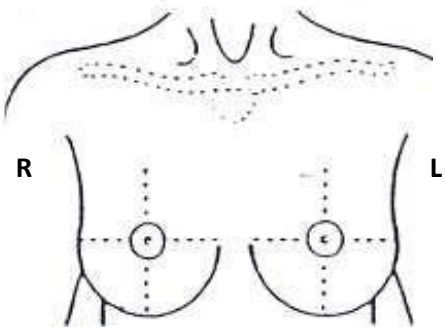
All information given in the questionnaire will remain strictly confidential and will only be divulged to the reporting thermologist and any other practitioner that you specify.

Questionnaire	**Yes**	**No**
1. Do you have a close relative who has had breast cancer?	____	____
2. Have you ever been diagnosed with breast cancer?	____	____
3. Have you ever been diagnosed with any other breast disease?	____	____
4. Have you had any biopsies or surgeries to your breasts?	____	____
5. Have you had any breast cosmetic surgeries or implants?	____	____
6. Have you had a mammogram in the past 12 months?	____	____
7. Have you had a mammogram in the past 5 years?	____	____
8. Have you had abnormal results from any breast testing?	____	____
9. Have you ever taken a contraceptive pill for more than one year?	____	____
10. Have you suffered with cancer of the womb?	____	____
11. Have you had pharmaceutical hormone replacement therapy?	____	____
12. Do you have an annual physical examination by a doctor?	____	____
13. Do you perform a monthly breast self-exam?	____	____

14. How many mammograms have you had in total? _____
15. What was the age when you had your first mammogram? _____
16. How many births have you had?_____ Age at birth of first child:_____
17. Had a vaccination in the past **4 WEEKS**? Indicate which arm LEFT RIGHT NO
18. Did you periods start before the age of 12? Y / N Or finish after the age of 50? Y / N
19. Do you smoke? Yes:____ No:____ Not in the last 12 months:____ Not in 5 years:____

Have you recently had any of these symptoms:	Right Breast	Left Breast
Pain	_____	_____
Tenderness	_____	_____
Lumps	_____	_____
Change in breast size	_____	_____
Areas of skin thickening or dimpling	_____	_____
Secretions of the nipple	_____	_____

Please us the image to the right to indicate areas of pain, tenderness, lumps, or skin rashes or irregularities.



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Extended Breast Questionnaire
please indicate if not applicable

Name:_____ **DOB:**_____
DD/MM/YYYY

DIAGNOSED WITH BREAST CANCER:

Cancer Type: Metastatic_____ Local_____ Lymph node involvement_____

Date of Diagnosis: Month_____ Year_____

Where: (left breast)

Upper/Outside_____Upper/Inside_____Lower/Outside_____Lower/Inside_____Nipple___

Where: (right breast)

Upper/Outside_____Upper/Inside_____Lower/Outside_____Lower/Inside_____Nipple___

Treatment: Surgery_____ Chemo _____Radiation _____Other _____None_____

DIAGNOSED WITH OTHER BREAST DISEASE:

Disease Type: Fibrocystic_____ Cystic_____ Mastitis_____ Other_____

BREAST BIOPSIES OR SURGERY:

Where: (left breast)

Upper/Outside_____Upper/Inside_____Lower/Outside_____Lower/Inside_____Nipple___

Where: (right breast)

Upper/Outside_____Upper/Inside_____Lower/Outside_____Lower/Inside_____Nipple___

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Please answer the questions below to the best of your ability and indicate if any are not applicable:

1. What is your surgical history?

2. What is your dental health history?

3. What is your general health history (injuries, fractures, illnesses etc.)?

4. What is your family medical history?

5. Have you been diagnosed with any health or medical conditions?

6. Please list any medications that you are taking.