Centre for Advanced Medicine (CAM)

670 Taunton Rd. E, Unit B4-B
Whitby, Ontario

905.655.7100
905.655.7155

Canadian Centre for Integrative Medicine (CCIM)

12 Main Street N.
Markham, Ontario

905.471.9355
905.4714348

New Patient Intake Form

Date: _____

Contact Information

Name: _____ Date of Birth: _____/_____/_____

Address: _____ E-mail: _____

Phone:

Home (_____) _____ - _____

Work (_____) _____ - _____

Cell (_____) _____ - _____

Emergency Contact:

Name _____

Phone (_____) _____ - _____

Relation _____

How did you hear about the Centre for Advanced Medicine?

_____

Please write the name of the person who told you about us (if applicable)

_____

We strongly encourage you to visit www.functionalmedicine.org for a better understanding of what to expect at our offices.

Form continues on page 2

Healthcare Questionnaire

Do you currently have healthcare insurance? ☐ Yes ☐ No

Coverage / Year: _____

Please list any other healthcare providers you are seeing

Name _____ Name _____

Phone (_____) _____ - _____ Phone (_____) _____ - _____

Name _____ Name _____

Phone (_____) _____ - _____ Phone (_____) _____ - _____

Medical History

Please indicate all medical conditions, illnesses, surgeries, injuries or hospital visits, and include the approximate dates. See 'Medical History' document on the last page of this form.

Please list your health concerns in order of importance

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

Please list the medical conditions you have been diagnosed with

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

Form continues on page 3

What types of therapies have you tried for the problem(s) listed above, or in general to improve your overall health?

☐ Diet Modification ☐ Intravenous (IV) Therapy ☐ Vitamins / Minerals ☐ Herbs

☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Drugs

Other:

_____

Do you experience any of these general symptoms on a **daily basis**?

☐ Debilitating Fatigue ☐ Shortness of Breath ☐ Insomnia ☐ Constipation

☐ Depression ☐ Panic Attacks ☐ Nausea ☐ Fecal Incontinence

☐ Disinterest in Sex ☐ Headaches ☐ Vomiting ☐ Urinary Incontinence

☐ Disinterest in Eating ☐ Dizziness ☐ Diarrhea ☐ Low Grade Fever

☐ Bleeding ☐ Discharge ☐ Itching / Rash ☐ Chronic Pain / Inflammation

Other:

_____

Have you had any laboratory analysis performed?
Example: stool, saliva, blood, urine, hair

_____

_____

Circle the level of stress you experience on a daily basis on a scale of 1 to 10
1 being no stress at all, and 10 being high amounts of stress

1 2 3 4 5 6 7 8 9 10

Form continues on page 4

Can you Identify the major causes of stress in your life?
Example: work, residence, finances, legal problems

_____

_____

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Just Right

What is your weight today? _____ ☐ lbs ☐ kg

Do you have any allergies?
Example: medications, environmental

_____

_____

Please list all current natural medications and prescriptions

_____

_____

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following?

☐ Aspirin	☐ Antacids	☐ Birth Control Pills
☐ Laxatives	☐ Diet Pills	☐ Implants / Injections
☐ Alcohol	☐ Tobacco	☐ Caffeine
Per day? _____	*What form?* _____	*What form?* _____
Per week? _____	*How often?* _____	*How often?* _____

☐ Recreational drugs _____

Form continues on page 5

Diet

Do you have any food allergies, intolerances or dietary restrictions? ☐ Yes ☐ No

If yes, please list:

_____

_____

What are your current dietary habits?

_____

_____

Environment

What is your occupation?

_____

What are your hobbies?

_____

Have you been, or are you currently exposed to toxins or hazardous chemicals on a daily basis?
Example: tobacco smoke, solvents, pesticides, unclean work environment

_____

_____

How is the emotional climate of your work and home environments on average?

_____

_____

How many hours do you work in a week? _____

Form continues on page 6

Are there any other lifestyle habits you have that we should be aware of?

_____

_____

How is your **energy** level on a daily basis?
1 being little to no energy, and 10 being high amounts of energy

1	2	3	4	5	6	7	8	9	10

How is your **mood** on a daily basis?
1 being always in bad mood, and 10 being always in a good mood

1	2	3	4	5	6	7	8	9	10

How is the quality of your **sleep** on an average night?
1 being poor quality; not well rested, and 10 being excellent quality; very well rested

1	2	3	4	5	6	7	8	9	10

Roughly how many hours do sleep a night? _____

Please list your **short-term** health goals

1. _____
2. _____
3. _____

Please list your **long-term** health goals

1. _____
2. _____
3. _____

Form continues on page 7

How actively are you trying to be healthy?
1 being not trying at all, and 10 being trying very hard

1	2	3	4	5	6	7	8	9	10

How aggressive would you like your treatment plan? _____
Please choose from the options listed below;

1. Slow & steady improvement over 6 months to a year
2. Improvement within 3 months
3. Dramatic improvement as quickly as possible

Is there anything else that you feel is important, but has not been covered?

_____

_____

_____

Please complete this entire form to the best of your ability & return to it the clinic reception

Please note: There will be a $40.00 charge for any cancellations made less than 2 business days from your scheduled appointment.

Form continues on page 8

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other _____

Date of last GYN exam _____

Mammogram ❑ + ❑ −

PAP ❑ + ❑ −

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

Age of first period _____

Date - last menstrual cycle _____

Length of cycle _____ days

Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

- ❑ Surgical menopause
- ❑ Menopause

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

- ❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

- ❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

- ❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

❑ Water: #glasses/d _____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk - #days/wk _____
- ❑ Run, jog, other aerobic - #days/wk _____
- ❑ Weight lift - #days/wk _____
- ❑ Stretch - #days/wk _____
- ❑ Other _____

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

❑ Skip meals - which ones _____

_____

- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others _____

_____

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Loose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

Form continues on page 9

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR FIRST APPOINTMENT

Patient Consent Form

It is important to the regulated health professionals at the Centre for Advanced Medicine that you are educated and informed. Informed consent is not just about signing a piece of paper, it is about really understanding and having the ability to ask questions and get clarity. If you have any questions at any time during your care at Centre for Advanced Medicine, we are committed to answering them.

Here is what you can expect from the Centre for Advanced Medicine team:

We believe in health restoration and helping you reach your genetic potential. That means we are providing support to bodily systems to optimize function. The tools we use to do this are largely natural products – diet and nutritional medicine, herbal medicine, and counseling. However, we also consider hormones and prescription drugs when necessary.

We want to fully understand the underlying process. That means we want to figure out WHY you are having the symptoms. As a result, we provide different types of assessments and review your standard lab tests more thoroughly. Lab tests ordered by your ND are NOT covered by OHIP. Any charges for lab tests will be discussed with you BEFORE they are ordered.

We look at our patients from a system's biology perspective and apply personalized precision medicine. Not all people with headaches have headaches for the same reason. As a result, we might ask you questions that have seemingly nothing to do with your headaches. Also, you might get a different treatment plan than your friend Betty who came in for the same problem. The reason, you are both different people and the CAUSE of your headaches is often different.

We are REALLY passionate about innovation, education, and health restoration as the best form of healthcare. As a result you should leave each consult with a deeper understanding of your problem.

Want to reach us by email? No problem. We use email a lot to check in, clarify treatment plans and give further information as needed. Here is what we can't do via email - assess and treat you for a new complaint. That, we have to do in person.

We work as part of a TEAM. There are Naturopathic Doctors, Medical Doctors, consultants and Registered Nurses on the Centre for Advanced Medicine team. All of these individuals work together to deliver your care safely and effectively. You will have one doctor who is primarily responsible for your care, but that doctor, and you, has access to the whole team when managing your case. The team collaborates to ensure best care. When you become a patient of Centre for Advanced Medicine you are a patient of the whole team. We believe you should in the driver's seat, the Centre for Advanced Medicine team are your navigators. We will never instruct you to refrain from seeking the advice or treatment from another regulated health care provider. We want to be a valued and trusted part of your health care team.

Form continues on page 10

Declaration & Consent to Treat

I understand that:

I may be assessed and treated in a way different than what is usually offered by an MD

If I am pregnant or lactating I will make sure the Centre for Advanced Medicine team know about it.

I accept the inherent risks of treatment at Centre for Advanced Medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to natural products or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting due to stress or needle fears
- Muscle strains and sprains, disc injuries from spinal manipulation

I agree to be a patient of the entire Centre for Advanced Medicine team of licensed and regulated Health Professionals – Including ND's, MD's, PhD's, nutritionists and RN's.

Initials: _____

I am at liberty to seek or continue medical care from a medical doctor or other care providers licensed to practice in Ontario.

Initials: _____

I understand that although Functional Medicine is very effective, I realize the results are NOT guaranteed.

Initials: _____

I understand care at Centre for Advanced Medicine is not covered by OHIP. I agree to pay my full account at the time of each visit.

Initials: _____

I understand that advice given via email will be only for clarification or information.

Initials: _____

I understand that a 48-hour cancellation policy is in effect. Full fees are applied without 48-hour notice.

Initials: _____

Form continues on page 11

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

Initials: _____

I am not only free to, but am enthusiastically encouraged, to ask as many questions as I need to feel confident about any assessment and treatment I am to receive at Centre for Advanced Medicine.

Initials: _____

I understand that I am able to withdraw my consent at any time and that the Centre for Advanced Medicine will adhere to the Personal Health Information Protection Act 2004.

Initials: _____

The Clinic's Health Information Custodian is Dr. Leigh Arseneau ND.

_____

Name of Patient / Representative (please print)

_____

Signature: _____ Date: _____

Witness: _____ Date: _____

Form continues on page 12

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR FIRST APPOINTMENT

Patient Privacy Policy Form

For collection, use & disclosure of personal information

Privacy of your personal information is an important part the Centre for Advanced Medicine, while providing you with quality Naturopathic Care. We understand the importance of protection 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.

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 protection of your information.

Our privacy policy outlines what (CAM) is doing to 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, the Board of Directors of Drugless Therapy- Naturopathy.

How our clinic collects, uses & discloses patients' personal information

CAM understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how CAM is 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, reportable diseases and individuals who may be an imminent threat to harm themselves or others.

Form continues on page 13

By signing this Patient Consent form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

_____

I have reviewed the above information that explains how your Clinic will use my personal information, and the steps your Clinic is taking to protect my information. I agree that CAM can collect, use, and disclose personal information about my health as set out above in the information about CAM's privacy policies.

Name of Patient / Representative (please print)

_____

Signature: _____ Date: _____

Form continues on page 14

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR FIRST APPOINTMENT

Email Consent Form

Dear Patient,

The clinic has recently updated its website and social media platforms to bring you the most up to date information on services and promotions. In accordance with the 2014 “anti spam” law we require your consent to correspondence through all electronic means. Please review and update by selecting your preferences below.

We use email/text messaging communication in the following ways:

- Appointment confirmations, reminders and scheduling changes, intake forms and other relevant scheduling information.
- Email newsletters including promotions relevant health articles and important clinic updates such as holiday hours and new services.
- Email communications to advise you when results are received (if not reachable by phone), sending treatment plans and to answer your questions where applicable.

Patient section:

I, the undersigned hereby give consent to the Centre for Advanced Medicine (CAM), its employees, and associates as well as any and all healthcare practitioners under its supervision to openly initiate and conduct ongoing electronic correspondence through all electronic devices including, cell phones, computers and tablets with myself the undersigned.

Name of Patient (Please print):

_____

Email (Confidential to you):

_____ @ _____

Signature: _____ Date: _____

***At any time you wish to opt out, please email us at info@advancedmedicine.ca or by telephone at **(905)-655-7100**. Patients are responsible for protecting patient’s own device passwords or other means of access to emails sent or received from CAM. Clinic is not liable for breaches of confidentiality caused by patient.*