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## The Macdonald Centre for Natural Medicine Ltd.

448-10<sup>th</sup> Street  
Courtenay, BC V9N 1P6

Dr. Deidre Macdonald  
Naturopathic physician

Phone 250-897-0235  
Fax 250-897-1797

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Dear New Patient,

Congratulations for putting your health first and deciding to investigate Naturopathic Medicine. I am confident that you will greatly expand your knowledge of your health care options and I look forward to sharing that experience with you.

Together we will endeavor to achieve your health goals. In order to understand you as a whole, I need to gather a significant amount of information. One the most efficient and therefore cost-effective tools I have is this comprehensive set of in-take forms. Please do your best to be thorough in filling them out, but if you don't understand or don't feel comfortable with a question, leave it out and proceed from there.

**Please drop off your completed forms to my office prior to your visit.** I will then have an opportunity to assess the information and make good use of your time during your scheduled appointment. Alternatively, you may fax your package to 897-1797.

**My office is located at 448-10<sup>th</sup> Street in Courtenay in a house/office.** If you turn at the Dairy Queen on Cliffe Ave., that will put you on 10<sup>th</sup> Street and we are 1.5 blocks up on the left between England and Fitzgerald Ave.

If the clinic is not open when you wish to drop off your forms, please seal the envelope, put your name on it, and place it in the **mail slot** of the front door. I am the only person who reviews these forms and your confidentiality will be strictly maintained. I sincerely thank you for sharing this important information with me and look forward to our first visit!

Love and blessings,

Dr. Deidre Macdonald  
Naturopathic physician

(P.S. Out of consideration for my patients with allergies and chemical sensitivities, I request that you refrain from wearing perfume or cologne on the days you will be visiting our office. Thank you.)

Check us out at [www.getwellhere.com](http://www.getwellhere.com)

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## *The Philosophy of Naturopathic Medicine*

### *THE HEALING POWER OF NATURE*

The healing process is ordered and intelligent. The body has the inherent ability – the vitality – not only to heal itself and restore health, but also to ward off disease. Illness is not caused simply by an invasion of external agents or germs, but is a manifestation of the organism’s attempt to defend and heal itself. The physician’s role is to identify and remove agents blocking the healing process, bolster the patient’s healing capacity, and support the creation of a healthy internal and external environment.

### *TREAT THE WHOLE PERSON*

Health and disease result from a complex interaction of physical, mental, emotional, genetic, spiritual, environmental, social, and other factors. The harmonious function of all aspects of the individual is essential to health. Within the body, the different systems are intimately connected, dynamically balanced. “Dis-ease” or imbalance in one part directly affects – may cause disease in – other parts of that whole. There is never a single cause for disease. All of the “pieces” must be integrated in order to create a whole picture of an individual and his/her illness. Therapy can then be directed at underlying as well as immediate causative factors, thus treating the whole person.

### *FIRST DO NO HARM*

Respecting the inherent ability of the organism to heal itself, the physician must be ever-mindful of the consequences or side effects of treatment. The more gentle and non-invasive the therapy, the less disruptive it will be to the patient’s integral whole. Whenever possible, suppression of symptoms is avoided as suppression may interfere with the healing process.

### *IDENTIFY AND TREAT THE CAUSE*

Illness does not occur without cause, and symptoms (nausea, rash, headache) are not the cause of illness. Symptoms are signals that the body is out of balance and are an expression of the body’s attempt to heal itself. Causes originate on many levels, but are often found in the patient’s lifestyle, diet, habits, or emotional state. When only the symptoms are treated, the underlying causes remain and the patient may develop a more serious, chronic condition.

### *PREVENTION IS THE BEST CURE*

Health is a reflection of how we choose to live. Physicians help patients recognize their choices and how those choices affect their health. The physician assesses risk factors and hereditary susceptibility to disease and makes appropriate intervention to prevent illness.

### *DOCTOR AS TEACHER*

The original meaning of the word “doctor” was “teacher”. A physician is a facilitator for a patient’s healing process. One of a physician’s principle responsibilities is to educate the patient and encourage self-responsibility for health. A cooperative doctor-patient relationship has inherent therapeutic value.

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## PATIENT INTAKE FORM

### Identifying Data

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ Sex **M** or **F** Marital Status \_\_\_\_\_

City: \_\_\_\_\_ Date of Birth: (M/D/Y) \_\_\_\_/\_\_\_\_/\_\_\_\_

Province: \_\_\_\_\_ Nationality/Race: \_\_\_\_\_

Postal Code: \_\_\_\_\_ Number of Children: \_\_\_\_\_

Telephone #: (home): \_\_\_\_\_ (work): \_\_\_\_\_ Cell: \_\_\_\_\_

Family MD: \_\_\_\_\_ Referred by: \_\_\_\_\_

Occupation: \_\_\_\_\_ e-mail address: \_\_\_\_\_

Are you on the Premium Assistance program with MSP? Yes \_\_\_ No \_\_\_ If Yes, CareCard #: \_\_\_\_\_

Extended Health Coverage? Yes \_\_\_ No \_\_\_

Have you attended a seminar by Dr. Macdonald? Yes \_\_\_ No \_\_\_

**Major Health Concerns** – Please state and describe your primary reason(s) for attending our clinic. When did it start, any significant events that preceded the beginning of your concern or factors that you suspect brought it on or make it worse.

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Other practitioners you are currently seeing or have recently seen and treatments you are receiving.

Name	Type of Practitioner	Treatment
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____

**Family Medical History** Please list the current age and all relevant medical problems. If deceased, list age and cause of death.

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brothers: \_\_\_\_\_

Sisters: \_\_\_\_\_

Spouse: \_\_\_\_\_

Children: \_\_\_\_\_

Any familial diseases?: \_\_\_\_\_

Which childhood diseases have you had? Chicken pox    mumps    measles    whooping cough    rheumatic or scarlet fever    diphtheria    polio    other \_\_\_\_\_

As an infant were you breast fed?: yes or no    For how long? \_\_\_\_\_ (months)

Immunizations: complete or partial    Adverse reactions \_\_\_\_\_

**Past surgeries:** (circle and state your age at the time)

Tonsils \_\_\_\_\_    appendix \_\_\_\_\_    gallbladder \_\_\_\_\_    hysterectomy \_\_\_\_\_

hernia \_\_\_\_\_    tubal ligation \_\_\_\_\_    Vasectomy \_\_\_\_\_    prostate \_\_\_\_\_

back \_\_\_\_\_    minor surgery \_\_\_\_\_    varicose veins \_\_\_\_\_    skin lesions \_\_\_\_\_

cosmetic \_\_\_\_\_    other(s) \_\_\_\_\_    Other hospital stays \_\_\_\_\_

**Major stresses:** List the 5 most significant, stressful events in your life. Indicate with a \* which ones currently impact you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Other Medical Concerns:** (Describe all you have at this time)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dental History:** (circle and state age)

Silver amalgams/crowns \_\_\_\_\_    gold amalgams/crowns \_\_\_\_\_    wisdom teeth removed \_\_\_\_\_

Dental appliances/bridges/dentures \_\_\_\_\_    dental implants \_\_\_\_\_    root canals \_\_\_\_\_

What condition are your teeth and gums in? \_\_\_\_\_

**Allergies and Drug Reactions:** list and describe the reaction.

Drug: \_\_\_\_\_

Food: \_\_\_\_\_

Chemical: \_\_\_\_\_

Pollens/Molds: \_\_\_\_\_

Insects/Animals: \_\_\_\_\_

**Current Medication:** List all prescription drugs/medications, and over the counter medications and why.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Vitamins, Supplements, Herbs, etc.** List all that you take regularly, and why.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Menstrual History:** (females)

Age of onset \_\_\_\_\_ Date of last period \_\_\_\_\_ Date of last PAP smear \_\_\_\_\_

Was PAP normal? \_\_\_\_\_ # of days between periods \_\_\_\_\_ Duration of bleeding \_\_\_\_\_

Amount of blood loss \_\_\_\_\_ PMS \_\_\_\_\_ Cramps \_\_\_\_\_ Is your period regular? \_\_\_\_\_

List any past menstrual or gynecological problems \_\_\_\_\_

Difficulty conceiving? \_\_\_\_\_ # of pregnancies? \_\_\_\_\_ # of deliveries? \_\_\_\_\_

Any birth complications? \_\_\_\_\_ # of caesarian sections? \_\_\_\_\_ # of miscarriages \_\_\_\_\_

# of abortions \_\_\_\_\_ # of D & C's \_\_\_\_\_ Age at menopause \_\_\_\_\_

Current menopausal symptoms \_\_\_\_\_

### **PERSONAL PROFILE / SOCIAL HISTORY**

**Dietary Habits:** Briefly list what you eat and drink at a typical meal.

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Supper: \_\_\_\_\_

Snacks: \_\_\_\_\_

How do you rate your diet? Excellent good average poor terrible

Do you follow a specific diet? Yes or No What kind? \_\_\_\_\_

Amount of water drank daily? \_\_\_\_\_ What type? Tap Bottled Filtered

Do you smoke? Yes or No Recreational drug use: Yes or No

Is this a concern for you? Yes or No

Alcohol use: Daily Several times per week Weekends only Occasional Rarely Never

Alcoholic beverage of choice \_\_\_\_\_ Amount consumed per use \_\_\_\_\_

Coffee \_\_\_\_\_ cups/day Black Tea \_\_\_\_\_ cups/day

**Employment History:** How many hours per week do you work? \_\_\_\_\_ Please list briefly all major jobs/occupations in the past \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Education:** What is the highest level of education you've completed? \_\_\_\_\_  
\_\_\_\_\_

**Travel History:** Have you been out of the country recently? Yes or No When? \_\_\_\_\_

For how long? \_\_\_\_\_ Where? \_\_\_\_\_

Are any of your health problems related to your travels? Yes or No

**Relationship History:** Any major problems with your marriage/relationship? Yes or No

Any past divorces? Yes or No How many? \_\_\_\_\_ Are you sexually active? Yes or No

Any sexual related concerns? Yes or No Please briefly describe \_\_\_\_\_  
\_\_\_\_\_

**General Health:**

Do you exercise regularly? Yes or No Type(s) \_\_\_\_\_

How often? \_\_\_\_\_ For how long? \_\_\_\_\_

Do you sleep well? Yes or No # hours per night \_\_\_\_\_

Do you sleep through the night? Yes or No How long to fall asleep? \_\_\_\_\_

Do you awaken feeling rested? Yes or No Any financial difficulties? Yes or No

Recent or long term? \_\_\_\_\_ Pets at home? Yes or No

How many? \_\_\_\_\_ What kind? \_\_\_\_\_

Do you regularly relax, meditate or pray? Yes or No

What do you do for stress management? \_\_\_\_\_

Age of the home you live in? \_\_\_\_\_ Is dust or mould a problem in your home? Yes or No

Has there been any recent renovations done to your home in the last 3 years? Yes or No

## REVIEW OF SYSTEMS

Please circle **Y** – a condition you have now. **P** – a condition you have had in the past, but is okay now. **N** – a condition you have never had. Record significant details in the margins or on the dots.

Present weight \_\_\_\_\_ (lbs)

Maximum weight \_\_\_\_\_ (lbs)

When? \_\_\_\_\_

Desired weight \_\_\_\_\_ (lbs)

Height \_\_\_\_\_

### General Body

Fatigue..... Y P N

Fever..... Y P N

Chills..... Y P N

Night sweats..... Y P N

### Skin

Eczema/rash..... Y P N

Psoriasis..... Y P N

Acne, boils..... Y P N

Hives..... Y P N

Peculiar moles..... Y P N

Lumps..... Y P N

Bruising..... Y P N

Pigmentation change..... Y P N

Itch..... Y P N

### Hair

Abnormal loss..... Y P N

Change in texture..... Y P N

### Nails

Brittle..... Y P N

Ridging..... Y P N

Pitting..... Y P N

Abnormal curvature..... Y P N

Not growing..... Y P N

### Head

Stress headache..... Y P N

Migraine headache..... Y P N

Head injury..... Y P N

Head pain..... Y P N

### Eyes

Impaired vision..... Y P N

Cataracts..... Y P N

Glaucoma..... Y P N

Eye pain..... Y P N

Discharge..... Y P N

Tearing..... Y P N

Dryness..... Y P N

Redness..... Y P N

Burning/itching..... Y P N

Light sensitivity..... Y P N

Blindness..... Y P N

Glasses or contacts..... Y P N

### Ears

Impaired hearing..... Y P N

Ringing..... Y P N

Dizziness..... Y P N

Recurrent infections..... Y P N

Discharge..... Y P N

### Nose / Sinuses

Impaired smell..... Y P N

Nose bleeds..... Y P N

Nasal/sinus congestion..... Y P N

Runny nose..... Y P N

Recurrent infection..... Y P N

Post nasal drip..... Y P N

Seasonal allergies..... Y P N

### Mouth / Throat

Impaired taste..... Y P N

Recurrent sore throat/infection..... Y P N

Gum disease..... Y P N

Sore tongue..... Y P N

Hoarseness/laryngitis..... Y P N

Bad breath..... Y P N

Canker sores..... Y P N

### Respiratory

Chronic cough..... Y P N

Shortness of breath..... Y P N

Wheezing..... Y P N

Blood in coughed up mucous..... Y P N

Chest pain..... Y P N

Recurrent pneumonia/bronchitis..... Y P N

Asthma..... Y P N

Emphysema..... Y P N

Tuberculosis..... Y P N

### Cardiovascular

High blood pressure..... Y P N

Murmurs, arrhythmia..... Y P N

Angina..... Y P N

Valve disease..... Y P N

Palpitations..... Y P N

Cold extremities..... Y P N

Varicose veins/phlebitis..... Y P N

Swelling in ankles..... Y P N

Strokes / heart attacks..... Y P N

Please circle **Y** – a condition you have now. **P** – a condition you have had in the past, but is okay now. **N** – a condition you have never had. Record significant details in the margins.

**Gastro-intestinal**

Change in appetite..... Y P N  
 Impaired swallowing..... Y P N  
 Heartburn/indigestion..... Y P N  
 Gas..... Y P N  
 Bloating..... Y P N  
 Abdominal pain..... Y P N  
 Nausea..... Y P N  
 Vomiting..... Y P N

# Bowel Movement/Day \_\_\_\_\_

Blood in stool..... Y P N  
 Constipation..... Y P N  
 Diarrhea..... Y P N  
 Liver disease/Jaundice..... Y P N  
 Gallbladder disease..... Y P N  
 Ulcers..... Y P N  
 Irritable bowel syndrome..... Y P N  
 Hemorrhoids..... Y P N

**Urinary**

Pain on urination..... Y P N  
 Increased frequency..... Y P N  
 Awakening at night to urinate..... Y P N  
 Urinary urgency..... Y P N  
 Blood in urine..... Y P N  
 Recurrent bladder, kidney infection..... Y P N  
 Kidney stones..... Y P N  
 Incontinence..... Y P N

**Female Reproductive**

Pelvic pain..... Y P N  
 Post intercourse bleeding..... Y P N  
 Post menopausal bleeding..... Y P N  
 Sexually transmitted disease..... Y P N  
 Discharge or sores..... Y P N  
 What do you use for birth control? \_\_\_\_\_  
 PMS – Premenstrual symptoms..... Y P N

**Breasts**

Do you self exam?..... Y P N  
 Lumps..... Y P N  
 Cysts..... Y P N  
 Pain or tenderness..... Y P N

Nipple discharge..... Y P N

**Musculoskeletal**

Joint swelling/inflammation..... Y P N  
 Joint pain/stiffness..... Y P N  
 Arthritis..... Y P N  
 Impaired range of motion..... Y P N  
 Weakness..... Y P N  
 Muscle cramps..... Y P N  
 Bone fractures..... Y P N  
 Disc disease..... Y P N

**Neurological**

Seizures..... Y P N  
 Fainting spells..... Y P N  
 Tremor..... Y P N  
 Paralysis..... Y P N  
 Numbness/tingling..... Y P N  
 Loss of memory..... Y P N  
 Weakness..... Y P N  
 Balance problems..... Y P N  
 Speech difficulties..... Y P N

**Blood/Lymphatic**

Anemia..... Y P N  
 Leukemia..... Y P N  
 Bruising/bleeding easily..... Y P N  
 Lymph gland swelling..... Y P N  
 Transfusions..... Y P N

**Endocrine/Hormonal**

Heat/cold intolerance..... Y P N  
 Excessive thirst/hunger..... Y P N  
 Thyroid problems/goiter..... Y P N  
 Diabetes..... Y P N  
 Excessive facial hair (female)..... Y P N

**Immune**

Frequent colds/infections..... Y P N  
 Allergic disorders (eg) seasonal allergies.... Y P N  
 Asthma, eczema, hives, etc..... Y P N  
 Do odors bother you?..... Y P N



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## **Fees and Payments**

The following information will explain the fees at our office:

**ALL FEES ARE DUE AT THE TIME THE SERVICE IS RENDERED.**

First Visit (45 min): \$125.00

Follow up Visits (1/2 hr): \$63.00

Extended Follow up Visits (1 hr): \$110.00

**CANCELLATION NOTICE: Please allow 2 days notice to inform our office of appointment cancellations. Appointments cancelled under 48 hrs or missed will be charged \$25.00 for each visit or testing appointment.**

## **EXTENDED MEDICAL BENEFITS:**

Extended Health Plans often cover some or all of the fees for Naturopathic *visits*. Contact your extended health carrier to determine how much is covered per visit and per year. **We recommend inquiring about all the “fine print” regarding reimbursement.** Patients are responsible for submitting their receipts to their companies for reimbursement.

If supplements have a DIN number (Drug Identification Number), write the number on the receipt and sometimes the extended health insurer will reimburse for those products.

## **PREMIUM ASSISTANCE:**

MSP will reimburse \$23.00 for patients that qualify for Premium Assistance to a maximum of 10 combined specialist (naturopathy, chiropractor, physiotherapy, etc.) appointments.

Additional fees for supplements are the responsibility of the patient.

- MSP refers to MEDICAL SERVICES PLAN, this is your BC health care.
- MSP Premium Assistance = subsidy for the BC health care plan for low income.
- Dr. Macdonald's office will submit a form to MSP on your behalf. *Please advise the receptionist if you qualify for 'Premium Assistance' at each visit*
- MSP will mail reimbursements directly to you the patient in 6-8 weeks.

This office accepts Cash, Cheques, Interac, Visa & Mastercard.

I have read the above and fully understand the contents.

Signed \_\_\_\_\_ Date \_\_\_\_\_