Better Health Clinic

Your First Appointment

Congratulations on booking your first appointment!

Here are a few reminders to get you prepared for your visit.

- Please fill out your intake forms before arriving to the clinic
- If you are taking any medications or supplements, please bring them to the clinic with you for your appointment
- Plan on being at the office for approximately 1 hour
- Parking for the clinic is located at the side of the building. You may enter off of Broadway or from the back lane.
- If you need to cancel or reschedule your appointment, please do so at least 24 hours in advance. Each patient is allocated 1 hour of time in the schedule; last minute cancellations or missed appointments will be invoiced. **Get Connected!**
- Check out our website at betterhealthclinic.ca where you can learn more about our services and sign up to receive our monthly newsletter
- Follow us on Facebook or on Twitter I look forward to working together on your health goals!

Yours in health,

Doctor Jayne Marquis ND

229 Broadway, Orangeville, ON L9W 1K4 | Phone 519-415-2266 | Fax 519-415-2267
www.betterhealthclinic.ca

Information Collection & Fee

Information Collection Policy

Privacy protocols at Better Health Clinic comply with the Personal Health Information Protection Act (PHIPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the standards of the Board of Directors Drugless Therapy – Naturopathy (BDDT-N), our regulatory body.

Your information may be accessed by regulatory authorities under the terms of the Drugless Practitioners Act, for the purpose of fulfilling our regulatory body's mandate or by law. Our office will not disclose your personal confidential information to insurance companies or to third-party companies. For all other types of disclosure, we require a signed consent form by the patient.

Our clinic recognizes the sensitive nature of the information that you have disclosed and all associates of the clinic have been trained in the appropriate use and protection of your information. Proper adherence of our Information Collection Policy ensures:

- 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 the BDDT-N regulations
- Our ability to remind you of upcoming appointments and maintain ongoing contact with you
- Advisement of proper treatment options
- Delivery of newsletters and other informational mailings where appropriate

Naturopathic Fee Policy

- Fees are due at time of service
- Phone consultations are available only after the initial consultation has been completed
- Supplements recommended to patients as part of therapeutic protocols may be purchased at this clinic when available but patients are not required to purchase supplements from this clinic
- Patients may ask to view their records from Windwood Clinic; if copies are required, they can be provided for a nominal fee
- 24-hour cancellation or change of appointment time is required to avoid being charged in full for the missed appointment
- All fees do not include any applicable taxes and are subject to change at any time

Service	Fee	
Initial adult appointment If lengthened to include homeopathic intake if needed	$150 $240	90 minutes 120 minutes
Initial pediatric appointment (children under 12)	$125	60 minutes
60 minute follow-up (extended)	$150	60 minutes
30 minute follow-up (regular)	$75	30 minutes
30 minute pediatric follow-up	$60	30 minutes
15 minute follow-up	$35	15 minutes
Phone consultation	$30 per 15 minutes	Minimum 15 minute charge applies
Homeopathic Intake 2 hours	$270	Initial appointment required or during
Consult for horses/animals	$70	
Supplements	Priced accordingly	

_____
Initial

Better Health Clinic
229 Broadway, Orangeville
Ontario L9W 1K4
Jayne Marquis ND 1743

Better Health Clinic

Dear New Patient,

I look forward to meeting you on our first appointment. Please complete the intake forms enclosed in this package prior to our first visit together. It is important that you fill out the forms completely and accurately so that our first meeting can be as productive as possible. All answers are strictly confidential.

Your first visit will be spent going over your health concerns and a relevant physical exam will be included on first or second visit. During this initial consultation, I will collect the information required to make an assessment of your situation. In most cases, some form of initial treatment will be implemented at this time. This may include any combination of homeopathy, dietary recommendations, herbs, Chinese medicine, or supplements. Your complete treatment protocol will be established at your first follow-up visit as this allows me time to make sure your protocol includes an individually chosen homeopathic as well as including the most current research standards for supplements etc. Subsequent visits will be booked as to review your progress and make appropriate changes to your program.

Payment for appointments is required at the end of each visit. While OHIP does not cover Naturopathic services, many private insurance policies offer partial or complete coverage. Official receipts will be issued at the end of each visit so that you may be reimbursed directly by your insurance company.

Some supplements that are prescribed can be purchased from the Better Health dispensary. Every effort has been made to ensure that all products are of the highest quality and reasonable cost. However, you are welcome to purchase your supplements elsewhere.

I am looking forward to meeting you and moving forward together in your health.

Doctor Jayne Marquis N.D.

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Pediatric Intake Form: age 0-12

Please complete this form as thoroughly as possibly prior to your first appointment.
The information you provide will be kept strictly confidential.

Contact information

date: _____

patient's name: _____ _____ sex: m ☐ f ☐
(first) (last)

date of birth: _____ height: _____ weight: _____
(mm /dd /yyyy)

mother's name: _____ mother's cccupation: _____

father's name: _____ father's occupation: _____

address: _____

city: _____ province: _____ postal code: _____

phone: home ( ) _____ - _____ work ( ) _____ - _____ ext____ cell ( ) _____ - _____

email: _____ may the clinic leave voice mail messages? yes ☐ no ☐

Name and relation to child of person filling out this form: _____

emergency contact name: _____ relation: _____

phone: home ( ) _____ - _____ work ( ) _____ - _____ ext____ cell ( ) _____ - _____

How did you hear about the clinic? _____

Other healthcare provider

medical/family doctor: _____ phone: ( ) _____ - _____

address: _____ fax: ( ) _____ - _____

date of last visit: _____ permission to contact: yes ☐ no ☐
(mm /dd /yyyy)

other health care provider: _____

type of practitioner: _____ phone: ( ) _____ - _____

address: _____ fax: ( ) _____ - _____

date of last visit: _____ permission to contact: yes ☐ no ☐
(mm /dd /yyyy)

Medical history

List the patient's primary health concerns in order of importance:

1: _____ 3: _____

2: _____ 4: _____

Check the number that best represents the patient's general state of health on a scale of 5 (5 = excellent, 1 = very poor):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Please list medical conditions, illnesses, hospitalizations, along with treatment interventions (if applicable):

1: _____

2: _____

3: _____

Please list all of the patient's medications (past and current), include dose, duration, and side-effects, if any:

_____

_____

Also, please list all supplements, vitamins, minerals, herbal preparations, homeopathics, etc.:

_____

_____

Please indicate any allergies (medications, environment, foods):

_____

_____

How many times has the patient been on antibiotics? _____

What screening tests has the patient had (blood, hearing, vision, speech, learning etc.)?

_____

_____

Dietary history:

Please describe the patient's typical diet:

breakfast: _____

lunch: _____

dinner: _____

snacks: _____

beverages: _____

patient was: ☐ breast fed ☐ formula fed, type _____ ☐ both for how long? _____

Please indicate newly introduced foods (in order of introduction) and any adverse reactions (e.g., bloating, gas, diarrhea, constipation, nausea, vomiting, or rashes):

1: _____ 2: _____

3: _____ 4: _____

current food allergies: _____

dietary restrictions (e.g., vegetarian, religious): _____

food cravings: _____

Is the patient thirsty?: ☐ yes ☐ no preference of drink temperature? ☐ cold ☐ room temperature ☐ hot

picky eater?: ☐ yes ☐ no number of meals per day: _____

How would you describe patient's appetite in general?: ☐ poor ☐ fair ☐ good ☐ excellent

Please describe the patient's dental history, including oral hygiene practice, grinding, number of cavities, fillings, etc.):

_____

Immunization Record (Check all applicable)

DPT- Diphtheria, Pertussis, Tetanus	_____	Td + P - Tetanus, Diphtheria, Polio	_____
D-PTP -Diphtheria, Pertussis, Tetanus, Polio	_____	Tetanus	_____
OPV- Oral Polio Vaccine	_____	MMR- Measles, Mumps, Rubella	_____
Hepatitis B	_____	Hemophilus B	_____
Influenza (Flu Shot)	_____	Men-C conjugate	_____
Pneumo-coccal conjugate	_____	Varivax (Chicken pox)	_____
Other:	_____		

If the patient had an adverse reaction to any of the above vaccinations please describe reaction:

_____

Family Medical History:

Has anyone in the patient's family had any of the following diseases? <u>If yes, please indicate which member.</u>

addiction _____	depression _____	lupus _____
allergies _____	diabetes _____	obesity _____
arrhythmia _____	down syndrome _____	rheumatoid arthritis _____
asthma _____	epilepsy _____	sickle-cell anemia _____
autism _____	heart disease _____	stroke _____
autoimmune disorder _____	high blood pressure _____	ulcerative colitis _____
bleeding disorder _____	hypothyroidism _____	cancer _____
hyperthyroidism _____	crohn's disease _____	irritable bowel syndrome _____

other conditions not listed above:

mother: _____ father: _____ sibling(s): _____

grandparent (maternal): _____ grandparent (paternal): _____

Review of system

For each item, please place a check mark next to the symptoms the patient is currently experiencing in the "Yes" column. If they have experienced it in the past, please write the year in which the symptom was experienced in the "P (year)" column (i.e. 2007, or 1997-2001). Only fill out those that apply.

	Yes	P (year)		Yes	P (year)		Yes	P (year)
abdominal bloating	☐		dizziness	☐		measles	☐	
acne	☐		ear ache	☐		meningitis	☐	
ADHD or ADD	☐		early menses	☐		mononucleosis	☐	
allergies	☐		eczema	☐		mumps	☐	
anemia	☐		encephalitis	☐		nose bleeds	☐	
anxiety	☐		eye crusting	☐		palpitations	☐	
bedwetting	☐		fevers	☐		pneumonia	☐	
bladder infection	☐		frequent infections	☐		psoriasis	☐	
body odour	☐		frequent runny nose	☐		recurring ear infections	☐	
bronchitis	☐		headaches	☐		rheumatic fever	☐	
cancer	☐		heart murmur	☐		roseola	☐	
chicken pox	☐		hemorrhoids	☐		rubella	☐	
chronic colds	☐		herpes	☐		scarlet fever	☐	
red and itchy eyes	☐		high blood pressure	☐		seizures	☐	
cold sores	☐		HIV	☐		severe head injury	☐	
colic	☐		hives or rashes	☐		strep throat	☐	
colitis	☐		hyperthyroid	☐		spina bifida	☐	
constipation	☐		hypoglycemia	☐		scoliosis	☐	
cough or wheezing	☐		hypothyroid	☐		thrush	☐	
crohn's disease	☐		impetigo	☐		ringing in the ears	☐	
cradle cap	☐		indigestion/gas	☐		ulcers	☐	
croup	☐		influenza	☐		ulcerative colitis	☐	
cystic fibrosis	☐		insomnia	☐		urinary tract infections	☐	
depression	☐		irritable bowel syndrome	☐		vomiting	☐	
diaper rash	☐		jaundice	☐		whooping cough	☐	
diptheria	☐		joint pain	☐		warts	☐	

Sleep:

Number of hours of sleep per day / night (including naps): _____ length of time it takes to fall asleep: _____

How would you describe the patient's sleep in general?:

poor fair good excellent

Please check if the patient experiences any of the following:

- ☐ dreams
- ☐ wakes up irritable
- ☐ night sweats / fever
- ☐ nightmares
- ☐ sleep-walking
- ☐ grinds / clenches teeth
- ☐ wakes often
- ☐ bed-wetting

comments: _____

_____

Social / home environment:

parents: ☐ married ☐ separated ☐ divorced

siblings: ☐ yes ☐ no if yes, how many?: _____

Patient's living environment (house, apartment, new, old, newly renovated, etc.): _____

Is the patient exposed to any of the following? please check all that apply:

- ☐ cigarette smoke
- ☐ pets
- ☐ chemical (paint, new carpet, etc.)
- ☐ gasoline
- ☐ pesticides / herbicides
- ☐ mold

Please describe the emotional environment of the patient's home: _____

_____

_____

Daily activity:

Please check all applicable and indicate how often:

- ☐ reading _____
- ☐ video games _____
- ☐ family time _____
- ☐ television _____
- ☐ computer _____
- ☐ exercise _____

other: _____

Education:

patient currently in: ☐ daycare ☐ school ☐ home type of school: _____ grade: ____

Please describe patient's general disposition, interaction with others and performance in daycare/school/home?:

_____

_____

Please add any information you feel to be relevant that has not been covered: _____

_____

Prenatal health

age of biological mother at time of patient's birth: _____

number of full-term pregnancies: _____ number of pregnancies not carried to term (miscarriage, stillborn, abortion): _____

was the pregnancy planned: yes ☐ no ☐ weight gained during pregnancy: _____

were there any fertility issues with this patient's conception? if yes, please explain: _____

_____

emotional state of mother during pregnancy: _____

please list any medications and supplements taken during pregnancy: _____

complications during pregnancy, include any tests performed: _____

_____

during the pregnancy, was the mother exposed to any of the following and if so, pleaes indicate how much/often:

- ☐ alcohol _____
- ☐ cold/flu _____
- ☐ infection (i.e. viral, yeast, group B strep) _____
- ☐ recreational drugs _____
- ☐ cigarette smoke _____
- ☐ over the counter medication _____
- ☐ prescription medication _____
- ☐ herbal preparations _____
- ☐ ultrasound _____
- ☐ x-ray _____
- ☐ amniocentesis _____
- ☐ chemical exposure _____
- ☐ amalgam fillings put in/removed from teeth _____
- ☐ excessive stress _____
- ☐ travel

please check any of the following complications during the pregnancy:

- ☐ nausea
- ☐ maternal cytomegalovirus
- ☐ gestational diabetes
- ☐ thyroid dysfunction
- ☐ preeclampsia /eclampsia
- ☐ maternal chicken pox
- ☐ bleeding
- ☐ maternal toxoplasmosis
- ☐ placenta previa
- ☐ vomiting
- ☐ maternal rubella
- ☐ physical/emotional trauma
- ☐ other _____

how would you describe the health of the mother during pregnancy?

☐ poor ☐ fair ☐ good ☐ excellent ☐ unknown

Natal history

place of birth: ☐ hospital ☐ home ☐ clinic other: _____

type of delivery: ☐ vaginal ☐ cesarean section was the labour induced?: ☐ yes ☐ no

length of labour: _____

length of pregnancy: ☐ full-term ☐ pre-term ☐ post-term ☐ premature: _____ weeks

at birth: weight _____ length _____ head circumference _____ APGAR score: _____

length of hospitalization of mother: _____ baby: _____

describe any physical or emotional complications with the delivery: _____

_____

did breastfeeding begin immediately? ☐ yes ☐ no if no, when did it begin? _____

please check any of the following that applied to the patient at birth:

☐ difficult delivery
☐ breech delivery
☐ shoulder dystocia
☐ long 2nd stage of labour
☐ forceps or suction used
☐ hip displacement
☐ jaundice
☐ vitamin K administered
☐ birth injuries
☐ problems with feeding
☐ antibiotic eye drops
☐ congenital abnormalities
☐ respiratory abnormalities
☐ medication
other: _____
☐ seizure

developmental history:

how would you describe the patient's health in the first year?

☐ poor ☐ fair ☐ good ☐ excellent ☐ unknown

please indicate the approximate age of the patient when the following developmental milestones were achieved:

weaned off breast milk _____ pulled up to stand alone _____ took first steps _____ spoke sentence _____

sat up alone _____ spoke first words _____ walked alone _____ dressed self _____

crawled _____ ate solid foods _____ fed self _____ toilet trained _____

please explain any developmental problems, if any: _____

_____

is the patient particularly sensitive to any of the following?:

☐ small spaces ☐ heights ☐ crowds ☐ cold ☐ heat ☐ wind ☐ drafts

☐ sunlight ☐ wool ☐ music ☐ smells (please list): _____