

# **Dr. Patricia J. Wales ND & Dr. Jennifer Bunzenmeyer ND**

Naturopathic Medicine at the Acadia Wellness Centre

# 2 - 430 Acadia Dr. SE, Calgary, AB T2J 0B2

(403) 301- 0123

Fax (403) 301-0105

[www.ndclinic.com](http://www.ndclinic.com)

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## **Welcome to our Naturopathic Office**

We want you to enjoy and benefit from your visits with us.

Your first visit will consist of **consultation, detailed history, a general physical exam and a more specific naturopathic examination**. Based on this information, initial recommendations for your treatment protocol will be made on your first visit. If we feel it is necessary for a more complete analysis of your health status, you may be asked to have further laboratory tests through your medical doctor, or additional testing through our office lab facilities. Through this healthcare assessment, we are able to establish a baseline measure of health that we can then use to monitor your progress.

On your second visit, **a detailed report of findings and an in-depth treatment plan** will be explained to you. Programs often include **dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy and traditional Chinese medicine**. Your program will also involve lifestyle recommendations that are logical and sensible. (We encourage you to have a support team as you make these changes. Often having someone else, be it a partner, family member or friend who is undergoing naturopathic care at the same time will help to ease you both toward better health.) This return visit is also a good time to ask any questions that you may have had after your initial visit. If you need immediate clarification on remedies, dietary recommendations or have a concern over any unfamiliar symptoms that may arise, please call our office.

On your following visits your progress will be monitored and treatments will be modified accordingly. The second visit is usually three to five weeks after your initial visit. If you are receiving acupuncture treatments visits will be more frequent, either once or twice weekly for 6-10 sessions. As you start to experience a new level of wellness, we suggest an office visit every three to four months for general disease prevention and health maintenance. If an acute, non-emergency condition occurs, please give us a call as we may be able to help with a naturopathic treatment.

**Many of our patients have allergies and are environmentally sensitive. We ask that on the day of your visit to our office you do not wear any scented products (perfumes, shaving lotions, hairsprays, etc.).**

**We request that if you are unable to keep a scheduled appointment, you give our office 2 business days notice. As we are closed on Mondays, this means notice early on Friday for appointments the following Tuesday. We are then able to provide that appointment time to someone on our waiting list. If we do not receive sufficient notice, you will be charged for the missed visit and you will be asked for your credit card information to pay for the missed visit.**

Naturopathic coverage is available through many extended healthcare plans; please inquire with your HR department. Payments for visits are due at the time of the appointment.

### **Effective Aug. 1, 2011, the fees (plus 5% GST) are:**

#### **Dr. Patricia J. Wales ND**

Initial visit	1 ¼ hour	\$ 200
Report visit	45 min	\$ 150
Regular visit	30 min	\$ 90

#### **Dr. Jennifer Bunzenmeyer ND**

Initial visit	1 ¼ hour	\$ 200
Report visit	45 min	\$ 150
Regular visit	30 min	\$ 90

We maintain a dispensary of professional quality supplements, botanicals and homeopathics for the treatment of our patients. Items are individually priced and GST is added.

We accept the following methods of payment:

**Visa, Mastercard, Debit Card, Cheque or Cash**

If you have any concerns, please contact our front desk staff and they will be happy to pass your message on to your naturopathic doctor.

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***Please fill out the following forms and bring to your first appointment.***

# Dr. Patricia J. Wales ND & Dr. Jennifer Bunzenmeyer ND

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## Naturopathic Patient Intake Form

Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to inform you of our office events and will not be distributed for any other use.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (F) \_\_\_\_\_

E-mail \_\_\_\_\_ Cell \_\_\_\_\_

Emergency Contact \_\_\_\_\_  
(Full name) (Relation) (Telephone)

I have read Welcome to Our Naturopathic Office provided with this form. I am aware of the type of treatments offered and I agree to abide by the office, payment & cancellation policies.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Past Occupations \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex M F Marital status \_\_\_\_\_

Number of children & their ages \_\_\_\_\_

Blood Type \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Ideal Weight \_\_\_\_\_

Religion or personal philosophy \_\_\_\_\_

Name of Medical Doctor \_\_\_\_\_ Date of last physical \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_ Date last lab tests \_\_\_\_\_

Have you been treated by a Naturopathic Doctor? \_\_\_\_\_ Other health practitioners? \_\_\_\_\_  
 Name \_\_\_\_\_ Name \_\_\_\_\_  
 When? \_\_\_\_\_ When? \_\_\_\_\_

Please tell us how you heard of our Clinic? Family \_\_\_\_\_ Friend \_\_\_\_\_ Ad \_\_\_\_\_ Yellow Pages.ca \_\_\_\_\_  
 Internet \_\_\_\_\_ Health Professional \_\_\_\_\_ Who recommended our clinic to you? \_\_\_\_\_

Please list (in order of importance) your <b>primary health concerns / reasons</b> for your visit.	Please indicate any <b>treatments</b> that you have tried previously to address your health issues and <b>how effective</b> you found these treatments.

Please turn over ⇒

Please do not write in this space. It will be cut off.

Please list all **pharmaceutical medications, herbals, vitamins and supplements** (& dosages, if known)

Now	In the Past

Please list any **allergies** you have and what kind of **reaction** occurs.

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Please list all **hospitalizations, fractures or major illnesses** that you have had.

Type of illness, operation / procedure                      Date                      Any ongoing concerns?

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How would you rate your **energy level**? \_\_\_\_\_ (from 1-10, **10 being highest**)

Do you wake-up feeling refreshed? Y\_\_ If N\_\_, give details. \_\_\_\_\_

What kind do of **water** do you drink and how many glasses of each kind per day?

Tap \_\_\_\_\_ Filtered \_\_\_\_\_ Spring \_\_\_\_\_ Reverse Osmosis \_\_\_\_\_ Distilled \_\_\_\_\_

How many **cups / day** do you drink of each the following?

Coffee \_\_\_\_\_ Black Tea \_\_\_\_\_ Herbal Tea \_\_\_\_\_ Do you add milk / cream? \_\_\_\_\_ Sugar? \_\_\_\_\_

Do you **smoke**? Y\_\_ # cigarettes / cigars per day \_\_\_\_ How many years? \_\_ In the past? Y\_\_ Quit when \_\_\_\_\_

Do you drink **alcohol**? Y\_\_ Type & # of drinks per week \_\_\_\_\_ In the past but quit? Y\_\_ \_\_\_\_\_

Do you use **recreational drugs**? N\_\_ Y\_\_ In the past? Y\_\_ What kind and how often? \_\_\_\_\_

Do you **exercise**? N\_\_ Y\_\_ Hours per week \_\_\_\_\_ Type of exercise \_\_\_\_\_

Do you watch **TV**? N\_\_ Y\_\_ # of hours per week \_\_\_\_\_

Please check all the **childhood illnesses** you have had.

- |                                  |                                      |   |  |                                    |
|----------------------------------|--------------------------------------|---|--|------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rubella     | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Mumps   | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet Fever  | <input type="checkbox"/> Polio           | <input type="checkbox"/> Asthma    |

Have you been **vaccinated**? N\_\_ Y\_\_ Did you have any adverse reactions? \_\_\_\_\_

What vaccines have you had recently? \_\_\_\_\_

Please check all of the following **conditions** that are applicable to **you & your family** and note who.

<input type="checkbox"/> Alcoholism		<input type="checkbox"/> Gout	
<input type="checkbox"/> Allergies		<input type="checkbox"/> Heart disease	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Heart murmurs	
<input type="checkbox"/> Asthma		<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Auto Immune		<input type="checkbox"/> Hypo / hyper thyroid	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Irritable Bowel	
<input type="checkbox"/> Crohn's or Colitis		<input type="checkbox"/> Kidney disease	
<input type="checkbox"/> Depression		<input type="checkbox"/> Liver disease	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Mental illness	
<input type="checkbox"/> Eczema		<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Gallbladder		<input type="checkbox"/> Stroke or aneurysm	
<input type="checkbox"/> GERD/hiatal hernia		<input type="checkbox"/> Ulcers	
<input type="checkbox"/> Glaucoma / Cataracts		<input type="checkbox"/> Other	

Please do not write in this space. It will be cut off.

**Informed Consent (Adult)**

Naturopathic doctors assess the whole person, taking into consideration the physical, mental, emotional and energetic aspects of an individual. Your naturopathic doctor will conduct a thorough case history, physical exam and may request specific laboratory tests and reports to be used as part of the treatment work-up.

It is very important that you inform your naturopathic doctor immediately of all disease process that you may be experiencing, and of any medication, over-the-counter drugs or supplements you are taking. If you are pregnant, suspect you are pregnant or are breast-feeding, please advise your naturopathic doctor.

**Statement of Acknowledgement**

As a patient of this office, I have read the information and understand that the health care to be provided is based on naturopathic and other supportive principles and practices. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to anyone other than Dr. Bunzenmeyer, Dr. Wales and other Acadia Wellness Centre practitioners that I consult unless so directed by myself or law requires it. I acknowledge that Dr. Wales and Dr. Bunzenmeyer may enhance my care periodically by discussing my case with each other. I will inform my naturopathic doctor if this is a concern to me. I understand that I may look at my medical records at any time and can request a copy of it by paying the appropriate fee.

I also recognize that even the gentlest therapies can have complications in certain physiological conditions, in very young children, or for those on multiple medications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy, and all medications including prescription drugs, over-the-counter drugs and supplements/remedies.

The slight health risks of some naturopathic treatments include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture or intramuscular vitamin injections
- muscle strains and sprains from physical treatments & muscle testing.

I understand that results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of my naturopathic treatment at this office. I also confirm that I have the ability to accept or reject this care of my own free will and choice and discontinue participation in these procedures at any time. I accept full responsibility for any fees incurred during care and treatment and acknowledge that payment is required on the day of service.

NAME of PATIENT (Please Print) \_\_\_\_\_

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

Please do not write in this space. It will be cut