*From Pain Relief to Wellness Care Naturally!!*

PICKERING Wellness Centre

1128 Kingston Road
Pickering, ON, L1V 1B4
**Tel**: (905) 420-9494
**Fax**:(905) 420-9449
**Email**: pickeringwellness@yahoo.ca
**Website**: www.pickeringwellness.ca

# NATUROPATH INTAKE HISTORY FORM

**Please tell us about you**

Name: Dr/Mr/Mrs/Miss_____
(**As it appears on your health card**)

Date: _____ Age: _____ Birthdate: d_____m_____y_____

Height: _____ Weight: _____ Shoe Size: _____

Address: _____ City: _____ Postal Code: _____

Email: _____ Occupation: _____

Home #: _____ Work#: _____ Cell# _____

Who can we thank for referring you to us? _____

Other family members under our care: _____

Other Health Care Provider(s):
Name: _____ Work #: _____
Name: _____ Work #: _____

## CONTEXT OF CARE OVERVIEW:

### Chief Health Concerns

What are your health concerns, in order of importance to you?
1. _____
2. _____
3. _____
4. _____

List any other concerns you would like to discuss:
_____
_____
_____
_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)
Yes_____ No_____
If yes, please specify_____

**INFORMED CONSENT TO TREATMENT & EMAIL COMMUNICATION**

1. I understand that Dr. Daniel Soubhi Sima'an ND is a Naturopathic Physician, and will use only natural, non-invasive methods of assessment and treatment.

2. I understand that any advice given to me as a patient at Pickering Wellness Centre is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.

3. I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in Ontario.

4. I understand that the Naturopathic Doctor reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.

5. I understand that I am accepting or rejecting this care by my own free will.

6. I understand that no employee or Naturopathic Doctor at Pickering Wellness Centre is suggesting to me to refrain from seeking the advice of another health care provider.

7. I understand that the services offered here are not covered by OHIP, and that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.

8. I understand that 24 hours' notice is required for appointment cancellation, otherwise I will be responsible for the cancellation fee.

9. I understand that any therapies recommended will be explained to me in full by the Naturopathic doctor, and that I will give consent to treatment based on informed consent.

10. I agree to disclose any and all medical conditions which may affect the effectiveness or side effects of Naturopathic care

11. I consent to receive and to transmit information via email with Dr. Sima'an ND and Pickering Wellness Centre.

12. I place no liability upon Dr. Daniel Soubhi Sima'an ND or the Pickering Wellness Centre for unforeseen effects or side effects of the treatments received.

Please be advised that by agreeing verbally when present with the doctor you are agreeing to the practitioner of Pickering Wellness Centre treat your health care in an integrated way using the knowledge of the associates within our practice.

Consent to Treatment:

Name _____ Signature X_____
Date _____

**Dr. Daniel Soubhi Sima'an B.Sc.**
**ND #3230**