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

NATUROPATHIC INTAKE FORM

All information is strictly confidential

Patient Information

Name: _____ Today's Date: _____
(First) (Middle) (Last) dd / mm / yy

Date of Birth: ___/___/___ Age: _____ Gender: F M
dd/ mm / yy

Home Address: _____

Town/ City: _____ Postal Code: _____

Home Telephone: ( ) _____ Work: ( ) _____

May we leave messages on your home phone relating to your visits? Y N

Emergency contact: _____ Phone:( )_____

Email Address: _____

Family Physician: _____ Phone:( )_____

Other Health Care Provider(s):
Name: _____ Phone: ( )_____
Name: _____ Phone: ( )_____

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.)
Y N

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 hour's 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:

Patient Name Patient Signature Date

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