Dear New Patient,

Thank you for taking the time to fill out the following form. The information you are providing is extremely valuable, in that it allows me to offer the best treatment options possible. Please bring this form to your first appointment. Please know that the information gathered on this form will be treated in a strictly confidential manner.

What to expect at your first visit:

- Your first visit will be 60 minutes long. During the first visit, I will review and discuss your patient intake form in more detail, answer any questions that you may have, perform any relevant physical examinations, and discuss treatment options.
- Some additional testing may be suggested during this visit (these tests are not included in the cost of the initial visit).
- I may recommend a series of acupuncture treatments, lifestyle or dietary changes, supplements, or herbs. Supplements and herbs are not included in the cost of the visit.

What to bring to your first visit:

- All the medications and supplements that you are currently taking
- Any recent blood work, imaging, or test results

I am looking forward to working with you.

Yours in health,

Dr. Mary Sawdon, ND
Naturopathic doctor
info@drmarysawdon.com
www.drmarysawdon.com

CONSENT FORM AND CANCELLATION POLICY

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Dr. Mary Sawdon ND will take a thorough case history, perform a physical examination, and prepare an individual treatment protocol. Dr. Mary Sawdon, ND is a licensed naturopathic doctor and will adhere to the standards of practice outlined by the governing bodies of the profession. Treatment protocols may include usage of any naturopathic modality, including but not limited to: botanical medicine, nutraceutical supplementation, physical medicine, homeopathy, hydrotherapy, traditional Chinese medicine and acupuncture, and diet and lifestyle counselling.

It is very important that you inform your naturopathic doctor immediately of any disease process from which you are suffering and any medications or over the counter drugs that you are currently taking. Please advise your naturopathic doctor immediately if you are pregnant, suspect you are pregnant, or if you are breast-feeding. As a patient you will receive information about your diagnosis and treatment, alternative courses of action, costs, expected benefits, risks, side effects and consequences of not having the diagnosis and/or treatment acted upon. There are some risks to treatment which include but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain or bruising from acupuncture, fainting or puncturing of an organ with acupuncture needles.

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 others without my consent, unless required by law. I understand that I may look at the medical record at any time and can request a copy of it by paying the appropriate fee.

I understand that Dr. Mary Sawdon ND will answer any questions that I have to the best of her ability. Because each individual responds differently to treatment, I understand that the results are not guaranteed. I do not expect the 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 agree to pay the fees for naturopathic services. I understand that fees, herbs, and supplements are to be paid for at the time of the consultation and visit. I understand that supplements, remedies, and botanicals are not included in the visit fee. I understand that there are no refunds or exchanges on visit fees.

I understand that a fee will be charged equivalent to the cost of the visit for any missed appointments or cancellations with less than **24 hours' notice**.

I have read and understand the above stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by Dr. Mary Sawdon ND. I intend this consent to apply to all my present and future naturopathic care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Printed name of patient: ____

Signature of patient or legal guardian: ______________________________ Date: ______________

Signature of Dr. Mary Sawdon, ND: ______________________________ Date: ______________

DR. MARY SAWDON
• NATUROPATHIC DOCTOR •

INTAKE FORM

<table>
<tr><td colspan="2">Last Name:</td><td colspan="2">First name:</td><td colspan="2">Middle Name:</td></tr>
<tr><td>Date of Birth (MM/DD/YYYY):</td><td colspan="2">Age:</td><td>Sex:</td><td colspan="2">Occupation:</td></tr>
<tr><td colspan="6">Contact Information</td></tr>
<tr><td colspan="2">Address:</td><td colspan="2">City, Province:</td><td colspan="2">Postal Code:</td></tr>
<tr><td colspan="2">May we leave messages regarding your visit: Yes/ No</td><td colspan="2">Phone number:</td><td colspan="2">Email:

Would you like to receive our newsletter?</td></tr>
<tr><td colspan="6">Emergency Contact Information</td></tr>
<tr><td colspan="2">Last Name:</td><td colspan="2">First Name:</td><td colspan="2">Relationship:</td></tr>
<tr><td colspan="3">Daytime phone number:</td><td colspan="3">Evening phone number:</td></tr>
<tr><td colspan="6">Other Healthcare Providers</td></tr>
<tr><td colspan="2">Name:

Specialty:

Phone number:</td><td colspan="2">Name:

Specialty:

Phone number:</td><td colspan="2">Name:

Specialty:

Phone number:</td></tr>
<tr><td colspan="3">Date of last medical doctor visit:</td><td colspan="3">Date of last physical exam:</td></tr>
</table>

<table>
<tr><td colspan="2">How did you hear about this clinic?

If referred, please state by whom:</td></tr>
<tr><td>Have you been treated by a Naturopathic doctor before?</td><td>If yes, by whom?

Date of last visit:</td></tr>
</table>

Goals
In your opinion, what are your most important health concerns:
1).
2).

3).

Medical History		
Height: Weight:	Are you trying to become pregnant? Yes/ No If you are female, are you pregnant? Yes/ No	
Immunization Record: Check all that apply. ○ DPT (Diptheria, Pertussis, Tetanus) ○ MMR (Measles, Mumps, Rubella) ○ Hepatitis B ○ Hepatitis A	○ Gardasil/ Cervarix (HPV vaccine) ○ HiB (Haemophilus influenza B) ○ BCG (Tuberculosis) ○ Polio ○ Flu vaccine	○ Pneumococcal conjugate ○ Meningococcal C conjugate (meningitis) ○ Varivax/ Varilix (chicken pox) ○ Other:
Adverse reactions to vaccine? Yes/ No If yes, list below:		
Childhood illnesses: ○ Measles ○ Asthma ○ Polio ○ Mumps	○ Whooping cough ○ Rubella (German measles) ○ Chicken pox	○ Rheumatic fever ○ Scarlet fever ○ Roseola

List any previously diagnosed medical conditions:	**Treatment**	**Year of diagnosis:**
1).		
2).		
3).		
4).		
5).		

Allergies (medication, food, supplements, environment)	**Reaction**
1).	
2).	
3).	
4).	

List all **prescription drugs** (oral contraceptive, etc), **over the counter medications**, **herbs and natural supplements** (vitamins, homeopathics, botanical tinctures etc) that you are taking.

Medication	**Dosage**	**Start date**

Family Medical History					
Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, seizures and other neurological conditions, dementia, hyper/hypothyroid. If deceased, please state age and cause of death.					
	Age	**Health History**		**Age**	**Health History**
Father			**Mother**		
Paternal grandfather			**Maternal grandfather**		
Paternal grandmother			**Maternal grandmother**		
Siblings			**Children**		

Diet and Lifestyle Habits			
Exercise	How many times do you exercise each week?		
	Type of exercise:		
Diet	Do you have any dietary restrictions?		
	Please list a typical day's diet: Breakfast:		
	Lunch:		
	Dinner:		
	Snacks:		
Caffeine	# of cups consumed in a day: Coffee:	Tea:	Cola:
Alcohol	Do you consume alcohol?	If yes, how many drinks/ week?	
	What type(s) of alcohol do you consume?		
Tobacco	Do you use tobacco?	If yes, how many per day?	
	What type(s) of tobacco?	How many years?	
Drugs	Do you use recreational drugs?	If yes, what kind and how often?	
Sleep	How many hours do you sleep?	Trouble falling asleep?	
	Trouble staying asleep?		
Stress	What are some stressors in your life?		