Fees and Cancellation Policy

Initial Naturopathic Visit- 60 minutes- $195
Initial Naturopathic Pediatric Visit – 45 minutes- $125.00
Follow up Naturopathic Visit- 30 minutes-$ 95.00
B 12 Injections: $23.00

Failure to show up for scheduled appointment: Full Fee
Failure to provide 24 hours notice to cancel or reschedule an appointment: 50% of Fee.

This fee is to cover the practitioner's time, as these appointment slots will not be filled by other patients in need or on the waiting list.

A minimum of 24 hours is required for the cancellation of an appointment in order to facilitate the filling of this spot with another patient.

While we do make every effort to contact patients in the days preceding their appointments, this confirmation should not eliminate the responsibility of the patient to take note of and attend their appointments.

If you need to cancel an appointment, please leave a message on our voicemail at 902-787-3388 or speak with the receptionist.

We appreciate your understanding and cooperation.

I have read and understand the cancellation policy

_____
Name

_____ _____
Signature Date

Naturopathic Medicine Intake Form

Health History Summary

Please ensure that you fill this form out and bring it with you before your visit appointment. You can email it to me at info@drglennacalder.ca.
Please bring your most recent bloodwork results to your first appointment if possible.
Kindly give me 24 hours notice if you have to cancel or change your appointment and you can avoid any late cancellation fees.

Name_____ Age_____ Birth Date_____
Address_____City_____Postal Code_____
Phone (home)_____(work)_____OK to leave a message? Y/N
Email address _____
Occupation_____ Employer_____
Marital Status: Sgl Mar C/L Div Sep Number of Children_____
Emergency Contact_____ Relation_____
Phone_____

Who may we thank for referring you?_____
Last medical Check up_____

Your Current Health Problems
What is your main reason for coming in today? _____
List in order of importance other health problems that are troubling you.
1_____ Since when? _____
2_____ Since when? _____
3_____ Since when? _____
4_____ Since when? _____
5_____ Since when? _____

Please rate the state of your health? Excellent Good Avg Fair Poor
Score you current level of energy from 1 – 10 _____ (10 being the highest)
One year ago what would you rate your energy out of 10? _____
What is your current weight? _____ 1 year ago? _____ Ideal weight____ Height_____
What did you have yesterday for:
Breakfast_____
Lunch_____
Supper_____
Snacks including drinks _____
Amount of Water _____ How much water on average do you drink?_____

Which of the following do you currently use? Please indicate the amount, frequency and how long you have been using it.
Alcohol _____ Tobacco_____
Hormones_____ Coffee/tea_____
Cortisones_____ laxatives_____
Sedatives _____ Antacids_____
Recreational drugs (which ones) _____

Medications

Med _____ Dose_____ since when? _____
Med_____ Dose_____ since when?_____
Med_____ _____Dose_____ since when?_____
Med_____ Dose_____ since when?_____
Med_____ Dose_____ since when?_____
Med_____ _____ Dose_____ since when?_____

Supplements/Vitamins/Herbs

Name/brand_____ Dose_____ Since when?_____
Name/brand_____ Dose_____ Since when?_____
Name/brand_____ Dose_____ Since when?_____
Name/brand_____ Dose_____ Since when?_____
Name/brand_____ Dose_____ Since when?_____
Name/brand_____ Dose_____ Since when?_____

Ailments Past and Present

Mark an **N** if you have the ailment now and/or mark a **P** if you have had it in the past.

Allergies	Weight Problems	Cancer	Headaches
Asthma	Gallstones	Epilepsy	Alopecia
Eczema	Gout	Migraine	Varicose Veins
Psoriasis	Arthritis	Pneumonia	Broken Bones
Ear Infection	Thyroid Problems	Diabetes	Numbness
Strep Throat	Anemia	Malaria	Tingling
Hay Fever	High Blood Pressure	Tuberculosis	Cold Hands
Measles	Rheumatic Fever	Small Pox	Cold Feet
Mumps	Fainting	Polio	Visual Problems
Chicken Pox	Poor Memory	Parasites	Warts
Whooping Cough	Balance Problems	Gas/Bloating	Mono
Diphtheria	Speech Problems	Hemorrhoids	Depression
Scarlet Fever	Ringing in ears	Herpes	Anxiety
Sinusitis	Jaundice	Venereal Disease	Sexual Abuse
Canker	Hepatitis	Syphilis	Emotional Abuse
Acne	Alcoholism	Gonorrhea	Rape
Tonsillitis	Stroke	Miscarriage	Child Abuse

What do you feel is your weakest organ system and why?_____
Are there any of these you feel you have never been well since?_____
Do you have any allergies to any drugs, herbs, foods, animals or other? Y/N
What?_____
Do you have any silver/mercury dental fillings? Y/N Have you had a root canal? Y/N

Digestion

Do you (burp have gas feel uncomfortable) after eating Yes/No
How often do you experience this problem? Always sometimes never
How long have you had this problem?_____
How often do you have bowel movements?_____
Is there (blood mucus undigested foods black stools)?_____

Any rectal itching? Y/N Are your stools (formed or loose)? Any diarrhea?_____
Ever have alternating constipation and diarrhea? Y/N How often?_____
Does your gas have a strong odor? Y/N Do you have flatulence (gas) frequently? Y/N

More Health History

Do you exercise? Y/N If yes how often? _____
On a scale of 1- 10 how would you rate the quality of your sleep? (10 being great) _____
How many hours of sleep do you think you need?___ How many hours do you get?____
Do you nap or rest during the day? Y/N For how long?_____
Are you usually cool warm hot average (Circle one).
How many times per year do you get a cold or a flu?_____
When was the last time you were on an antibiotic?_____ What was it for?_____

Reproductive

Are you sexually active? Y/N Is this more or less than one year ago?_____
Sexual preference: Heterosexual Bisexual Homosexual
Do you use birth control? Y/N If yes what type of birth control?_____

Female

Age of first menses?_____If periods have stopped at what age did they stop?_____
Are your cycles regular? Y/N Periods begin every_____days and lasts ____days
Are your periods Heavy Medium Light What color is the blood?_____
Are there any clots? Y/N Any cramps with your period? N/Y
Do you have any spotting or bleeding between periods?Y/N
Do you have premenstrual symptoms? Y/N
Number of pregnancies_____ Number of abortions____ Number of miscarriages_____
Number of live births_____ Any problems getting pregnant?_____
Do you get regular PAP smears? YES/ NO Any abnormal PAP's YES/NO
Do you do regular self breast exams? Y/N Have you noticed any breast lumps? Y/N

Male

How often do you get up in the night to urinate?_____ Has this increased recently? Y/N
Any problems with impotency? (Getting or maintaining an erection) YES/NO
Do you have abnormal discharges from your penis? Y/N_____
Any prostate problems? Y/N Have had your prostate examined? Y/N When?_____

Kidney and Bladder

Have you ever had a bladder infections? Y/N How Many?_____
How was it treated?_____
Your urine is …..bright yellow dark yellow cloudy pale or clear strong odor
Do you have difficulty stopping or starting urination? Yes/No_____
Do you sweat? (profusely moderate little very little) Is there an odor? Y/N

Family History

Please put a check by the illness that was/is present in your family.

	Mother	Father	Sibling	Grandparents	Other relative
Cancer					
T.B.					
Heart Disease					
Arthritis					
KidneyDisease					
Depression					
Anemia					

Asthma					
Diabetes					
High Blood Pressure					
Other					

Informed Consent

Dr. Calder utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

The first visit may include a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up.

Statement of Acknowledgement

Printed name _____

As a patient of Dr. Calder I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-exiting symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

I also confirm that I have the ability to accept or reject the care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

Signature ***Date*** ***Witness***

_____ _____ _____

Thank you for taking the time to fill out this questionnaire. I assure you it will help me to improve your health.