

Dr. Stacey Welton, ND

The Health Loft
47 Stewart Street
Toronto, ON M5V 2V8
o : 647 346 2281
f : 647 436 5547
w: thehealthloft.ca



Confidential Patient Information (please use BLOCK LETTERS)

Date: _____
(mm/dd/yy)

Personal Details

Prefix: Dr Mr Mrs _____
Ms Miss Last Name First Name Initial(s)

Address City Province Postal Code

() - () - () - / /
Home Phone No. Work Phone No. Mobile Phone No. Date of Birth (mm/dd/yy)

Gender (M/F) Occupation e-mail address

Who referred you? _____

Emergency Contact

Name Relationship () - () -
Daytime Phone Evening Phone

Information

1. Please list all current medications with doses (prescriptions, over the counter, supplements, botanicals, homeopathics, etc.):

2. Have you ever seen an ND before? YES / NO
Please briefly describe your experience:

3. What would you like to address in this visit?
i) _____
ii) _____
iii) _____

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4. What are your long-term health goals?

- i) _____
- ii) _____
- iii) _____

5. What behaviours/habits do you currently engage in that you believe *support* your health?

- i) _____
- ii) _____
- iii) _____

6. What behaviours/habits do you currently engage in that you believe are *self-destructive*?

- i) _____
- ii) _____
- iii) _____

7. What potential obstacles can you foresee in adhering to treatment?

- i) _____
- ii) _____
- iii) _____

8. How committed are you in adhering to treatment: Very / Somewhat / Minimally

Medical History / Other

1. Approximately when was your last physical exam? _____

2. Are you currently working with a Doctor of Conventional medicine? YES / NO

3. Are you currently working with a professional counsellor or other therapist? YES / NO

4. Are you under the care of any specialists? YES / NO
Please list (whom/when):

_____	_____
_____	_____
_____	_____

5. Have you ever had any special testing done (e.g. MRI, XRAY, Colonoscopy, etc.)
Please list (what/when):

_____	_____
_____	_____
_____	_____

6. Please indicate any serious conditions, illnesses or injuries, and any hospitalizations along with approximate dates?

_____	_____
_____	_____
_____	_____

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7. Do you have any allergies? (Food/environmental/meds) YES / NO
Please List:

8. Is there anything else you would like to comment on?

Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature: _____

Date: _____

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Informed Consent to Naturopathic Treatment

This is to acknowledge that I have been informed and understand:

- Any treatment or advice provided to me as a patient of Dr. Stacey Welton is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider.
- I have been fully informed of the benefits and potential risks associated with treatment and acknowledge that I understand these benefits and risks.
- I am at liberty to seek or continue with medical care from a medical doctor or another healthcare provider licensed to practice in Ontario
- I am aware that I can withdraw my consent at any time.
- I consent to the collection, use and/or disclosure of my personal information or medical history by The Health Loft as outlined by privacy legislation and the board of drugless therapy – naturopathy. (PIPEDA) (BDDT-N)

I, _____, acknowledge that I have discussed or have had the opportunity to discuss, with my naturopath, the nature and purpose of my treatment in general and my treatment in particular as well as the contents of this Consent.

I consent to the treatments offered or recommended to me by my naturopath. I intend this Consent to apply to my present and future naturopathic care.

Dated this _____ day of _____, 20 ____.

Patient Signature _____ Name _____

Witness Signature _____ Name _____

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Financial Policy

Payment

- Payment for all services is due when rendered.

Cancellation Policy

- We would appreciate at least 24 hours notice if you are unable to keep your scheduled appointment. If we do not receive this notice then you may be responsible for the fee of the scheduled visit.

Non-Payment Procedures

- Should you have an appointment and leave the premises without making payment, we are entitled to charge the appointment fee to your credit card.

Credit Card Type _____

Credit Card Number _____

Name as it appears on Card _____

Expiry Date _____

I, _____, have read the above and understand that I am personally responsible for paying the fees for all services rendered. I authorize The Health Loft to charge any fees due as per the Financial Policy to the credit card information provided above.

Name _____

Signature _____

Date _____