Sarah S. Wyer B.Sc.H., N.D.
30 Edinburgh Road North, Unit 2B, Guelph, ON, N1H 7J1
Tel (519) 822-7075 Fax (519) 822-8843

Agreements

Welcome to our office. By coming in today, you have made a commitment to your health. I hope you enjoy your experience with naturopathic medicine as we work together to help you attain your full health potential.

Services Offered:
Clinical Nutrition
Botanical Medicine
Homeopathic Medicine
Lifestyle Counselling
Body Work (Cranialsacral Therapy)
Acupuncture
Laboratory Testing

Fees: Payment is required upon receipt of service. Payment methods include cash, Visa, Mastercard, cheque and debit.

Initial Visit	75-90 minutes	$160.00
Follow-Up Visit	30-45 minutes	$75.00
Acupuncture (in series)	30-45 minutes	$64.00
Acute Visit	15 minutes	$30.00

Fees for Children, Seniors, and Full-Time Students:

Initial Visit	75-90 minutes	$120.00
Follow-Up Visit	30-45 minutes	$64.00

All fees are subject to HST and exclude costs of any naturopathic medicines and laboratory testing that may be recommended. None of our fees are covered by OHIP. However, naturopathic services are covered by most private health insurance plans; please check your individual policies. Non-insured portions are eligible medical expenses for federal income tax purposes.

NSF: NSF cheques are subject to a $25.00 charge.

Cancellation Policy: If you cannot make your appointment, please call the office at least 24 hours prior to your scheduled visit and leave a message at (519)822-7075. Any visit not cancelled with at least 24 hours' notice is subject to the FULL visit charge. **Initial appointments require a credit card form (which can be found at wyernaturopathic.ca) to be filled out and received by us prior to your appointment in order to secure your spot.**

Your visit: The time we spend in the office is dedicated to *you* and *your* health. You will be asked a number of detailed questions that help provide me with a comprehensive understanding of your health concerns. Take your time in answering these questions. Everything that goes on in this office is strictly confidential. If at any time during the course of your care you feel your needs have not been heard, attended to appropriately, or handled with consideration and efficiency, I welcome and encourage your constructive feedback. Your questions are always welcome. I look forward to working with you toward optimal health and well-being.

WYER WELLNESS centre

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DECLARATION AND CONSENT TO TREATMENT OF A CHILD

Child's name:_____

Each person seeking care in this clinic should understand that the practitioner is a licensed naturopathic doctor and practices primary care differently than a medical doctor does. If medical diagnosis is required, it must be obtained from a licensed medical doctor.

Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction and natural therapeutics for its correction. The assessment and therapeutic methods used in this clinic for patients younger than 18 years of age include clinical nutrition, homeopathic medicine, botanical medicine, hydrotherapy, detoxification techniques, acupuncture, soft tissue and joint manipulation, parenteral therapies, and lifestyle modification techniques.

My signature acknowledges that:

1. I have been informed of and I understand that:
    a. The treatments received in this office are different from those usually offered by a medical doctor or other licensed health care provider.
    b. I am at liberty to seek or continue to seek medical care for this child from a physician or other health care provider qualified to practice in Ontario.
    c. I confirm that none of the above listed naturopathic doctors, nor anyone else under their control has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider in the care of this child.
2. I declare that I have received a full and complete explanation of the treatment or services that my child may receive at this office and hereby authorize and consent to treatment.
3. I agree to pay my full amount at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests and other fees. I am aware that these fees are not covered by OHIP.

I, (*print name)*_____, **have read, understood, and acknowledge the above statements and hereby give my consent to treatment of the child named above. I agree to take responsibility for all fees incurred.**

Signature: (*please sign in my office*)_____ **Date:** _____

Relationship to child: _____

Witness' Signature: _____ **Date:** _____

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PRIVACY FORM

PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collection, using and disclosing your personal information responsibly and in compliance with policy requirements governing the naturopathic profession. We will try to be as open and transparent as possible about the way we handle your personal information.

In this clinic, Sarah S. Wyer, ND acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of its sensitive nature. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic is doing to ensure that:

- Only necessary information is collected about you;
- We only share information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy (BDDT-N).

How our clinic collects, uses and discloses patients' personal information:

The clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns;
- To provide health care;
- To advise you of treatment options;

- To establish and maintain contact with you;
- To send you any pertinent information and mailings;
- To remind you of upcoming appointments;
- To communicate with other treating health care providers;
- To allow us to efficiently follow up for treatment, care and billing;
- To complete claims for insurance purposes;
- To comply with legal and regulatory requirements of our regulatory body, the BDDT-N acting under the authority of the *Drugless Practitioners Act*;
- To invoice for goods and services;
- To process credit card payments;
- To collect accounts receivable;
- To assist this clinic to comply with all regulatory requirements;
- To comply generally with the law;
- To allow potential purchases, practice brokers or advisors to conduct an audit in preparation for a practice sale.

By signing the consent section (below) of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I agree that the Wyer Wellness Centre can collect, use and disclose personal information

about **me / my child**, (*print patient name*)_____, as set out in the information about the clinic's privacy policies above.

_____ _____

Signature of patient (18+) or parent/guardian of child (<18) **Date**

_____ _____

Signature of witness **Date**

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Personal Information – Child (<14 yrs)

Child's name: _____ Sex: **M / F** Age: _____ Date of birth (dd/mm/yy) _____
Address: _____ City _____ Postal Code_____

Parent/Guardian name(s):
_____
Address (if different from child's): _____ City _____ Postal Code_____
Phone (Home) (___)_____ (Work) (___)_____ Cell (___)_____ **OK to leave a message? Y / N**
Siblings (names & ages) _____
Emergency contact name: _____ Relationship to child: _____ Phone (____)_____

Family Doctor/Pediatrician Name:
_____
Phone (____)_____ Fax (_____)_____ Address:_____
_____
Date of last visit:_____Findings of concern?_____

Midwife/Obstetrician (for child under 2 yrs) Name:
_____
Phone (____)_____ Fax (_____)_____ Address:_____
_____

Date of last visit:_____Findings of concern?_____

Major health concern(s) and date(s) of onset:
_____

_____
_____
_____

What treatments are you currently trying?

_____
_____
_____

What treatments have you tried in the past?

_____
_____
_____

Any other health concerns?

_____
_____
_____

Has/have the above condition(s) been diagnosed by a health practitioner? **Y / N**
If so, when (date) and by whom? _____

Medication and Supplement History:

Taking Currently:	**Date:**	**Taken in the Past:**	**Date:**

Confidential Health History – Child (<14 yrs)

FAMILY HISTORY

Parents' age at time of conception: **Mom:** _____ **Dad:** _____ __

Parents' level of health at time of conception: **Mom:** excellent / good / fair / poor

Dad: excellent / good / fair / poor

Relative:	**Age if Living:**	**Health Concerns:**	**Age at Death:**	**Cause of Death:**
Sister(s)				
Brother(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Any other blood relatives with notable health conditions (i.e. cancer, heart disease, stroke, mental illness, substance use, etc.)				

Please check any of the following that pertain to your **child's immediate family**:

Allergies		Anxiety		Asthma		Autoimmune diseases	
Birth defects		Bleeding disorders		Cancer		Deafness	
Depression		Diabetes		Eczema		Heart disease	
Hepatitis		Herpes		HIV/AIDS		Hypertension	
Kidney disease		Mental illness		Peptic Ulcer		Substance use (drugs/alcohol)	
Tuberculosis		Thyroid disease		Visual problems		Other	

If other, please explain:

_____

PRENATAL HISTORY

Please check any conditions **experienced by mom during pregnancy:**

Diabetes		Edema (swelling)		Emotional trauma		Fainting	
German Measles		Herpes		Hypertension		Infections	
Nausea		Physical trauma		Pregnancy-Induced Hypertension (PIH)		Thyroid Problems	
Vomiting		Weight gain/loss		Anxiety or Depression		Other	

If other, please explain:

_____

Please indicate any emotional traumas that mom experienced during pregnancy:

_____

_____

Please list any **medications** taken during the pregnancy (include **over-the-counter, prescriptions & nutritional supplements**):

_____

_____

_____

Did mom use any of the following during pregnancy?

Caffeine: **Y / N** how much, how often? _____ Cigarettes/tobacco: **Y / N** how many, how often? _____ Alcohol: **Y / N** how much, how often? _____ Recreational Drugs: **Y / N** If yes, please list:

_____

What kind of pre-and peri-natal care did mom receive?

_____

_____

How would you describe the pregnancy?

_____

_____

Was there any history of a complicated pregnancy before the birth of this child?

_____

_____

BIRTH HISTORY

Duration of gestation? 9 months _____ Early: ___days ___wks Late: ___days ___wks

Duration of labour? _____

Was labour spontaneous? **Y / N** If no, how was it induced? _____

Type of delivery? Vaginal ____ C-section ____ Emergency c-section _____

Location of delivery? Home ____ Hospital ____ Birthing Centre ____ Other_____

Parties present for birth: _____

Any interventions used? Anesthesia ____ Epidural ____ Episiotomy ____ Forceps ____

Vacuum ____ Other _____

Birth weight: _____ length: _____

Please check if any of the following were experienced at or soon after your child's birth:

Allergic reactions		Birth defects		Colic		Difficulty feeding	
Fevers		Failure to thrive		Hypoxia		Jaundice	
Meningitis		Rashes		Respiratory difficulties		Seizures	
Unusual weight gain		Unusual weight loss		Other			

If other, please explain:

_____

Did your child undergo any of the following interventions? Incubation _____ Medications _____

Respirator _____ Surgery ____ Bili-lights _____ Other _____

CHILD'S HEALTH HISTORY

Known Allergies (please list):_____

Any sensitivities? (please list):_____

Hospitalizations (reasons and dates):_____

Does your child receive an annual physical exam or check-up? **No / Yes,** from:

_____

Does your child sleep through the night? **Y / N** Bedtime: ____ Wake time:_____

What is the child's napping pattern during the day?

_____

Pattern of waking during the night?_____

Any bad dreams or nightmares? **Y / N**

Please circle any of the following that you have observed during your child's sleep: **sleepwalking / talking / laughing / shouting / moaning / teeth grinding or clenching / crying / twitching / sweating / other**

Please check any of the following that pertain to your child:

Allergies		Asthma		Bed wetting		Bladder infections	
Bloody urine		Body/breath odor		Bronchitis		Burning urine	
Chicken pox		Colds		Constipation		Cough	
Cradle cap		Croup		Diarrhea		Ear infections	
Easy bleeding		Easy bruising		Eczema		Emotional trauma	
Eye infections		Fatigue		Fever		Fractures	
Frequent urination		Fungal infections		Gas		Growing pains	
Hair loss		Hearing problems		Lice		Measles	
Meningitis		Mood changes		Mumps		Nausea	
Nervousness		Night sweats		Nose bleeds		Pneumonia	
Physical trauma		Rash		Rheumatic fever		Rubella	
Scarlet fever		Seizures		Sleeping problems		Sore throat	
Stomach flu		Strep throat		Tonsillitis		Unusual fears	
Vision problems		Vomiting		Walking/crawling problems		Whooping cough	
Learning difficulties		Behavioural problems		Eating problems		Other	

If other, please explain:

_____

_____

Has your child ever traveled outside of Canada? **Y / N** Where & when?

_____

IMMUNIZATION HISTORY

Please indicate approximate dates where applicable:

Measles, Mumps, Rubella (MMR): _____ Polio: _____ Small Pox: _____

Influenza: _____ Hepatitis: _____ Chicken Pox: _____ HPV: _____

Diphtheria, Pertussis, Tetanus (DPT): _____ Pneumococcal Pneumonia/Meningitis: _____

Please indicate if any adverse or odd reactions occurred after vaccination?

Fever		Excessive crying		Pain		Swelling	
Joint pain		Limping		Mood changes		Rash	
Loss of appetite		Vomiting		Insomnia		Other	

If other, please explain:

_____

NUTRITIONAL HISTORY

Was your child breastfed? **Y / N** If yes, for how long? _____

If no, please indicate what food was used and include brand:

_____

Other than water, what was the first liquid introduced to your child?

_____

Please list solid foods in the approximate order of introduction:

Food	**Age of Introduction**	**Any adverse reaction noted?**

How would you describe your child's eating habits?

_____

Is your child a vegetarian? **Y / N** Food aversions?_____ Food cravings?_____

Please outline your child's typical daily diet:

Breakfast:

_____

Lunch:

_____

Dinner: _____

Snacks: _____

Water intake:

_____

Other fluids:_____

SOCIAL HISTORY

How would you describe your child's temperament?

_____

_____

_____

How does your child interact with other children?

_____

How does your child interact with adults?_____

Please indicate any emotional shocks or traumas your child has experienced:

_____

_____

_____

How does your child handle stress?

_____

_____

How does your child express his/her emotions?

_____

_____

How do you think other people would describe your child?

_____

_____

How would you describe your child's performance at school?

_____

_____

Have any behavioral problems been noted at school/daycare/sitters?

_____

_____

What are your child's hobbies and extracurricular activities?

_____

_____

Please describe the physical activity level of your child:

_____

_____

HOME ENVIRONMENT

How many people live in your home? _____ Are there any smokers in your home? **Y / N**

Do you have any pets? _____

How old is your home, approx.? _____

How is your home heated? _____

How would you describe the emotional climate in this child's household?

_____

_____

_____

Any additional information that may be relevant to your child's health care and overall wellness?

_____

_____

Any other concerns or comments?

_____

_____

_____

Thank you for taking the time to complete this detailed questionnaire. It will be a valuable resource for us as we work together to help optimize your child's health and well-being, as well as a great time-saver during your first appointment. Looking forward to meeting with you in the near future at the Wyer Wellness Centre.