



6 Guelph St., Georgetown, ON  
(905) 702-1944

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Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent's Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

E-Mail Address (optional –if you would like to receive newsletters, etc.): \_\_\_\_\_

How did you learn about this clinic? \_\_\_\_\_

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize me to do so.

MAJOR COMPLAINTS IN ORDER OF IMPORTANCE

SINCE

CAUSE

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

WHAT TREATMENTS OR REGIMES IS YOUR CHILD FOLLOWING?

SINCE

RESULTS

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

WHICH OF THE FOLLOWING CONDITIONS HAS YOUR CHILD HAD?

Abscesses, allergies, amnesia, arthritis, asthma, cancer, chicken pox, cold sores, depression, diabetes, emphysema, epilepsy, gall stones, goiter, gonorrhea, gout, hay fever, heart disease, hepatitis, oral herpes, influenza, kidney disease, leukemia, malaria, german measles, red measles, mononucleosis, mumps, parasites, peritonitis, pleurisy, pneumonia, rheumatic fever, scarlet fever, sexual abuse, skin disease, strep throat, sinusitis, sunstroke, stroke, syphilis, tonsillitis, tuberculosis, typhoid fever, warts, whooping cough, worms

ANY OTHER MAJOR CONDITIONS? \_\_\_\_\_

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ARE THERE ANY OF THE PRECEDING CONDITIONS AFTER WHICH THE CHILD HAS NEVER BEEN TOTALLY WELL AGAIN, OR WHICH HAVE BEEN MORE SEVERE THAN USUAL? WHICH ONES?

WHAT OPERATIONS HAS YOUR CHILD HAD?                      WHEN?                      COMPLICATIONS, IF ANY?

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |

WHAT MAJOR INJURIES HAS YOUR CHILD HAD?                      WHEN?                      LONG TERM EFFECTS?

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |

ALLERGIES? \_\_\_\_\_

Age at first menses? \_\_\_\_\_ Number of pregnancies \_\_\_\_\_

What vaccinations has your child had? \_\_\_\_\_

Any adverse affects from them? \_\_\_\_\_

What exercise does your child do now and how much? \_\_\_\_\_

How often does your child have a full and complete bowel movement? \_\_\_\_\_

How often does your child get headaches? \_\_\_\_\_ What triggers them? \_\_\_\_\_

INDICATE BELOW WHICH OF THE FOLLOWING AILMENTS, OR ANY OTHER AILMENTS, HAVE AFFECTED YOUR CHILD'S RELATIVES:

- |            |            |           |               |            |              |
|------------|------------|-----------|---------------|------------|--------------|
| alcoholism | asthma     | diabetes  | gout          | insanity   | skin disease |
| allergies  | cancer     | epilepsy  | hay fever     | paralysis` | syphilis     |
| arthritis  | depression | gonorrhea | heart disease | pneumonia  | tuberculosis |

| RELATIVE              | AGE IF ALIVE | AGE AT DEATH | AILMENTS |
|-----------------------|--------------|--------------|----------|
| Mother                |              |              |          |
| Father                |              |              |          |
| Sisters               |              |              |          |
| Brothers              |              |              |          |
| Maternal Grandmother  |              |              |          |
| Maternal Grandfather  |              |              |          |
| Maternal Aunts/Uncles |              |              |          |
| Paternal Grandmother  |              |              |          |
| Paternal Grandfather  |              |              |          |
| Paternal Aunts/Uncles |              |              |          |



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IS YOUR CHILD CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN(S)?

| PHYSICIAN | FOR WHAT CONDITIONS | TREATMENT |
|-----------|---------------------|-----------|
|           |                     |           |
|           |                     |           |

HAS YOUR CHILD BEEN TREATED WITH HOMEOPATHY BEFORE?

| PHYSICIAN | FOR WHAT CONDITIONS | WHEN |
|-----------|---------------------|------|
|           |                     |      |
|           |                     |      |



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## **Informed Consent**

***Nicole Meier, N.D.***

**We want your informed consent for the services we are to provide. This means that we want you to understand the services we provide, the cost involved, and what we do with the personal information we obtain about you. If you have any questions about this, please ask.**

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. The following outlines the therapies we may utilize:

***Individual diets and nutritional supplements*** are recommended to address deficiencies, treat disease processes, and promote health.

***Botanical medicine*** is a plant-based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations for the treatment of illness and disease.

***Homeopathy*** is a form of medicine based on the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal, or mineral origins are used to stimulate the body's ability to heal itself.

***Asian medicine*** includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally.

***Physical medicine*** refers to the use of hands-on techniques such as soft tissue work and spinal manipulation.

***Hydrotherapy*** refers to the use of hot/cold water applications to improve circulation and stimulate the immune system.

***Lifestyle counseling*** involves identifying risk factors and making recommendations to help optimize one's physical, mental and emotional environment.



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During your initial visits, your Naturopathic Doctor will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take blood and urine samples.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. It is very important, therefore, that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

Health risks associated with Naturopathic Medicine include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process.
- Allergic reactions to supplements or herbs.
- Pain, bruising or injury from venipuncture or acupuncture.
- Fainting or puncturing of an organ with acupuncture needles.
- Muscle strains and sprains or disc injuries from spinal manipulation.

\_\_\_\_\_  
**Initials**

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 my medical record at any time and can request a copy, by paying the appropriate fee. I have read and understand the privacy policy of Cornerstone Health Centre.

\_\_\_\_\_  
**Initials**

I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. 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. I voluntarily consent to the diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

\_\_\_\_\_  
**Initials**

I understand that any treatment or advice provided to me by any of the above Naturopathic Doctors is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from another licensed health care provider.

\_\_\_\_\_  
**Initials**

I understand the fee schedule as stated below.

\_\_\_\_\_  
**Initials**

I understand that I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. N. Meier, N.D. has not suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

\_\_\_\_\_  
**Initials**

I understand that I may purchase any recommended medicines or supplements from the dispensary of Cornerstone Health Centre OR any pharmacy/retail store of my choice.



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As the patient, you are responsible for the total charges incurred (visit fees plus any supplements or medicinal substances) for each visit. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. Most insurance companies do not cover the supplements that we prescribe and dispense.

| Consultations                           | Initial Visit (75 min)   | Second Visit (45min) | Repeat Visits (30min) |
|---|--|----------------------|-----------------------|
| Adult                                   | \$155.00   | \$110.00             | \$65.00               |
| Child (under 16yrs)                     | \$ 125.00 (1 hour)   | \$50.00 (30 min)     | \$50.00               |
| Senior (65yrs+)                         | \$125.00   | \$80.00              | \$55.00               |
| Acupuncture                             | \$ 125.00 (1 hour)   | -                    | \$65.00 (45 min)      |
| Phone Consultation For A Child Patient  | \$15.00 (up to) 10 minute consultation<br>\$30.00 (up to) 20 minute consultation |                      |                       |
| Phone Consultation For An Adult Patient | \$20.00 (up to) 10 minute consultation<br>\$40.00 (up to) 20 minute consultation |                      |                       |
| Missed Appointment Fee                  | \$40.00 if less than 24 hrs notice   |                      |                       |

| Testing/Injection |         |
|-------------------|---------|
| B12 Injection     | \$10.00 |
| Pleonot           | \$15.00 |
| Pascoeuleucyn     | \$10.00 |
| Urinalysis        | \$ 5.00 |

- *Electrodermal Screening (if required) is billed in addition to regular visit fees. Prices vary up to a maximum of \$160.00 + hst*
- *Prices vary for blood work and further diagnostic testing.*
- *All prices subject to hst*

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Patient (or Parent /Guardian): \_\_\_\_\_

Signature of Naturopathic Doctor: \_\_\_\_\_



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## ***Consent for Personal Information***

I understand that to provide me with Naturopathic services, Nicole Meier, N.D. will collect some personal information about me. For example; address, phone number and health history.

I have reviewed Nicole Meier, N.D.'s Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information, and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policy, and they have been answered to my satisfaction.

I understand that only if I check off the following boxes will I receive the following:

- I would like to receive notice when it is time to review whether I need new goods or services
- I would like to receive newsletters and other informational mailings from Nicole Meier, N.D.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Nicole Meier, N.D. using and disclosing personal information about me as set out above and in the above Privacy Policy.

Signature: Parent /Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Notes made by Nicole Meier, N.D.