

Are you ready for a new way to look at your health and your life? Are you looking for a dynamic medicine that treats YOU rather than your symptoms? Welcome to True Potential Health Services and my private medical practice that incorporates Naturopathic medicine, acupuncture, and Bowen therapy. My goal as an ND is to find your best path to healing by listening and learning from you. No one knows your body or your state of health the way you do. I believe you hold the key to your own well-being. My job is to help you discover what you already know and use it to better your life.

The philosophy of Naturopathic medicine is based on six vital concepts:

- | | |
|----------------------------------|----------------------------|
| 1.) The Healing Power of Nature | 2.) First Do No Harm |
| 3.) Identify and Treat the Cause | 4.) Doctor as Teacher |
| 5.) Prevention | 6.) Treat the Whole Person |

As a Naturopathic doctor, I practice multiple disciplines. These include nutrition, lifestyle counseling, botanical medicine, homeopathy, physical medicine and stress management. I am certified in acupuncture and practice traditional oriental medicine as well as Bowen therapy.

Working towards optimal health is a lifestyle. Not only do we aim to eliminate and prevent disease, we allow ourselves the experience to thrive in life on many levels. The process of achieving better health is not a ‘quick fix’. It includes a deep look into one’s lifestyle, goals, challenges; a journey that takes time and dedication. I am honored to work with you in pursuit of your optimal health and I look forward to helping you reach your true potential.

The initial visit is approximately 60 minutes. Follow-up visits are usually 45 minutes but can vary in length, depending on the complexity of the issues and the type of treatment applied.

Attached to this letter is your health questionnaire. I would like you to take time filling it out in your home, without distraction. Please read the consent form and fee schedule thoroughly. If you have extended health care coverage for Naturopathic medicine, you will be responsible for reimbursement.

I thank you for your interest in health and look forward to working with you.

Sincerely,

Dr. Marcoux

Dr. Michelle Marcoux, BSc, ND
Naturopathic Family Physician
Bowen Therapist

Dr. Michelle Marcoux ND

PH (306) 373-5209 | FAX (306) 373-5207

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PEDIATRIC INTAKE FORM (BIRTH TO 12 YEARS)

Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to inform you of office events and will not be distributed for any other use.

Patient's Name: _____ Date: _____

Age: _____ Date of Birth: _____ Gender: _____ Health Card Number: _____

Parent/Guardian's Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone (home): _____ (work): _____

Parent's email address: _____

How did you hear about this clinic? _____

Has any other family member already been a patient at this clinic? _____

Contacts (in order of preference):

1. Name: _____ Ph: (H) _____ (W) _____ (C) _____

Address: _____ Relationship to child: _____

2. Name: _____ Ph: (H) _____ (W) _____ (C) _____

Address: _____ Relationship to child: _____

With whom does the child live? _____

May messages be left relating to your visits? Y/N Which phone number? _____

Please List Other Health Care Providers (name, type of care, phone/contact information):

1. _____

2. _____

3. _____

Name of doctor's office/hospital/clinic where your child's health records are kept: _____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? Please list in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Does your child have a contagious disease at this time? Y / N

If yes, what? _____

How would you describe your child's general state of health? Excellent Good Fair Poor

Does your child have any allergies?

- Food: _____
- Medications: _____
- Environmental: _____

Please list all current medications and supplements your child is taking (incl. herbs, vitamins, and homeopathics):

Please list any past medications your child has taken: _____

How many times has your child been treated with antibiotics? _____

MEDICAL HISTORY (please indicate severity: 1 – mild, 2 – moderate, 3 – severe)

- | | | |
|------------------|----------------------|---|
| ____ Chicken pox | ____ Scarlet fever | ____ Tonsillitis, approx no. of times: _____ |
| ____ Measles | ____ Pneumonia | ____ Ear infections, approx no. of times: _____ |
| ____ Mumps | ____ Frequent colds | ____ Strep throat, approx no. of times: _____ |
| ____ Rubella | ____ Rheumatic fever | ____ Other: _____ |

Has your child ever had any of the following? (please indicate when, where, and the results)

Electroencephalogram (EEG): _____

Psychological evaluations: _____

Hearing test: _____

Speech/language tests: _____

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Other tests or evaluations not listed: _____

Injuries/surgeries/hospitalizations (please list): _____

IMMUNIZATIONS

MMR DPT Chicken pox Polio Rubella
 Measles Diphtheria Small pox Mumps Tetanus
 H. influenza Flu shot Others: _____

Adverse reactions: Y / N

Please describe: _____

FAMILY HISTORY

Heart disease Diabetes Birth defects Kidney Disease
 Hypertension Arthritis Tuberculosis Other (please list):
 Cancer Allergies Asthma
 Mental illness Osteoporosis Juvenile Arthritis

I don't know the family medical history

Do either of the parents have a chronic illness? Y/ N (please describe):

PRENATAL HISTORY

What was the health of the parents at conception?

- Mother: Poor Fair Good Excellent Unknown
- Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy? Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy? Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y / N / Unknown

Did the mother experience any of the following during the pregnancy:

Bleeding High blood pressure Nausea Vomiting Diabetes Thyroid problems
 Physical or emotional trauma Other _____

Previous pregnancies, miscarriages, or complications by natural mother? _____

Did mother receive prenatal care? Y / N

Prenatal Vitamins? Y / N

Did the mother use any of the following during the pregnancy? (please check and list detail)

___ Tobacco ___ Alcohol ___ Recreational Drugs: _____

___ Prescription Medications: _____

___ Over-the-counter medications: _____

___ Supplements: _____

___ Other: _____

BIRTH HISTORY

Term: ___ Full ___ Premature (list wks) _____ ___ Late (list wks) _____

Length of labor: _____ Type of birth (home, hospital, C-section) _____

Complications: _____

Interventions (forceps, drugs/anesthesia, induced, etc.): _____

Birth city & province: _____ Birth time: _____ Birth weight: _____

Did your child have any of the following problems shortly after birth?

___ Rashes ___ Birth injuries ___ Blue baby ___ Fever

___ Jaundice ___ Seizures ___ Cerebral palsy ___ Birth defects

___ Other: _____

Did your child ever experience colic? Y / N How severe? *mild moderate severe*

HEALTH AND DEVELOPMENT

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Please describe your child's sleep pattern:

Does your child: ___ wake early ___ have difficulty falling asleep ___ have night terrors ___ have no sleep problems

How would you describe your child's temperament?

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

ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental? _____

Symptoms Experienced During Allergic Reaction:

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Burning urine | <input type="checkbox"/> Bloody uring | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Vomiting spells | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Anemia | <input type="checkbox"/> Night sweats | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Chronic rash | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Flat feet | <input type="checkbox"/> No appetite | <input type="checkbox"/> Body/breath odor | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Allergies |

ENVIRONMENT

Is the child in: school daycare home care other _____

What are your child's favorite activities? _____

Does the child exercise regularly? Y / N How much, how often? _____

How many hours/week does your child: watch TV _____ play on computer or video games? _____

How often does your child read (not for school) or how often does someone read to your child?

Daily Several times a week Weekly Less than weekly

Does anyone in the child's household smoke? Y / N Are there animals in the home? Y / N

How is the child's home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)?

Please describe: _____

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How would you describe the emotional climate of the child's home?

DIET

Infant Feeding: ___ Breast fed (how long): _____ ___ Formula (type): _____

What foods were introduced before 6 months? (Please list approximate month as well.)

6–12 months?

Does your child have any food allergies or intolerances? Please list.

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

Please describe your child's typical daily diet:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Beverages (type and total quantity): _____

REVIEW OF SYSTEMS

0 = never	1 = occasionally	2 = frequently	3 = all the time
MENTAL/ EMOTIONAL			
Mood Swings	0	1	2 3
Irritability	0	1	2 3
Hyperactivity	0	1	2 3
Introvert/extrovert	0	1	2 3
Motion/car sickness	0	1	2 3
Anxiety/nervousness	0	1	2 3
Cries easily	0	1	2 3
Unusual fears	0	1	2 3
Sleep problems	0	1	2 3
Nightmares	0	1	2 3
ENDOCRINE			
Heat/cold intolerance	0	1	2 3
Fatigue	0	1	2 3
Excessive thirst	0	1	2 3
Excessive hunger	0	1	2 3
Low blood sugar	0	1	2 3
High blood sugar	0	1	2 3
SKIN			
Rashes	0	1	2 3
Eczema, Hives	0	1	2 3
Acne, Boils	0	1	2 3
Itching	0	1	2 3
HEAD			
Headaches	0	1	2 3
Head Injury	0	1	2 3
Dizzy spells	0	1	2 3
High fevers	0	1	2 3
EYES			
Glasses or contacts	0	1	2 3
Tearing or dryness	0	1	2 3
Eye pain/strain	0	1	2 3
EARS			
Earaches	0	1	2 3
Impaired hearing	0	1	2 3
NOSE AND SINUSES			
Frequent colds	0	1	2 3
Nose Bleeds	0	1	2 3
Stuffiness	0	1	2 3
Hayfever	0	1	2 3
Sinus problems	0	1	2 3
Loss of smell	0	1	2 3
MOUTH AND THROAT			
Frequent sore throat	0	1	2 3
Canker sores	0	1	2 3
Breath odor	0	1	2 3
RESPIRATORY			
Cough	0	1	2 3
Wheezing	0	1	2 3
Asthma	0	1	2 3
Bronchitis	0	1	2 3
CARDIOVASCULAR			
Heart disease	0	1	2 3
Murmurs	0	1	2 3
URINARY			
Frequent urination	0	1	2 3
Bed wetting	0	1	2 3
GASTROINTESTINAL			
Belching/passing gas	0	1	2 3
Stomach aches	0	1	2 3
Constipation	0	1	2 3
Diarrhea	0	1	2 3
Bowel Movements	How often? _____		
MUSCULOSKELETAL			
Joint pain/stiffness	0	1	2 3
Muscle spasms/cramps	0	1	2 3
Broken bones	0	1	2 3
BLOOD/PERIPHERAL VASCULAR			
Anemia	0	1	2 3
Easy bleeding/bruising	0	1	2 3

CONTEXT OF CARE REVIEW

What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have for your child from working with our clinic?

Is there anything that you feel is important that has not been covered?

Thank you & welcome to our clinic. I look forward to working with you and your child.

Informed Consent and Request for Naturopathic Medical Care and Acupuncture

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Michelle Marcoux, ND, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, _____, hereby request and consent to examination and treatment with Naturopathic medicine and acupuncture by Dr. Michelle Marcoux, and/or other licensed doctors of Naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Michelle Marcoux, and/or with the allied health care provider, providing backup:

- 1.) My suspected diagnosis(es) or condition(s)
- 2.) The nature, purpose, goals and potential benefits of the proposed care
- 3.) The inherent risks, complications, potential hazards or side effects of treatment or procedure
- 4.) The probability or likelihood of success
- 5.) Reasonable available alternatives to the proposed treatment procedure
- 6.) Potential consequences if treatment or advice is not followed and/ or nothing is done

I understand that a Naturopathic evaluation and treatment may include, but are not limited to:

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, laboratory evaluation of blood, urine, stool and saliva)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials). Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water)
- Lifestyle counseling and support
- Bowen therapy (gentle, non-forceful physical therapy)

The scope of practice of acupuncture is outlined below. I understand that traditional oriental medicine and acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Moxa (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick)
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Dietary advice (based on traditional oriental medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals, and animal materials)

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Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat, hydrotherapies; allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulation; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief or pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

Notice to pregnant women: All female patients must alert the provider if they have confirmed or suspect pregnancy as some therapies prescribed could present a risk to the pregnancy.

Notice to individuals with bleeding disorders, pace makers, and/or cancer: For your safety it is vital to alert your provider, Dr. Michelle Marcoux, ND, of these conditions.

Please Initial:

- I understand that Dr. Michelle Marcoux, ND, is currently not licensed to prescribe drugs or any controlled substances.
- I understand that Dr. Michelle Marcoux, ND, is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.
- I recognize that even the gentlest therapies may potentially have complications in certain conditions, in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, and all medications, including over the counter drugs (eg. Tylenol) and supplements.

I do not expect Dr. Michelle Marcoux and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Marcoux explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

Printed Name of Patient

Signature of Patient

Printed Name of Guardian

Signature of Guardian

Fee Schedule

Please see complete Fee Schedule located on our website, www.truepotentialhealth.com

Phone consultations are billed at the same rate as return visits.

Lab work and supplements prescribed by Dr. Marcoux are an additional cost and not included in the visit fee.

Please note: Patient is responsible for payment at the time of service, unless previously arranged by Dr. Marcoux. A portion of your visit may be claimed through your extended health coverage, please check with your provider. We are happy to provide physical exams at no extra charge. All other testing is done at additional charge, please ask Dr. Marcoux for prices during your visit. You will be billed for phone consultations except those regarding problems or questions with prescribed treatments. ***Because fees are subject to change, please confirm at time of booking.***

Cancellation policy: Any appointments cancelled with less than 24 hours notice will be subject to a charge for the full cost of the missed visit.

I clearly understand that Dr. Marcoux is not a medical doctor, but a Naturopathic doctor who practices with natural therapeutics.

I have reviewed the above fees and understand that I am responsible for payment at the time of service, unless previously arranged by Dr. Marcoux. I also understand that I will be billed for phone consultations, except those regarding questions about prescribed treatments.

I also understand that I will be charged the full visit fee for appointments cancelled without 24 hours notice, except in cases of emergency.

Signed: _____

Date: _____