Dr. Amy Punké
NATUROPATHIC DOCTOR
106 Stellarton Rd.,
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Information Collection & Fee Policies

Information Collection Policy

Privacy protocols at Dr. Amy Punké, Naturopathic Doctor's practice comply with the Personal Health Information Protection Act (PHIPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the standards of the College of Naturopathic Doctors of Alberta (CNDA), our regulatory body.

Your information may be accessed by regulatory authorities under the terms of the College of Naturopathic Doctors of Alberta (CNDA), for the purpose of fulfilling our regulatory body's mandate or by law. Our office will not disclose your personal confidential information to insurance companies or to third-party companies. For all other types of disclosure, we require a signed consent form by the patient.

Our practice recognizes the sensitive nature of the information that you have disclosed and all associates of the practice have been trained in the appropriate use and protection of your information. Proper adherence of our Information Collection Policy ensures:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal information complies with the CNDA regulations
- Our ability to remind you of upcoming appointments and maintain ongoing contact with you
- Advisement of proper treatment options
- Delivery of newsletters and other informational mailings where appropriate

Naturopathic Fee Policy

- Fees are due at time of service
- Phone consultations and acute appointments are available only after the initial consultation has been completed
- Supplements recommended to patients as part of therapeutic protocols may be purchased at this Wellness Center when available but patients are not required to purchase supplements from this location
- Patients may ask to view their records from Dr. Amy Punké, ND
- 24-hour cancellation or change of appointment time is required to avoid being charged 100% of missed appointment

Service	Fee	Description
Initial Appointment Adult	$170	90 minutes
Initial Appointment Pediatric	$130	60 minutes
45-Minute Follow-up Appointment	$85	45 minutes
30-Minute Follow-up Appointment	$70	30 minutes
Facial Accupuncture Appointment	$100 + extra needles if required	60 minutes
Acupuncture 45 minutes	$75	Initial appointment required
Phone Consult	$40 per 15 minutes	Minimum 15 minute charge applies
15-Minute Acute Appointment	$45	Initial appointment required
B12 (Methylcobalamin) Injection	$15 + tax	Initial appointment required
Biopuncture	$ 15 + $5/vial	15 minutes
Lab testing	Priced accordingly	Food allergy & intolerance testing, Salivary Hormone Panel

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Informed Consent

Naturopathic medicine is a system of healthcare that takes a natural approach to assessment, diagnosis and treatment with a focus on prevention, restoration and health maintenance. Naturopathic doctors (ND) assess the whole person, taking into consideration the physical, mental, emotional, and spiritual aspects of the individual. Gentle and non-invasive therapies and treatment approaches are used to stimulate the body's inherent healing capacity.

Your naturopathic doctor will take a thorough medical and health history and answer any questions that may arise throughout the treatment process. A physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Your ND will exercise judgment during the course of your treatment that is in your best interest, based on the facts that are known.

A number of different approaches may be used throughout the treatment process. Naturopathic modalities include:

- Diet & lifestyle counselling
- Clinical Nutrition
- Botanical Medicine
- Traditional Chinese Medicine & Acupuncture
- Homeopathy
- Hydrotherapy

It is very important that you inform your ND immediately of any disease process from which you are suffering and any medications/over-the-counter drugs or supplements that you are currently taking. Please advise your naturopathic doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding. Caution must be taken in some physiological conditions such as pregnancy and lactation, very young children, people with diabetes, heart, liver or kidney impairment and/or with people taking multiple medications. Dr. Amy Punké, ND is trained to handle emergencies, should the need arise.

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 intramuscular injections, acupuncture
- fainting or puncturing of an organ with acupuncture needle

I understand:

_____ Initial A record will be kept of the health services provided to me and that it will be kept confidential and will not be released to others without my consent or unless required by law. I may look at my medical record at any time and request a copy by paying the appropriate fee.

_____ Initial Information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential, unless consent has been provided.

_____ Initial Treatment results are not guaranteed.

_____ Initial My naturopathic doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have to the best of his or her ability.

_____ Initial I am free to withdraw my consent and discontinue treatment at any time.

_____ Initial Fees and supplements are to be paid for at the time of the appointment. Payment can be made in cash, debit, VISA and Mastercard.

_____ Initial If I have coverage for naturopathic medicine, the practice of Dr. Amy Punké will do their best at direct billing of my insurnace company however, I am responsible for knowing the terms and conditions of my policy.

_____ Initial A fee will be charged of 100% for missed appointments or cancellations with less than 24 hours notice.

_____ Initial My naturopathic doctor may prescribe supplements that can be purchased from the clinic dispensary; however, I am under no obligation to purchase them on-site. Most insurance companies do not cover the cost of supplements prescribed and dispensed by naturopathic doctors.

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I have read and understand the policies and information stated above. I intend this consent form to cover the entire course of treatment for my present condition.

Patient Name (please print): _____

Signature of Patient or Guardian: _____

Date: _____

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Contact Information:

Name: _____ Age: _____ Date of Birth: _____Gender: ☐M ☐F
Address: _____Email: _____
Phone (H): _____ (W): _____ (C): _____
Emergency contact: _____ Relationship: _____Phone: _____
Medical doctor: _____Phone: _____
Address: _____
How did you become aware of us? _____
How would you like to be reminded of upcoming appointments? _____

Insurance

Do you have private insurance? ☐Y ☐N; If yes, with whom:_____
Do we have permission to contact your insurance company to inquire about your medical coverage for Naturopathic Medicine? ☐Y ☐N

Notes (for office use):

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Adult Intake Form

This confidential information of your medical record and health history will be kept within the possession of Dr. Amy Punké, ND and will not be released to any individual except when you have authorized this release in writing or when required by law. Please complete this form as thoroughly as possible to optimize your health care outcomes.

Health Goals/ Concerns:

What main health goal(s)/concern(s) brought you to the clinic today?
(please list top 4 in order of importance to you)

1)_____
2)_____
3)_____
4)_____

Describe any factors you suspect may have played a role in the onset and perpetuation of your condition(s):

_____
_____
_____

Previous practitioners consulted for condition(s): ☐MD ☐ND ☐Other_____

Please explain their diagnosis, therapy and results where applicable: _____

_____
_____

What types of therapy have you tried for this problem? (please circle)

☐Diet modification ☐Vitamin/mineral supplements ☐Herbs ☐Homeopathy ☐Chiropractor

☐Acupuncture ☐Conventional drugs ☐Osteopathy ☐Other_____

What makes it better? _____ What makes it worse? _____

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Medical History:

How would you describe your general state of health: ☐Excellent ☐Good ☐Fair ☐Poor

Do you wear a medical alert bracelet/tag? ☐Y ☐N For what condition? _____

What is your blood type? ☐A ☐B ☐O ☐AB ☐Unsure

Do you wear: ☐Corrective lenses ☐Dentures ☐Hearing aid ☐Medical devices/prosthetics/implants

For the following tables, please use the back of this page if more room is required:

Medical Conditions: Please indicate any hospitalizations, surgeries and injuries you have experienced:

Hospitalization / Surgery/ Injury	Date	Symptoms	Condition Resolved?

X-rays, CT Scans, EKGs, ECGs, MRIs, or other imaging scans you've had in the past:

Scan/ Screen/ Test	Date	Reason	Result

Allergies and/ or food sensitivities:

Allergy/ Sensitivity	Symptoms	Treatment/ Avoidance?

Current medications/supplements: Please list ALL medications or supplements you take on a regular basis:
Please bring all supplements with you to your first visit

Medication/Supplement	Dose (if known)	Length of Use	Reason for Taking

Screening Tests: Please indicate when you had the following screening tests (if known):

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Please bring a copy of any test results you have to your first visit

Screen/ Test	Date	Screen/Test	Date
PAP (Females)		DEXA Scan (Bone Density)	
Digital Rectal Exam (Males)		Complete Blood Count (CBC)	
PSA Test (Males)		Cholesterol	
Breast Exam (Both)		Blood Glucose	
Mammogram		Other: _____	

Date of last complete physical exam: _____

Have you taken antibiotics within the last 5 years? ☐ Y ☐N If yes, how many times? _____

Were you frequently given antibiotics as a child? ☐Y ☐N How often? _____

Have you ever been diagnosed with any of the following?

☐Alcoholism	☐Colitis	☐ Genetic Disorder	☐Mono
☐Alzheimer's	☐Crohn's Disease	☐Glaucoma	☐Osteoarthritis
☐Anemia	☐Depression	☐Gastric/Duodenal Ulcer	☐Osteoporosis
☐Asthma	☐Diabetes	☐Head Injury	☐Pancreatitis
☐Autoimmune Disease	☐Drug Addiction	☐Hepatitis	☐Pneumonia
☐Benign Prostatic Hypertrophy	☐Eating Disorder	☐High Blood Pressure	☐Psoriasis
☐Bronchitis	☐Eczema	☐High Cholesterol	☐Rheumatoid Arthritis
☐Cancer	☐Emphysema	☐HIV	☐Skin Condition
☐Cardiovascular Disease	☐Endometriosis	☐Intestinal Parasites	☐STD
☐Celiac Disease	☐Epilepsy	☐Mental Illness	☐Stroke
☐Chronic Fatigue Syndrome	☐Fibromyalgia	☐Migraine Headaches	☐Thyroid Condition

☐Other:_____

Childhood History:

Were you breastfed? ☐Y ☐N If yes, for how long? _____

Were you immunized? ☐Y ☐N If yes, any reactions? _____

Which "childhood" illnesses did you have?

☐ADD/ADHD	☐Eczema	☐German Measles	☐Mumps
☐Frequent Ear Infections	☐Meningitis	☐Red Measles	☐Rheumatic Fever
☐Chicken Pox	☐Whooping Cough	☐Thrush/Candida	☐Autism/Asperger's

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Family History:

Has anyone in your family been diagnosed with any of the following conditions?

☐Alcoholism	☐Diabetes	☐Heart Disease	☐Multiple Sclerosis
☐Alzheimer's Disease	☐Drug Abuse	☐High Blood Cholesterol	☐Osteoporosis
☐Asthma	☐Eczema	☐High Blood Pressure	☐Osteoarthritis
☐Cancer	☐Epilepsy	☐Kidney Disease	☐Psoriasis
☐Depression	☐Fibromyalgia	☐Mental Illness	☐Thyroid Disorder

Please list any other illnesses of your relatives, such as: parents, siblings, grandparents, aunts and uncles:
_____
_____
_____
_____
_____
_____
_____

Diet & Health Habits:

General energy level out of 10 (1=lowest, 10=highest): ___What time of day is it highest? ___ Lowest? ___

Weight: _____ Weight one year ago: _____ Height: _____ Ideal Weight: _____

Do you consider yourself: ☐Underweight ☐Slightly Underweight ☐Slightly Overweight ☐Overweight ☐Just Right

What time of day do you eat the following: Breakfast _____Lunch: _____Dinner: _____

Do you consume: ☐Canned foods ☐Pop ☐Aspartame (e.g. diet pop, gum) ☐Deli meats
☐Margarine ☐Juice

Are you on a special diet? ☐Y ☐N Explain: _____

Do you crave flavors: ☐Sweet ☐Salty ☐Sour ☐Bitter ☐Spicy ☐ Other: _____

Do you ever have indigestion or stomach pain, discomfort, nausea, vomiting after eating certain foods? If so, please describe: _____
_____
_____

How are your bowel movements? Do you have:

☐Diarrhea ☐Dry Stools ☐Alternating Diarrhea/Constipation

☐Constipation ☐Loose Stools ☐Straining

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How many bowel movements do you have per day? _____ What time of day? _____

Do you have: ☐Gas ☐Bloating ☐Bad Breath

How many glasses of water do you drink on an average day? _____ Do you feel thirsty? ☐Y ☐N

What temperatures of beverages do you prefer? ☐Cold ☐Room Temperature ☐Hot

Do you drink purified water/filtered water? ☐Y ☐N

Please provide examples of things you typically consume at the following meals:

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Do you smoke?	☐Y	☐N	How long ago did you start? _____	Number of cigarettes per day:___
Did you smoke in the past?	☐Y	☐N	For how long? _____	Number of cigarettes per day:___
Do you drink alcohol?	☐Y	☐N	What type? _____	How frequently?_____
Do you take recreational drugs?	☐Y	☐N	What type? _____	How frequently?_____
Do you drink coffee?	☐Y	☐N	How many cups per day?_____	

How often do you exercise? ☐5-7 days/week ☐3-4 days/week ☐1-2 days/week Length?_____
What do you do for exercise/movement? _____

How many hours of sleep do you get each night? _____ Do you wake feeling rested? ☐Y ☐N Do you nap? ☐Y ☐N

Do you wake in the night? ☐Y ☐N For any particular reason? _____ At any particular time? ___

Do you dream frequently? ☐Y ☐N Do you remember your dreams? ☐Y ☐N

Do you have trouble falling asleep? ☐Y ☐N Do you have trouble staying asleep? ☐Y ☐N

Female Reproductive

Age menses began: _____ Average number of days of menstruation at present: _____
Average number of days between periods at present: _____
Are you pre-menopausal, menopausal or postmenopausal? _____

Are you sexually active? ☐Y ☐N

Could you be pregnant? ☐Y ☐N
Birth Control: What type(s), when and for how long? _____
_____

Number of pregnancies: _____ Sex Drive (please circle): None / Low / Medium / High
Number of miscarriages: _____
Number of abortions: _____

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Male Reproductive

Sex Drive (please circle): None / Low / Medium / High

Are you sexually active? _____

Date of last prostrate exam: _____

Discharge of Sores? ☐Y ☐N

Decreased Sex Drive? ☐Y ☐N

Itchiness? ☐Y ☐N

Prostate Problems? ☐Y ☐N

Prostate Cancer? ☐Y ☐N

Rashes in Genital Area? ☐Y ☐N

Sexually Transmitted Infection: ☐Y ☐N
If yes, what kind and when:
_____

Testicular Hernia? ☐Y ☐N

Testicular Masses ? ☐Y ☐N

Testicular Pain ? ☐Y ☐N

Personal Information/ Lifestyle:

Do you identify as: ☐Straight ☐Homosexual ☐Bi-sexual ☐Trans-gendered ☐Other:_____

Marital status: ☐Single ☐Married ☐Separated ☐Widowed ☐With partner

Number of dependants _____ Ages_____

Occupation: _____ Shift work? ☐Y ☐N Do you enjoy your work? ☐Y ☐N

☐Sometimes

Is your job associated with potentially harmful chemicals (e.g. pesticides, solvents, radioactivity) or health and/or life threatening activities (e.g. firefighting, mining, etc.)? Please specify: _____

_____

Hours/day you spend: Working:_____ Driving:_____ Watching TV:_____

In front of computer:_____ Video games:____

Circle the level of stress you are presently experiencing in your life (10=highest):

1 2 3 4 5 6 7 8 9 10

Please list the major causes of stress for you (work, finances, relationship, health, etc.):

_____

_____

Have you experienced any major trauma, loss, or life changing significant events?_____

_____

Have you worked with a counsellor, psychologist, or psychiatrist? ☐No ☐Currently ☐In the past

Do you have any hobbies/ What do you like to do for fun or to relax?_____

_____

Do you have a regular religious or spiritual practice? ☐Y ☐N Please explain:

_____

_____

Is there anything else that you feel is important that hasn't been addressed on this form?

_____

_____

_____

_____

Thank you for taking the time to fill out this form!

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Review of Systems

Please circle symptom with the appropriate letter: (C: Currently P: Past) If the symptom does not apply to your case, please leave it blank

Systemic			**Comments**
Chills	C	P	
Chronic Generalized Pain	C	P	
Dizziness/Vertigo	C	P	
Dizziness upon rising	C	P	
Fainting	C	P	
Fatigue	C	P	
Frequent Colds	C	P	
Light headedness	C	P	
Low Grade Fever	C	P	
Night Sweats	C	P	
Strong Body Odour	C	P	
Skin			**Comments**
Acne	C	P	
Boils	C	P	
Changes in Mole(s)	C	P	
Colour Change	C	P	
Dry Skin	C	P	
Eczema/Dermatitis	C	P	
Hives	C	P	
Itching	C	P	
Lumps	C	P	
Nail Changes	C	P	
Rashes	C	P	
Skin Cancer	C	P	
Eyes			**Comments**
Far Sighted	C	P	
Near Sighted	C	P	
Blind Spot(s)	C	P	
Sensitive to Sun	C	P	
Cataract(s)	C	P	
Astigmatism	C	P	
Blurred Vision	C	P	
Discharge	C	P	
Dry Eyes	C	P	
Eye Pain	C	P	
Glaucoma	C	P	
Itching	C	P	
Redness	C	P	
Tearing	C	P	
Ears			**Comments**
Discharge	C	P	
Earache	C	P	
Feeling of Fullness	C	P	
Frequent Infections	C	P	

Impaired Hearing	C	P	
Ringing	C	P	
Sensitive Hearing	C	P	
Wax Build-Up	C	P	
Nose & Sinuses			**Comments**
Allergies	C	P	
Frequent Nose Bleeds	C	P	
Nasal Discharge	C	P	
Sinusitis/Sinus Problems	C	P	
Stuffiness	C	P	
Mouth & Throat			**Comments**
Bleeding of Gums/Tongue	C	P	
Canker Sores	C	P	
Cold Sores	C	P	
Dentures	C	P	
Gum Problems	C	P	
Frequent Sore Throat	C	P	
Hoarseness	C	P	
Loss of Taste	C	P	
Metal Fillings	C	P	
Phlegm	C	P	
Root Canal(s)	C	P	
Sore Tooth/Teeth	C	P	
Tonsillitis	C	P	
Head & Neck			**Comments**
Dandruff	C	P	
Goiter (Enlarged Thyroid)	C	P	
Headaches	C	P	
Hair Loss, Excessive	C	P	
Hair Growth/Hirsutism	C	P	
Migraines	C	P	
Pain/Stiffness of Neck	C	P	
Swollen Glands	C	P	
Thinning Eyebrows	C	P	
Respiratory			**Comments**
Difficulty Breathing	C	P	
Hyperventilation	C	P	
Pain on Breathing	C	P	
Persistent Cough	C	P	
Persistent Respiratory Infection	C	P	
Shortness of Breath	C	P	
Shortness of Breath on Exertion	C	P	
Shortness of Breath While Lying Down	C	P	
Spitting Up Blood	C	P	
Sputum	C	P	
Wheezing	C	P	
Cardiovascular			**Comments**
Angina	C	P	
Abnormal Heart Tests	C	P	

Chest Pain(s)			
Cholesterol, Elevated	C	P	
Heart Murmur(s)	C	P	
Heart Palpitations	C	P	
High Blood Pressure	C	P	
Low Blood Pressure	C	P	
Peripheral Vascular			**Comments**
Bruise Easily	C	P	
Bleed Easily	C	P	
Cold Hands/Feet	C	P	
Cyanosis (Skin Appears Blue)	C	P	
Deep Leg Pain	C	P	
Extremity Numbness	C	P	
Extremity Swelling	C	P	
Extremity Ulcers	C	P	
Hemorrhoids	C	P	
Leg Cramps	C	P	
Leg Pain Worse with Exercise	C	P	
Lymph Node Swelling	C	P	
Numbness or Tingling	C	P	
Past Transfusions	C	P	
Raynode's Syndrome	C	P	
Varicose Veins	C	P	
Wounds Heal Slowly	C	P	
Urinary			**Comments**
Blood in Urine	C	P	
Cloudy Urine	C	P	
Dribbling of Urine	C	P	
Frequent Infections	C	P	
Increased Frequency	C	P	
Increased Urgency	C	P	
Inability to Hold Urine	C	P	
Hesitancy	C	P	
Kidney Stones	C	P	
Pain on Urination	C	P	
Strong Urine Odour	C	P	
Unusual Change in Colour of Urine	C	P	
Frequent urination at Night	C	P	
Gastrointestinal			**Comments**
Abdominal Pain	C	P	
Anal Fissures	C	P	
Anal Prolapse	C	P	
Belching, Excessive	C	P	
Bloating	C	P	
Constipation	C	P	
Diarrhea	C	P	
Fecal Incontinence	C	P	
Gallstones	C	P	
Heartburn	C	P	
Indigestion	C	P	
Nausea	C	P	

Painful Bowel Movement	C	P	
Pain on Swallowing	C	P	
Passing Gas, Excessive	C	P	
Rectal Bleeding	C	P	
Vomiting	C	P	
Worse with Fatty Foods	C	P	
Number of Bowel Movements Each Day:_____or Each week:_____			
Stool			**Comment**
Blood in Stool	C	P	
Black/Tarry Stool	C	P	
Greenish Stool	C	P	
Hard Stool	C	P	
Loose Stool	C	P	
Mucus in Stool	C	P	
Stool Floats	C	P	
Undigested Food in Stool	C	P	
Yellow/Pale Stool	C	P	
Musculoskeletal			**Comments**
Backache	C	P	
Bone Pain	C	P	
Broken Bones	C	P	
Heel Spurs	C	P	
Joint Pain	C	P	
Joint Stiffness	C	P	
Joint Swelling	C	P	
Limited Joint Motion	C	P	
Muscle Cramps	C	P	
Muscle Spasms	C	P	
Muscle Weakness	C	P	
Muscle Wasting	C	P	
Sprain Joints Easily	C	P	
Endocrine			**Comments**
Change in Thirst	C	P	
Change in Appetite	C	P	
Cold Intolerance	C	P	
Excessive Sweating	C	P	
Heat Intolerance	C	P	
High Blood Sugar	C	P	
Low Blood Sugar	C	P	
Recent Weight Gain	C	P	
Recent Weight Loss	C	P	
Seasonal Depression	C	P	
Thyroid Problems	C	P	
Neurological			**Comments**
Learning Challenges	C	P	
Loss of Balance	C	P	
Loss of Coordination	C	P	
Loss of Memory	C	P	
Paralysis	C	P	
Seizures/Convulsions	C	P	
Speech Difficulties	C	P	

Tremor(s)	C	P	
Unusual Sensations	C	P	
Emotional			**Comments**
Anger, Excessive	C	P	
Anxiety/Nervousness	C	P	
Depression	C	P	
Irritability, Excessive	C	P	
Insomnia	C	P	
Mood Swings	C	P	
Panic Attacks	C	P	
Fears/Phobias	C	P	
Worry, Excessive	C	P	
Female Reproductive			**Comments**
Bleeding Between Periods	C	P	
Blood Clots	C	P	
Breast Lumps	C	P	
Breast Tenderness	C	P	
Breast Discharge	C	P	
Cervical Dysplasia (abnormal Pap smear)	C	P	
Cervical Cancer	C	P	
Decreased Sex Drive	C	P	
Difficulty Conceiving	C	P	
Endometriosis	C	P	
Excessive Flow	C	P	
Fibroids	C	P	
Hot Flashes	C	P	
Hysterectomy	C	P	
Increased Sex Drive	C	P	
Irregular Cycles	C	P	
Night Sweats	C	P	
Ovarian Cancer	C	P	
Ovarian Cysts	C	P	
Painful Menses	C	P	
Pain on Intercourse	C	P	
Scanty Flow	C	P	
Sexually Transmitted Infection: What kind and when: _____	C	P	
Sexual Difficulties	C	P	
Uterine Cancer	C	P	
Vaginal Discharge	C	P	
Vaginal Dryness	C	P	
Vaginal Itching	C	P	
Yeast Infections	C	P	