Dr. Ingrid Pincott
NATUROPATHIC PHYSICIAN INC

Dear Future Patient;

Congratulations for putting your health first and investigating Naturopathic Medicine and its benefits to your optimal health care program. I am confident that you will learn to understand the over view that naturopathic physicians offer their patients and the great potential for optimizing your health condition. The word doctor comes from "docere" which means to teach and I consider myself a coach as it is my goal to help you maintain your health moving forward.

In making your appointment you have implied that you are ready to make some changes in your life to experience better health. Taking your precious time to fill out this questionnaire will help me to understand what your goals and expectations are and together we will formulate a patient centered health care plan. The ultimate goal I see for you is helping you take responsibility for your health and I am just one of the health care professionals on your team.

All the information you share with me will be kept in the utmost confidentiality and I am the only person who reviews these forms. Please return these forms immediately (especially to get on our cancellation list) and this will give me time to go through them before your visit. You may drop them off at the office during office hours or you may also fax the completed forms to 250-850-2078 (if doing so please use black ink when filling out the forms – for easier reading). If you are uncomfortable answering any of the questions just leave them and we will discuss them during your first visit. The first four pages are the most important for you to complete for the first visit.

At the first visit for those 10 years or older, we like to do a simple urine test. Please come expecting to give a specimen.

We will call and email one week before your appointment to confirm. We ask that you call us back to let us know that you received the confirmation. If you have to cancel or reschedule your appointment we require 24 hours notice to avoid the cancellation fee. We book this time exclusively for you so it is difficult for us to fill this time on short notice.

Designated parking for my patients is provided behind the building at 1170 Shoppers Row as parking on Shoppers Row is limited to one hour only.

I sincerely thank you for sharing your important information with me and I look forward to seeing you at your first appointment.

To Your Health,

Dr. Ingrid Pincott, ND
"We are Committed to providing Outstanding Naturopathic Medical Care- No Exceptions."

ADVANCING PRIMARY CARE FOR 90 YEARS
90
WWW.BCNA.CA

Suite 300, Chateau Building 1170 Shoppers Row Campbell River, BC V9W 2C8 Tel. 250-286-3655 / 1-800-898-6699 Fax 250-850-2078 www.drpincott.com

300-1170 Shopper's Row
Campbell River, BC V9W 2C8
Phone (250) 286-3655 or (800) 898-6699
Fax (250) 850-2078 – www.drpincott.com

Please complete all 7 pages and return by fax or mail at least 24 hours prior to your appointment

SERVICE FEES

There is no GST on naturopathic professional services.

First Visit	60 minutes	$ 160.00
	90 minutes	$ 240.00
Return Visit	30 minutes	$ 85.00
	45 minutes	$ 125.00
E.D.S. Testing -	Initial	$ 140.00
(Vega-Style)	Retest (30 minutes)	$ 60.00

There is no additional charge for physical exams, PAPs and EAV Organ Testing. All other testing is done at additional charge. All services and pharmacy are paid for at time of service. A reimbursement for a portion of your visit may be claimed through your extended health coverage or, if you have premium assistance, through Health Insurance BC or Medical Services Plan. Call **HIBC/MSP** at (800) 663-7100 to determine if you qualify for premium assistance. HIBC/MSP does not pay for phone consultations. We are happy to provide Seniors (65 years of age and over) a 10% discount off of all visits and most medicines. Members of the same family who are living under the same roof and members of HANS also receive a 10% discount off of their visit fees. **Because fees are subject to change, please confirm at time of booking**.

I clearly understand that Dr. Pincott is not a medical doctor, but a naturopathic doctor, a specialist in natural therapeutics. I also understand that her practice and philosophy of medicine may not be accepted by my MD, pharmacist, dietician or nurse and this is acceptable to me.

This clinic respects and upholds an individual's right to privacy. Please refer to the copy of our privacy code attached to our patient health record.

We provide a mail order service to anywhere in Canada to facilitate renewal of remedies with applicable shipping charges.

APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE ARE CHARGED TO THE PATIENT FOR A FEE EQUIVALENT TO THE AMOUNT OF TIME BOOKED.

_____ Please initial if you would like to receive email communication including Dr. Pincott's published articles.

I have read the above and fully understand the contents.

Signed_____ Date_____

DR. INGRID PINCOTT, NATUROPATHIC PHYSICIAN

CONFIDENTIAL PATIENT HEALTH RECORD

Today's Date: _____

Name: _____ Age: _____ Birthdate: _____ Sex: F M

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Business Phone: _____

Care Card No: _____ Profession: _____

Employer: _____ Employed full or part time: _____

Email Address (to receive free newsletter): _____

Check one: Married Single Widowed Divorced Separated Common Law Same Sex

Number of Children _____ MD Physician _____

Person to notify in an emergency: _____ Relationship: _____ Phone: _____

How did you hear about this clinic? _____

CURRENT HEALTH CONDITION

What health concerns/problems brought you to this office today? _____

_____

_____

_____

_____

Has anything recently changed or become worse? _____

_____

What are the most significant measures which you have taken to date to improve your state of health?

_____

_____

_____

Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these continuing to impact your life? _____

_____

_____

_____

_____

_____

_____

PERSONAL HEALTH HABITS:

Height:_____ Current Weight: _____lbs. One year ago:_____ lbs. Maximum weight ____ lbs. in 19____

Smoker: Yes No Smoked _____years Amount/day: _____ Year stopped: _____

Are you exposed to second hand smoke?___ Do you use artificial sweeteners? Chew gum? Yes No

Alcohol Use: Yes No Type:_____ Frequency: _____

Recreational Drug Use: Yes No Type:_____ Frequency:_____

Coffee: Yes No_____ cups/day Tea: Yes No _____ cups/day Water: _____ cups/day

Purified water type____ Tap water _____ Milk _____ Juice _____

Herbal Tea: Yes No _____ cups/day Soft Drinks: Yes No _____ 8oz servings/day

Diet: Any food groups that you avoid: Yes No _____

Diet: Are there any food groups that you tend to eat a lot of? Yes No _____

Diet: Do you consume dairy products? Yes No _____

On a scale of 1 to 10 with 10 being the highest, please rate your average STRESS level:_____

On a scale of 1 to 10 with 10 being the highest, please rate your average ENERGY level:_____

How many hours of sleep do you get a night?_____ Do you wake up feeling rested? Yes No Sometimes

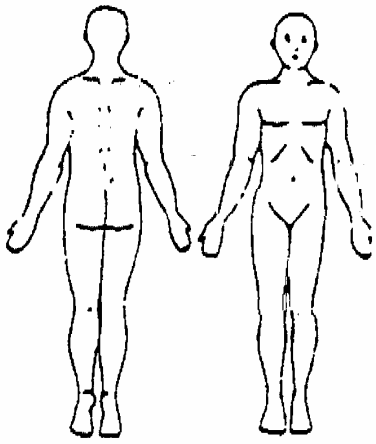
Regular exercise: Yes No Type: _____ Duration:_____ Frequency: _____

Women: Are you currently pregnant? Yes No Not Sure

Type of Birth Control Used:_____ If history of Birth Control Pill use, how many years? _____

MEDICAL HISTORY: Please check only those that pertain to YOU personally.

Alcohol Abuse
Allergies
Anemia
Arthritis
Asthma
Bladder / Urinary Problems
Bleeding Problems
Blood Pressure Problems / Stroke
Cancer
Colitis
Frequent colds, flu, sore throats
Diabetes
Digestive Disturbances
Ear Problems
Eating Disorders
Edema
Epilepsy
Eye Problems
Fatigue, Chronic
Female Gynecological Problems
Mononucleosis
Fever
Gall Bladder / Liver Problems
Gum / Teeth Problems
Hay Fever
Headaches
Head Injury / Serious Injury
Heart Disorders
Hepatitis
Hypoglycemia
Jaundice
Joint Problems
Kidney Problems
Lung Problems
Occupational Exposure to Toxic Substances
Parasites
Psychological Difficulties / suicidal / depression
Sexually Transmitted Diseases
(herpes, chlamydia, gonorrhea)
Skin Problems
Thyroid
Ulcer



Please outline on the diagram
the area of your discomfort.

FAMILY MEDICAL HISTORY: Please check relative areas for blood relatives *NOT* including yourself.

Asthma
Arthritis
Bleeding Problems
Cancer
Diabetes
Eating Disorders
Epilepsy
Gout
Hay fever, Allergies
Heart Problems
High Blood Pressure
Kidney Problems
Mental Disorders
Obesity
Stroke
Substance Abuse
Tuberculosis
Thyroid Problems
Osteoporosis

Thank you

Current Care Overview:

1. Have you consulted your MD regarding your chief complaints today, what therapies were prescribed and what was the result?

2. Have you worked with a professional counselor, psychologist, or other therapist now or in the past, and if so for what reasons and did you get results?

3. Have you consulted a Naturopathic Physician before, for what reason, and was the treatment successful?

4. Would you like to have those records sent here to this office for your file?

5. Are you currently attending a chiropractor and for what complaints?

6. Do you attend other health care professionals such as dentist, optometrist, acupuncturist, massage therapist, physiotherapist? Please explain the complaints.

7. Please list all of your health concerns whether you feel they are related to your primary concern or not.

8. Please list all drugs and medications which you are currently prescribed, the reason and the effect.

9. Which medications have you used in the past, the reason and the effect?

10. If you take supplements please list brands and dosages of all products you are taking and the reason for taking them.

Personal Health History:

1. Were you breast fed and for how long? _____

2. Were you a colicky baby? _____

3. What was your health as a child until age 12? _____

_____

4. Did you have any other childhood diseases other than chicken pox, measles, and mumps? _____

_____

5. Please list all surgeries you have had, dates and reasons, and if you felt they were successful. _____

_____

_____

_____

6. Have you ever had parasites that you know of? _____

7. Have you ever traveled to a third world country, if so for how long? _____

_____

8. What do you feel your weakest organ system is? _____

_____

9. How many times each year do you get a cold, flu or bronchitis? How many days are you sick with it? Do you miss work because of it? _____

_____

_____

10. How many times have you had antibiotics in your life? _____

11. Describe your bowel function, how often, size, floating, sinking, undigested food, odor, mucous, blood, loose, unformed, formed? _____

_____

_____

12. Please list all of your allergies; food and environmental. _____

_____

13. Explain your dental health. How many mercury amalgam fillings do you think you have? Any root canals?

_____

a) any problems ever since you have had dental work? _____

_____

14. Has there been a trauma or sickness that you felt you have never recovered from and you have not been well since? Please explain _____

_____

_____

_____

_____

Clarifications of Goals:

1. Why did you choose our clinic to support your health needs rather than your MD? _____

2. What do you know about our approach? _____

3. What expectations or goals do you have around your care with us? _____

4. For your care to be a true win for you, what do you see happening over the next three months?

5. What do you believe to be the key areas that you must effectively address in order to access more of your healing potential? What current behavior and lifestyle habits do you believe you need to change to benefit your health? ie diet, rest, relaxation, creative expression, occupation, addictive behaviors etc.

6. Which of these areas is the single most important one to be addressed right now. _____

7. What behavior or lifestyle habits do you currently engage in regularly that you believe support your health?

8. Do you consider yourself currently to be proactive with respect to your health and in what ways?

a) If no, have you ever been and if so why did you stop? _____

9. What do you perceive YOUR role or responsibility is with respect to your healthcare? _____

10. What do you perceive as MY responsibility with respect to your healthcare? ie How can I best assist you in attaining better health? _____

11. What is your present level of commitment to learn and implement healthy changes which will improve your health and well-being? Rate from 1-10. _____

a) If below 8 what will it take to increase your level of commitment? _____

12. What do you believe your present lifestyle and state of health is costing you in future health, longevity, % energy of each day, quality of life and/or relationships, peace of mind and happiness? _____

13. What are your top three priorities or values in your life presently? _____

14. What resources do you currently allocate to your health and well being? ie how much time, money and energy do you invest in your health right now? _____

15. How much time, money and energy are you willing to invest in your health? _____

16. What obstacles to you see and or feel exist to your achieving your goals for your health, peace of mind and happiness? _____

Privacy Policy For Dr. Pincott's Office

Dr. Pincott and her staff are committed to preserving and safeguarding your right to privacy. We will not sell, transfer or otherwise disclose any of your personal information to any third party without your consent. As part of this commitment we want you to know how we collect, use, maintain and otherwise manage your personal information in our custody and control. Please note that phone calls to or from the office may be recorded to control the quality of our services and for training purposes.

What Personal Information Do We Collect and Why?

We collect your personal health care number and your birth date on our intake form as an identity number for the lab we use for blood work, for the CCA for PAP smears and for completing MSP cards. We use your birth date as a personal identifier for all other labs contracted through our clinic for diagnostic testing. We collect your address for our point of sale program, TMAN, for ease of service to each patient. We collect your credit card for current transactions including labs testing but we do not keep it on file. We collect your e-mail address if you have specified that you would like to receive Dr. Pincott's articles and newsletters by email. We collect referral information to send out "Thank you" notes to those who have referred you to the office. This information is used by Dr. Pincott's staff only, who have been trained to handle personal information following the mandates in this policy.

When is Your Personal Information Disclosed to Third Parties?

We only supply your personal information to medical labs as a means of identifying your blood samples. Each lab must also adhere to federal privacy laws. We do not share your information with anyone else without your consent which we obtain from you by signing a "Release of Records" form.

How Do We Maintain the Security of Your Personal Information?

We take every precaution to ensure your personal information is kept confidential and secure. Our computer systems are frequently updated with firewall and anti-virus programs. All papers with personal identification on them are shredded, by a reputable company, here on the premises. This may include credit card transaction slips, e-mails, TMAN invoices, and typed or handwritten handouts with personal information on them. Charts containing personal information are stored away from public view and out of date patient files (i.e., not used in the last five years) are securely stored in a storage locker.

What About the Personal Information of my Children?

We will not collect personal information from children without the permission of the custodial parent/guardian or caregiver. In the case of divorced or single parent homes, we obtain this consent from the adult caregiver bringing the child into the office.

Comments or Questions?

If you would like to correct any of your personal information we have in our possession or remove your name from our e-mail contact list or mailing lists, simply contact our office. Changes to your file or the release of personal information cannot be made by us or provided to a third party without your consent. By law we keep patient files a minimum of seven years. Our point of sale system, TMAN, maintains a database of all your invoices. This is very useful in case you require details for income tax or extended medical submissions. Contact the clinic at: 300-1170 Shopper's Row, Campbell River, BC, phone 250-286-3655 or link to www.DrPincott.com If you have concerns regarding this clinic's privacy policy which cannot be answered by Dr. Pincott or clinic staff, you may contact the College of Naturopathic Physicians of BC, the licensing and regulatory body for naturopathic physicians in BC, by phone at 604-688-8236 or by e-mail at office@cnpbc.bc.ca

Email Communication

We regularly contact patients by email to confirm appointments, etc. If you do not want to receive email communication please let us know.