Dr. Jennifer Bunzenmeyer ND ***Doctor of Naturopathic Medicine***

12427 Bonaventure Drive SE Suite 201 Calgary, AB T2J 3N8 ***www.DrJennBND.com***
(587) 471-5377 ***Fax (403) 255-2997*** ***info@drjennbnd.com***

Welcome to my Naturopathic Office

I want you to enjoy and benefit from your visits with me.

Your first visit will consist of **consultation, detailed history, a general physical exam and a more specific naturopathic examination**. Based on this information, initial recommendations for your treatment protocol will be made on your first visit. If I feel it is necessary for a more complete analysis of your health status, you may be asked to have further laboratory tests through your medical doctor, or additional testing through our office lab facilities. Through this healthcare assessment, I am able to establish a baseline measure of health that I can then use to monitor your progress.

On either your first or second visit, **a detailed report of findings and an in-depth treatment plan** will be explained to you. Programs often include **dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy and traditional Chinese medicine**. Your program will also involve lifestyle recommendations that are logical and sensible. (I encourage you to have a support team as you make these changes. Often having someone else, be it a partner, family member or friend who is undergoing naturopathic care at the same time will help to ease you both toward better health.) This return visit is also a good time to ask any questions that you may have had after your initial visit. If you need immediate clarification on remedies, dietary recommendations or have a concern over any unfamiliar symptoms that may arise, please call my office.

On your following visits, your progress will be monitored and treatments will be modified accordingly. The second visit is usually three to five weeks after your initial visit. As you start to experience a new level of wellness, we suggest an office visit every three to four months for general disease prevention and health maintenance. If an acute, non-emergency condition occurs, please give me a call as I may be able to help with a naturopathic treatment.

Many of our patients and staff have allergies and are environmentally sensitive. I ask that on the day of your visit to our office, you do not wear any scented products (perfumes, shaving lotions,hairsprays, etc.).

I request that if you are unable to keep a scheduled appointment, you give my office 2 business days notice. We are then able to provide that appointment time to someone on my waiting list. If we do not receive sufficient notice, you will be charged for the missed visit and you will be asked for your credit card information to pay for the missed visit.

Naturopathic coverage is available through many extended healthcare plans; please inquire with your HR department. Payments for visits are due at the time of the appointment.

Effective January 1, 2017, Appointment Fees (no GST for visits) are:

Initial visit	1 ¼ hour	$ 250
Report visit	45 min	$ 185
Regular visit	30 min	$ 110
Longer Regular visit	45 min	$ 165
Hour visits	60 min	$ 220

I utilize an Online Dispensary (***Fullscript***) of professional quality supplements, botanicals and homeopathics for the treatment of my patients. Most supplements I recommend for you will available through this online ordering system.

We accept the following methods of payment:
Visa, Mastercard, Debit Card

If you have any concerns, please contact my front desk staff and they will be happy to pass your message on to myself.

Please fill out the following forms and bring to your first appointment.

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Naturopathic Patient Intake Form

Our professional regulatory college (CNDA) 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.

First Name ________________________________ Last Name _____________________________________

Address ____

City ____________________________ Province _________________ Postal Code __________________

Telephone (H) ______________________ (W) ________________________ (F) _______________________

E-mail ____ Cell _______________________

Emergency ___________________________ ________________________________ ________________

(Print Name) Phone Relationship

By signing here, you give ***Dr. Jennifer Bunzenmeyer ND*** permission to send you email regarding upcoming visits, online dispensary through Fullscript, newsletters and notices on events. Your email will not be distributed for any other use.

_________________________________ ____________________________________ ________________

(Print Name) (Signature) (Dated)

Occupation _________________________________ Employer _____________________________________

Past Occupations ____

Date of Birth __________________ Age ______Sex M F Marital status __________________

Children & their ages ____

Blood Type _____________ Height ______________ Weight ______________ Ideal Weight ____________

Religion or personal philosophy____

Name of Medical Doctor ______________________________ Date of last physical ____________________

Phone (____) ______________ Fax (_____) ______________ Date last lab tests _____________________

Have you been treated by a Naturopathic Doctor? Other health practitioners?

Name ____________________________________ Name(s) ___________________________________

When? ___________________________________ When? _____________________________________

Please tell us how you heard of our Clinic? Family ___ Friend ___ Co-Worker ___Ad ___ Facebook ___

Internet____ Health Professional _____ Who recommended our clinic to you? _______________________

Please list (in order of importance) your **primary health concerns** / **reasons** for your visit.	Please indicate any **treatments** that you have tried previously to address your health issues and **how effective** you found these treatments.

Please turn over

Please list all **pharmaceutical medications, herbals, vitamins and supplements** (& dosages, if known)

Now	In the Past

Please list any **allergies** you have and what kind of **reaction** occurs.

Please list all **hospitalizations, fractures or major illnesses** that you have had.

Type of illness, operation / procedure	Date	Any ongoing concerns?

How would you rate your **energy level**? _____ (from 1-10, **10 being highest**) Time to go to Bed ______

Wake time _____ Do you wake-up feeling refreshed? Y__ If N__, give details _______________________

How many glasses of **water / day** do you drink? Please indicate numbers & type below.

Tap_________ Filtered________ Spring _________ Reverse Osmosis_________ Distilled _________

How many **cups / day** do you drink of each the following?

Coffee _____ Black Tea _____ Herbal Tea _____ Do you add milk / cream? _____ Sugar? ______

Do you **smoke**? N__ Y__ # cigarettes/ cigars per day __ How many years? __ In the past? Y __ Quit when ____

Do you drink **alcohol**? N__ Y__ Type & # of drinks per week _________________ In the past but quit when? Y ______

Do you use **recreational drugs**? N ___ Y ___ In the past? Y ____ What kind and how often? ____________________

Do you **exercise**? N__ Y__ Hours per week _____ Type of exercise _________________________________

Do you watch **TV**? N___ Y___ # of hours per week____ Hours computer use at Home ___ Work ___

Please check all the **childhood illnesses** you have had.

	Measles		Rubella		Whooping Cough		Rheumatic Fever		Allergies
	Mumps		Chicken pox		Scarlet Fever		Polio		Asthma

Have you been **vaccinated**? N___ Y___ Did you have any adverse reactions? _____________________

What vaccines have you had recently? ____

Please check all of the following **conditions** that are applicable to **you & your family** and note who.

Alcoholism			Gout		
Allergies			Heart disease		
Arthritis			Heart murmurs		
Asthma			High blood pressure		
Auto Immune			Hypo / hyper thyroid		
Cancer			Irritable Bowel		
Crohn's or Colitis			Kidney disease		
Depression					
Diabetes			Mental illness		
Eczema			Osteoporosis		
Gallbladder			Stroke or aneurysm		
GERD/hiatal hernia			Ulcers		
Glaucoma / Cataracts			Other		

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Informed Consent (Adult)

Naturopathic doctors assess the whole person, taking into consideration the physical, mental, emotional and energetic aspects of an individual. Your naturopathic doctor will conduct a thorough case history, physical exam and may request specific laboratory tests and reports to be used as part of the treatment work-up.

It is very important that you inform your naturopathic doctor immediately of all disease processes that you may be experiencing, and of any medication, over-the-counter drugs or supplements you are taking. If you are pregnant, suspect you are pregnant or are breast-feeding, please advise your naturopathic doctor.

Statement of Acknowledgement

As a patient of this office, I have read the information and understand that the health care to be provided is based on naturopathic and other supportive principles and practices. 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 anyone other than Dr. Bunzenmeyer unless so directed by myself or law requires it. Please note Dr. Bunzenmeyer is mandated to break confidentiality in the following cases:

- You disclose to her that you have a plan to harm yourself or another person.
- She is subpoenaed by law to give a copy of your file.

By signing below, I acknowledge the above regarding confidentiality and understand what provisions Dr. Bunzenmeyer needs to follow regarding confidentiality. I will inform Dr. Bunzenmeyer if this is a concern to me. I understand that I I may look at my medical records at any time and can request a copy by paying the appropriate fee.

I also recognize that even the gentlest therapies can have complications in certain physiological conditions, in very young children, or for those on multiple medications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy, and all medications including prescription drugs, over-the-counter drugs and supplements/remedies.

The slight health risks of some naturopathic treatments include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic / sensitivity reaction to supplements or herbs
- pain, fainting, bruising or injury from acupuncture, venipuncture or intramuscular vitamin injections
- muscle strains and sprains from physical treatments & muscle testing.

I understand that results are not guaranteed. I do not expect Dr. Bunzenmeyer to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of my naturopathic treatment at this office. I also confirm that I have the ability to accept or reject this care of my own free will and choice and discontinue participation in these procedures at any time.

I accept full responsibility for any fees incurred during care and treatment and acknowledge that payment is required on the day of service.

NAME of PATIENT (Please Print) ____

DATE ______________________ SIGNATURE ____________________________________