

**Dr. Jen Corbeil, ND  
Naturopathic Doctor**

Suite 105 – 1001 Cloverdale Ave.  
Victoria, B.C. V8X 4C9  
(T): 250.382.2225  
jencorbeil.nd@gmail.com

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Welcome to Naturopathic Medicine! A holistic philosophy is the foundation underlying Naturopathic Medicine and it's from this whole-person perspective that I seek to gain a comprehensive understanding of all aspects that may be affecting your health.

As your Naturopathic Doctor, it is important that I am aware of your current health status, your complete medical history, as well as what areas of your health you would like to see change in the future. Please complete this form as thoroughly as possible, as your responses will greatly assist in the development of a personalized treatment plan.

***\*Please bring all of the completed forms in this package with you to your first visit.***

Name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender: Male: \_ Female: \_  
(Month/ Day/ Year)

Occupation: \_\_\_\_\_

Live with: \_ spouse \_ partner \_ children (how many? \_\_\_\_\_) \_ roommate \_ parents \_ alone

**CONTACT INFORMATION** *\*Please inform us if your contact information changes\**

Address:  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Phone (H): \_\_\_\_\_ (Bus.): \_\_\_\_\_ (Cell): \_\_\_\_\_  
E-mail: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone (H): \_\_\_\_\_ (Bus.): \_\_\_\_\_ (Cell): \_\_\_\_\_

**HEALTHCARE PROVIDERS:**

Primary Health Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
When was your last physical exam? \_\_\_\_\_

Are you currently under the care of a specialist? \_ Yes \_ No  
Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently under the care of alternative health care providers? \_ Yes \_ No  
Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONTEXT OF CARE**

What about Naturopathic Medicine interests you?

What expectations do you have from this visit?

What are your long term health goals?

What expectations do you have of me personally as your naturopathic doctor?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? *(Please rate from 1 to 10, 10 being 100 % committed).*

1    2    3    4    5    6    7    8    9    10

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

What behaviours or lifestyle habits do you currently engage in regularly that you believe are not supportive of optimal health?

What potential obstacles do you foresee in adhering to the therapeutic protocols which I will be sharing with you?

Who do you know that will sincerely support you consistently with the potential lifestyle changes you will be making?

How would you describe your general state of health?

**HEALTH CONCERNS**

Please list your health concerns, in order of greatest importance to you.

1. \_\_\_\_\_ 5. \_\_\_\_\_  
 2. \_\_\_\_\_ 6. \_\_\_\_\_  
 3. \_\_\_\_\_ 7. \_\_\_\_\_  
 4. \_\_\_\_\_ 8. \_\_\_\_\_

**VITAMINS AND SUPPLEMENTS**

*Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are currently taking:*

Supplement (include the brand)	Total Daily Dose	Reason for Use	Duration of Use

**PRESCRIPTION MEDICATIONS**

*Please list all current medications and indicate the total dosage taken in one day:*

Current Medications	Total Daily Dose	Reason for Use	Duration of Use

*Please list any medications used in the past 12 months, but have now discontinued.*

Medication in Past 12 Months	Total Daily Use	Reason for Use	Duration of Use

Are there any medications that you have used for more than 5 years of your life, which you have not already mentioned? \_\_\_\_\_

Number of times on antibiotics in the past 10 years: \_\_\_\_\_

Do you regularly use any of the following? Laxatives    Sleeping pills    Antacids    Painkillers    Diet pills

If so, please indicate type, frequency, and amount: \_\_\_\_\_

**MEDICAL HISTORY**

How would you describe your general health during childhood?     Excellent     Fair     Poor     Very Poor

**Which childhood illnesses have you had?**

- Asthma             Chicken Pox             Mumps             Polio  
 Rheumatic Fever     Scarlet Fever             Roseola             Other: \_\_\_\_\_  
 Rubella (German Measles)     Whooping Cough             Measles

**Which vaccinations have you had?**

- HBV (hepatitis B)     Hepatitis A     Meningococcal     Other: \_\_\_\_\_  
 MMR (measles, mumps, rubella)     Tetanus Booster     Smallpox  
 Hib (*Haemophilus influenza b*)     Polio     Typhus  
 DPT (diphtheria, tetanus, pertussis)     VZV (chicken pox)     Influenza (flu shot)

**Adverse Reactions**

*Please describe any adverse reactions, allergies, or sensitivities you have experienced with prescription or over-the-counter medications, recreational drugs, vaccinations (childhood, travel, flu, hepatitis), or natural medicines (herbs, vitamins, minerals, homeopathics)*

Name of Drug, Vaccine or Natural Medicine	Describe the reaction

**Past Surgeries and Tests** *(Please check all that apply)*

Surgeries	Year	Tests	Year
Abdominal/Gastrointestinal		Chest x-ray	
Appendectomy (Appendix removal)		Colon x-ray	
Brain		Abdominal x-ray	
Caesarean Section		Kidney x-ray	
Cancer (type?)		Echocardiogram	
Gallbladder		Electrocardiogram (ECG or EKG)	
Heart		Mammogram	
Hernia		Colonoscopy	
Mastectomy (breast)		Sigmoidoscopy	
Hysterectomy (ovaries/uterus/both)		TB test	
Sinuses		CT scan	
Tonsillectomy		MRI	
Tubes in ears		Ultrasound	
Tubes in ears		Blood test (specify if possible)	
Vasectomy		Other (specify)	
Other (specify)			

Please list any hospitalizations and the year in which they occurred:

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Please list any major injuries or traumas you have suffered and indicate the year they occurred: \_\_\_\_\_

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Dental Work: How many silver amalgam fillings do you have? \_\_\_\_\_ How many root canals? \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

Relation	Significant Health Concerns/Diagnoses	If Deceased, list cause and age at death
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings		

**DIET**

What is a typical daily diet for you?

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Other (including beverages): \_\_\_\_\_

Is there anything about your diet you would like to change? \_\_\_\_\_

On average how many meals do you eat per day? 1 2 3 4 5 >5

Which is usually your largest meal?  Breakfast  Lunch  Dinner

List any foods that you crave regularly: \_\_\_\_\_

List any foods you exclude from your diet: \_\_\_\_\_

Do you follow a specific diet regime?  Vegetarian  Vegan  Other \_\_\_\_\_

Any known food allergies/ intolerances/ sensitivities? \_\_\_\_\_

**LIFESTYLE**

Educational Background: \_\_\_\_\_

How many hours/ week on average do you work? \_\_\_\_\_ Do you enjoy your job? Y / N

How many times per week do you exercise?  Never  < 1/wk  1-3/wk  3-5/wk  >5/wk

What types of exercise do you do? \_\_\_\_\_

How long do you spend exercising each time? \_\_\_\_\_

Energy level (please circle): Low 1 2 3 4 5 6 7 8 9 10 High

Do you experience fatigue? Y / N Do you sleep well? Y / N Do you wake feeling well rested? Y / N

How many hours/ night do you typically sleep? \_\_\_\_\_

Do you have troubles falling asleep at night? Y / N If yes, Why? \_\_\_\_\_

Do you wake throughout the night? Y / N If Yes, Why? \_\_\_\_\_

How many times/ night? \_\_\_\_\_

Do you wake at the same time every night? Y / N

If Yes, what time(s)? \_\_\_\_\_

Do you snore? Y / N

Do you smoke? \_ Yes (# packs per day \_\_\_\_\_ , # of years \_\_\_\_\_ ) \_ Never smoked

Smoked in the past ( # of years \_\_\_\_\_; # packs per day \_\_\_\_\_; Year that you quit \_\_\_\_\_)

Regularly exposed to second hand smoke? Y / N \_ Use chewing tobacco

Do you use recreational/street drugs? \_ Yes \_ No \_ In the past

If yes, which drugs, how often, and for how long? \_\_\_\_\_

Have you ever had a problem with an addiction? Y / N If Yes, Please specify (i.e. alcohol, food, drug):

\_\_\_\_\_

When was your last vacation? \_\_\_\_\_

**Mental/Emotional:**

\_ Prolonged sadness/grief      \_ Easily angered      \_ Mental illness      \_ Panic attacks

\_ Anxiety/Nervousness      \_ Indecision      \_ Mood swings      \_ Memory problems

\_ Depression      \_ Irritability      \_ Phobia

What are the major stresses in your life? (i.e. financial, job related, health, family, spiritual)

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Has there been an event or illness from which you have never fully recovered from? \_\_\_\_\_

\_\_\_\_\_

Indicate your current stress level on a scale of 1-10:

Low 1 2 3 4 5 6 7 8 9 10 High

How do you deal with stress? \_\_\_\_\_ Does this approach help sufficiently? \_\_\_\_\_

How would you describe your spirituality? \_\_\_\_\_

What do you do for recreation? (i.e. What are your hobbies and interests?) \_\_\_\_\_

\_\_\_\_\_

Additional comments/ Anything you would like to share that hasn't already been covered: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**CONSENT TO SERVICES FORM**

**FEE SCHEDULE** (as of September 15, 2010):

**Initial visit** (90-120 minutes): \$145

**Follow-up visits** (generally 30-45 minutes): \$75

**Brief/Acute visits** (15 minutes): \$30

**Youth visits (18 and under):** 15% off of regular rate; and note that visit lengths are generally shorter

**Acupuncture visits** (30-45 minutes): \$65

(Initial acupuncture visit if not already a naturopathic patient (60 minutes): \$90)

**Craniosacral therapy and Reiki sessions:** \$75 per hour

**Telephone Consultations\*:** 15 minutes or longer: follow-up visit fees apply

*\* Please note that telephone consultations are generally intended for follow-up consultation and clarification of treatment protocols. Telephone consults are offered to new patients only after an initial visit has been conducted and a treatment plan has been initiated.*

A sliding scale is available, and any special financial arrangements should be made directly with Dr. Jen Corbeil in advance of consultation.

**Herbal Dispensary & Naturopathic Medicines:**

Jen may recommend that you take certain products as part of your treatment plan. Please note that you are free to choose where you purchase the recommended products, but that certain professional product lines are only available through licensed Naturopathic Doctors. All associated costs will be made aware to the client upon recommendation of specific health products.

**Booking Appointments:**

Please schedule your appointments in advance, and plan to arrive for appointments on time. Visits that begin late due to a patient's late arrival will be charged the full visit fee.

**Payment for Services:**

Payment for services is due at the end of each visit and a receipt will be given when payment is received. Please retain this receipt for your insurance or income tax claims, if applicable. Fees may be paid by cash, cheque, Visa, MasterCard or debit. A surcharge of \$35.00 will apply to all NSF cheques. Please note that refunds are not available for medical services rendered, including lab tests performed. Extended health benefit plans often offer limited coverage for naturopathic medicine. Plans and policies differ, so please check with your provider regarding your coverage and claim procedures.

**Cancelled and Missed Appointments:**

**Please ensure to give at least 24 hrs. cancellation notice.** This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on the same day or missed appointments, a \$40.00 fee will be charged. Consideration will be given to unforeseeable circumstances.

**Confidentiality:**

Everything that you communicate, directly or indirectly, to Jen Corbeil, ND is confidential, unless you give written permission to disclose information to a third party. Confidentiality is respected at all times. It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to:

- 1. report incidents of child abuse (physical, sexual or emotional) and neglect;
- 2. comply with a court ordered subpoena;
- 3. prevent harm to yourself or another person should such plans be disclosed;
- 4. report a health professional who has sexually abused a patient

**In Case of Emergency:**

Emergency medical services are not offered by Jen Corbeil, ND. In case of an emergency, patients should dial 911, or proceed to the Emergency Department of the nearest hospital.

**Statement of Acknowledgment**

I, \_\_\_\_\_ have read, understood and agree to the contents herein:  
(print name)

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***\*Please sign and return this form to your Naturopathic Doctor on your first visit***

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**CONSENT TO TREAT FORM**

**Statement of Consent**

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

As a patient of this practice I have read the information and understand that the form of medical care is based on Naturopathic Medical principles. I acknowledge that my Naturopathic Doctor, Jen Corbeil, ND, endeavours to provide the best possible diagnosis and course of treatment, but that no warranty is made with respect to any treatment, action, or medical advice given, as many factors will be important in determining actual results. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over-the-counter drugs and supplements. The slight health risks of some naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations.

I also acknowledge that I have the ability to accept or reject this care of my own free will and choice. I give permission and consent to Jen Corbeil, ND, to provide naturopathic consultation, assessment and/or treatment to me [and/or my child \_\_\_\_\_ who is my son/daughter].

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

***\*Please sign and return this form to your Naturopathic Doctor on your first visit.***