



***Nicola McFadzean, N.D.***  
***Naturopathic Doctor***

Dear New Patient:

Thank you for choosing Dr. Nicola as your healthcare provider. She is dedicated to making your experience a most satisfying one.

The enclosed information is necessary in order for us to complete your in office file and for our participation in your health care. You are encouraged to make copies of these documents for your records. **Please email or fax these forms back, and also mail or bring the originals to Dr. Nicola's office.**

- ✓ Patient Information Form
- ✓ Office Policies and Procedures
- ✓ Credit Card Authorization
- ✓ Health History Questionnaire

If you have copies of recent medical and laboratory reports, please provide them to the office at least one day prior to your appointment. If you cannot provide them prior to your appointment, you may bring them with you.

Please don't hesitate to contact us should you have any questions. Dr. Nicola looks forward to assisting you.

**Appointment Date** \_\_\_\_\_ **Time** \_\_\_\_\_

**1111 Ft. Stockton Drive, #H**  
**San Diego, CA 92103**  
**(619) 546 4065 ph**  
**(619) 270 2582 fax**

**Web: [www.restormedicine.com](http://www.restormedicine.com)**  
**Email: [info@restormedicine.com](mailto:info@restormedicine.com)**

# *Nicola McFadzean, N.D.*

## *Patient Information*

(PLEASE PRINT CLEARLY)

Patient Name \_\_\_\_\_  
Last First Middle initial

Home address \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary phone: Daytime ( ) \_\_\_\_\_ Evening ( ) \_\_\_\_\_

Cell phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Email address \_\_\_\_\_

Skype ID \_\_\_\_\_

Employed by \_\_\_\_\_

Occupation \_\_\_\_\_

What name do you prefer to be called?  
\_\_\_\_\_

Who referred you to our office?  
\_\_\_\_\_

Who is your medical insurance carrier? HMO \_\_\_\_ PPO \_\_\_\_  
\_\_\_\_\_

**In case of emergency contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Work phone ( ) \_\_\_\_\_

**For children under 18 years of age:**

Mother's full name \_\_\_\_\_

Father's full name \_\_\_\_\_  
\_\_\_\_\_

# *Nicola McFadzean, N.D.*

## *Office Policies and Procedures*

### **Hours:**

- Mondays, Wednesdays and Fridays 10am-5pm (PST).
- Office visits and telephone consultations are by appointment only.

### **Fees:**

- Initial consultation (45-60 mins) - \$325.
- Follow up (20-30 mins) - \$165.
- Brief follow up (10-15 mins) - \$85.

### **Appointments**

- Appointments are scheduled by telephone or email. Please leave possible dates and times. The staff at RestorMedicine will confirm your appointment time with you.
- Payment is due at the time of your consultation. Methods of payment are: Visa, MasterCard, Discover, check, and cash.
- First appointment: All initial paperwork must be completed, signed, and received by our office preferably 2 business days prior to your scheduled appointment. Please fax or email these forms (as single PDF file if emailing). Also send an electronic photograph (JPEG format) for our medical records.
- First appointment: If paying by check for a phone consultation, the check must be received in advance of your consultation. If paying by credit card you may be asked to provide your credit card number at time of scheduling to hold the appointment.
- Follow-up consults may be scheduled in 15, 30 or 60-minute blocks of time.
- Consultations with other healthcare providers and/or any research requested by the patient are billable services and will be charged at the hourly rate.
- Scheduled consultations that include review of lab tests require that laboratory test results be received at least 24 hours prior to appointment.

### **Medical Letters:**

- Medical letters to schools, insurance companies, disability, etc. are a billable service. If these items are requested there may be an additional charge based on the time involved at the hourly rate to complete your request.

### **Office Consultations:**

- Please advise the doctor if wheelchair access is required.

### **Phone Consultations:**

- Dr. Nicola will call you at the time of your scheduled consultation. Please allow a 10 minute window from your appointment time to hear from Dr. Nicola.
- Dr. Nicola requires patients outside of the USA to call the office at the time of their scheduled phone consultation. If this is not possible, then phone consultation phone bill charge will be billed to the patient. Dr. Nicola also uses Skype (user name is NicolaMcF).

**Cancellations:**

- Patients who forget their appointment or cancel less than 24 hours prior to the appointment will be required to pay 50% of the missed visit fee. Please understand that a missed appointment could have gone to another patient. New patients may be required to provide a credit card number when their appointment is scheduled to hold their appointment time.

**Questions and Follow-up:**

- Please direct e-mails, faxes or letters regarding you or your child’s care to info@restormedicine.com. Questions must be brief and concise. Dr. Nicola will determine if a phone or office consult is needed to answer your question(s). Otherwise, she or an administrative assistant will respond to your inquiry. When leaving a voice mail message, please be brief and concise and always include your name and phone number, including the area code.
- **Please Note: We try to accommodate questions regarding treatment clarification at no charge. Simply put, if you have a quick question about a supplement or diagnostic test we recommended or a therapy reaction you may be experiencing, then by all means contact us. However, if the response to a question you submit requires doctor research and/or review, you may be billed for the time involved at the doctor’s hourly rate, or requested that you schedule a phone consultation.**

**Follow-up Office Consultations:**

- We generally recommend that all patients minimally have an office consultation with Dr. Nicola every 6 months.

**Insurance:**

- Dr. Nicola does not accept any insurance plan, nor bill insurance on your behalf. She will supply you with a “superbill” or medical receipt that you can submit to your carrier for reimbursement. She makes no guarantee of payment or reimbursement by your insurance carrier.
- Dr. Nicola does not accept insurance liens, assignments, or any reimbursement from your insurance carrier.

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**Acceptance of Policies and Procedures**

By completing the following you agree to the policies and procedures detailed above.

Patient (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature (patient or responsible party): \_\_\_\_\_

If signed by party other than patient, print name: \_\_\_\_\_

**Nicola McFadzean, N.D.**

**Credit Card Authorization**

I, (print name) \_\_\_\_\_, authorize Nicola McFadzean, N.D. dba RestorMedicine to bill my credit card as listed below.

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**Name on Credit Card** \_\_\_\_\_

**Credit Card Details**

Visa            Card # \_\_\_\_\_ Exp date \_\_\_\_\_

MasterCard    Card # \_\_\_\_\_ Exp date \_\_\_\_\_

3 digit code on the back of the card \_\_\_\_\_

**Billing Address for Credit Card**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (include area code): \_\_\_\_\_

**Authorization**

\_\_\_\_\_  
Card Holder's Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Today's Date

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This authorization may be revoked at any time when the following stipulations have been performed.

1. Patient has already made new financial agreement that has been signed and dated or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated).
2. Patient's account is paid in full.

# Pediatric Health Questionnaire

Child's Name \_\_\_\_\_

Child's Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Male / Female

Weight: \_\_\_\_\_

## **Autistic-Spectrum Disorders:**

Age of Autistic Spectrum Disorder (ASD) Diagnosis? \_\_\_\_\_ Mild \_\_\_ Moderate \_\_\_ Severe \_\_\_

Symptoms became apparent at what age? \_\_\_\_\_

What signs and symptoms first became noticeable that alarmed you as a parent? (please list as many initial developmental problems as possible, ie. poor eye contact, aggressive behavior, etc.):

What developmental issues does child suffer with currently if different from above?

Are there any other diagnoses that your child has received? \_\_\_\_\_

## **Other Health Issues:**

Does your child suffer with other health problems: \_\_\_Allergies \_\_\_Asthma \_\_\_Constipation \_\_\_Diarrhea

\_\_\_Eczema\_\_\_ Kidney Problems \_\_\_Lung Disease \_\_\_ Diabetes \_\_\_Thyroid Disease \_\_\_Heart Disease

\_\_\_ Seizures\_\_\_ Repeated Infections \_\_\_Other, please explain \_\_\_\_\_

Did your child's condition change following an illness, infection and/or seizure disorder (such as a febrile seizure)

\_\_\_No \_\_\_Yes, please explain \_\_\_\_\_

Has your child had a tick bite? \_\_\_ Yes \_\_\_ No EM rash \_\_\_ yes \_\_\_ no

Diagnosis of Lyme disease? \_\_\_ Yes \_\_\_ No Testing for Lyme disease \_\_\_ yes \_\_\_ no

Prior treatment for Lyme disease? \_\_\_\_\_

## **Digestive Health:**

Does child have periodic loose stools/diarrhea \_\_\_ Yes \_\_\_ No

Offensive Gas \_\_\_Yes \_\_\_No Undigested Food Stuff in Stools \_\_\_Yes \_\_\_No

Is your child potty trained \_\_\_Yes \_\_\_No Does your child suffer with reflux/heartburn \_\_\_Yes \_\_\_No

Is your child currently taking an acid-blocking medication such as Tagamet, Pepcid, etc. \_\_\_Yes \_\_\_ No

Did occurrence of digestive problems occur following a particular vaccine \_\_\_Yes \_\_\_No \_\_\_ Unsure

Does your child produce formed stools \_\_\_Yes \_\_\_ No Have they ever? \_\_\_Yes \_\_\_ No

## **Antibiotic History:**

How many courses of antibiotics has your child received in lifetime: \_\_\_ 0-5 \_\_\_ 5-10 \_\_\_ 10-15 \_\_\_ 15-20 \_\_\_ 20+

Main reason for antibiotic use: \_\_\_ Ear Infections \_\_\_ Bronchitis \_\_\_ Pneumonia \_\_\_ Sinus Infection \_\_\_ Intestinal

Infection \_\_\_ Other (please explain) \_\_\_\_\_

Was your child ever treated for a yeast infection following antibiotic use \_\_\_\_\_

## **Home Environment:**

How old is your current home \_\_\_ Has your child lived in a home that had lead-based paint \_\_\_ Yes \_\_\_ No

Is your flooring carpet \_\_\_ hardwood \_\_\_ tile \_\_\_ Do you have carpeting in the bathrooms \_\_\_\_\_

Has there ever been any exposure in the home to molds \_\_\_ Yes \_\_\_ No, explain \_\_\_\_\_

Do you use commercial cleaners in the home \_\_\_ Yes \_\_\_ No

Has your child used or sleep in fire retardant clothing or bedding \_\_\_ Yes \_\_\_ No

Is child exposed to outside pesticides, fungicides, etc. \_\_\_ Yes \_\_\_ No

**Mothers Pregnancy and Labor:**

Did Mom have any complications during pregnancy, ie. \_\_\_High Blood Pressure\_\_\_ Seizures \_\_\_ Diabetes \_\_\_  
\_\_\_Infections that antibiotic treatment \_\_\_Viral Infections (Flu, Mono) \_\_\_\_\_  
Does Mom know her Rh status \_\_\_ (+ or -) Blood Type \_\_\_  
Did Mom receive Rhogam during pregnancy \_\_\_Yes \_\_\_No  
Did Mom receive any vaccinations during pregnancy \_\_\_Yes \_\_\_No, which ones \_\_\_\_\_  
Did Mom receive any vaccinations after pregnancy while breastfeeding \_\_\_Yes \_\_\_No  
Was your child delivered vaginal\_\_\_ or C-section\_\_\_  
Forceps and/or suction devices used \_\_\_\_\_ Was there any concern for birth trauma \_\_\_\_\_

**Mother's Medical History:**

\_\_\_Low Thyroid \_\_\_ Thyroid Cancer \_\_\_ Parathyroid problems \_\_\_ Nightblindness (difficulty seeing at night)  
\_\_\_ Autoimmune Disorders (Lupus, Connective Tissue, Rheumatoid Arthritis, Autoimmune Thyroid)  
Mercury Fillings in Mouth \_\_\_ Dental work that contains Nickel \_\_\_  
Other, please explain \_\_\_\_\_  
Did Mom have any dental work done during pregnancy \_\_\_Yes \_\_\_No  
Did mom have mercury fillings removed while breastfeeding child \_\_\_Yes \_\_\_No

**Family History:**

Is there a family history of Developmental Disorders, ie. Autism, PDD? Please explain:  
  
Is there a family history of other Neurological Disorders, ie. Multiple Sclerosis, etc.  
  
Is there a family history of Asthma, Allergies, Autoimmune Disorders (Lupus, Rheumatoid Arthritis, etc.)?  
  
Is there a family history of Clotting or Blood Disorders, Strokes, Hemophilia, Platelet Disorders?  
  
Is there a family history of Psychiatric Disorders, ie. Depression, Schizophrenia, etc.?  
  
Is there a family history of Genetic disorders?  
  
Is there a family history of Seizures, Vaccine Reactions?  
  
Is there a family history of Celiac Disease, or Gluten Intolerance?

**Vaccination Status:**

Has child received all the recommended vaccinations for their age? \_\_\_ Yes \_\_\_ No  
Has your child received: \_\_\_DTP \_\_\_DTaP \_\_\_MMR \_\_\_Hib \_\_\_Hep B \_\_\_OPV \_\_\_IPV  
\_\_\_Pneumonia \_\_\_Chicken Pox \_\_\_Flu \_\_\_Others (please list)\_\_\_\_\_  
Do you feel your child's behavior change after a particular vaccination? \_\_\_Yes \_\_\_No. If yes, please indicate  
which vaccine(s) \_\_\_\_\_  
How long after the above vaccine(s) did child become symptomatic? (ex. Minutes, days, etc. \_\_\_\_\_  
  
Did your child receive any vaccinations when they were sick \_\_\_Yes \_\_\_No, please explain\_\_\_\_\_  
  
Did your child suffer any vaccine reactions \_\_\_Fever \_\_\_ Inconsolable screaming \_\_\_Excessive lethargy\_\_\_  
\_\_\_Rashes \_\_\_Vomiting \_\_\_Seizures \_\_\_Other\_\_\_\_\_

**Medication Usage:**

Has child taken steroid medication \_\_\_Yes \_\_\_No. If Yes, which kind \_\_\_Inhaled \_\_\_oral

Has child taken medication for yeast/candida infection \_\_\_No \_\_\_Yes, please list \_\_\_\_\_

Is child currently taking medication for yeast \_\_\_Yes \_\_\_No

Are they taking supplements for yeast \_\_\_Yes \_\_\_No, please list \_\_\_\_\_

Please list other medication child is currently taking:

**Supplements:**

Please list all supplements child is currently taking, including nutritional oils, ie. Cod Liver, Flax, etc:

**Diet:**

Is child on a Gluten Free Diet \_\_\_Yes \_\_\_No

Is child on a Casein Free Diet \_\_\_Yes \_\_\_No

Has child benefited by being on a GF/CF diet: \_\_\_\_\_

**DAN! Therapies:**

Has child received Secretin \_\_\_No \_\_\_Yes. If yes, have they benefitted \_\_\_\_\_

Is child receiving Cod Liver Oil \_\_\_No \_\_\_Yes. Any benefits? \_\_\_\_\_

Is your child receiving Bethanocol Treatment \_\_\_No \_\_\_Yes. Any benefits? \_\_\_\_\_

Has child received IVIG (Intravenous Immunoglobulins) \_\_\_Yes \_\_\_No. Any benefits? \_\_\_\_\_

Is child currently receiving IVIG therapy \_\_\_Yes \_\_\_No

**Does child currently have Mercury/Amalgam/Silver Fillings?** \_\_\_Yes \_\_\_No

Has child received Mercury Chelation w/DMSA \_\_\_Yes \_\_\_No DMPS \_\_\_Yes \_\_\_No EDTA \_\_\_Yes \_\_\_No

Any benefits from chelation therapy? \_\_\_\_\_

Has child received Chelation Therapy for other Heavy Metals besides Mercury?

\_\_\_\_\_  
Has your child taken antifungals in the past, ie. Nystatin, Diflucan? \_\_\_Yes \_\_\_No

Is child taking Transfer Factor? \_\_\_Yes \_\_\_No Colostrum \_\_\_Yes \_\_\_No

Other DAN! Therapies \_\_\_\_\_

**Other Important Information:** If pertinent, please take the time to tell us more about the medical history of your child in relation to their autism diagnosis. If more space is needed you may use the back of this document.