Nature Doctors
Naturopathic Family Medicine Inc.
7-1200 Waverley St
Winnipeg, MB R3T 0P4
(204) 943-6079

Informed Consent

Naturopathic medicine is the treatment and prevention of diseases and disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Using a variety of treatment modalities, gentle, non-invasive techniques stimulate the body's inherent healing capacity.

Diet and Nutrition
Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.

Botanical Medicine
Botanical Medicine is a plant-based medicine using herbal teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. These compounds are also used to boost the body's immune system and prevent disease.

Homeopathic Medicine

Homeopathic Medicine seeks to stimulate the body's defense mechanisms and processes so as to prevent and treat illnesses. It is a curative system of medicine that works to restore the body's state of health, vigor and balance by using and enhancing the body's own healing, defensive and recuperative powers.

As Naturopathic Medicine is a holistic approach to health, lifestyle is considered relevant to most health problems. Your Naturopathic Doctor will help you identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment. They will do a thorough case history and a complaint-oriented physical examination. If required,(and upon client consent) the physical may include specific testing or examinations such as BIA, urine analysis, gynecological, breast, rectal, prostate or genital exams,

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Declaration and Consent to Treatment

Even the gentlest therapies have their complications. Certain conditions propose higher risk, such as: pregnancy, lactation, those on multiple medications or who have certain diseases such as diabetes, heart, liver or kidney disease, or are very young. To ensure your safety, it is very important that you inform your naturopath immediately of:

- any disease process that you are suffering from
- if you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or if you are breast-feeding

There are some potential health risks to treatment by Naturopathic Medicine. Although rare, these include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from Venipuncture, Acupuncture or Cupping
- Fainting or puncturing of an organ with Acupuncture needles

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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 others unless so directed by myself or when law requires it. I understand that I may look at my medical record at anytime and can request a copy or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of their ability. I understand that results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise their judgment during the course of procedures which they feel are in my best interest, based on the known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below):

____

____

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

I. Any treatment or advice provided to me as a patient, is not mutually exclusive from any treatment or advice that I may now be receiving, or may in the future receive from another licensed health care provider;

II. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Manitoba;

III. No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

IV. The treatment and therapies rendered or recommended by this Clinic may be different from those offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment or services that I may receive at Nature Doctors Naturopathic Family Medical Centre Inc. and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as other applicable fees. I understand that I must give **2 full business days to change or cancel an appointment**. If I do not follow this cancellation policy, or simply do not show up for my appointment, I agree to pay the full cost of the appointment.

Patient's Full Name: ____
First Middle Last

Date of Consent: ____________________
Day Month Year

ND you will be seeing: ______________________

Signature of patient or legal guardian ____________________________________

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PATIENT INTAKE FORM

Name: ____
Address: ____
City: ____________________ Province: ______ Postal Code: ______________
Phone (Home): ______________ (Work): ______________ (Cell): ______________
E-mail: ____
Sex: ________ Date of Birth: ________________________ Age: ______
Occupation: ________________ Employed By: ____________________
Past Occupations: ____
Who do you live with? __________________ Number of children: ________
Best contact # to reach you at? ____________ May we leave a message? ________
Emergency Contact: ____________ Phone: ____________ Relation: ____________
Name of Medical Doctor: __________________ Phone: ______________

How did you hear about us? Friends ❒ Family ❒ Presentation ❒ Website ❒ Other: __________
____

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless authorized by you.

Health Concerns

What are your main health concerns in order of importance to you?

____
____
____
____

Vitamins and Supplements

Please list all vitamin/mineral/herbal supplements you are currently taking:
Please bring in all supplements to initial visit*

Supplement (Including Brand)	Dosage	When did you begin this supplement?

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Medication

Please list all prescription and non-prescription medications you are currently taking:
Please bring in all medications to initial visit*

Medication	Dosage	When did you begin this medication?

Please list all prescription medications you have taken in the **past** for longer than six months. Indicate how long you took each medication.

____
____

Family History

Next to each individual listed below, please put an "L" for living or "D" for deceased, as well as present age or age at the time of death. Please indicate if the family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis…

Relationship	L/D	Age	Diseases Suffered/ Cause of Death
Mother			
Father			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Sister(s)			
Brother(s)			
Maternal Aunts			
Maternal Uncles			
Paternal Aunts			
Paternal Uncles			

Medical History

Please list any injuries and/or major surgery you have had and when they occurred:

____
____
____
____

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Please list any major illnesses or diseases that you have or have had:

____
____
____
____

Vaccinations (please check)

- ❑ DPT (Diphtheria, Pertussis, Tetanus)
- ❑ MMR (Measles, Mumps, Rubella)
- ❑ Chicken Pox
- ❑ Polio
- ❑ Flu Shot
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Other ______________

Did you experience any symptoms from them? If yes, please explain.

____
____

Review of Symptoms

Please check "✓" any of the following that apply to you or write "P" beside the box if you have experienced any in the past.

General

- ❑ Fatigue
- ❑ Change in appetite
- ❑ Change in thirst
- ❑ Cravings
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Chronic Chills or fever
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Allergies
- ❑ Cancer
- ❑ Diabetes

Skin and Hair

- ❑ Dryness
- ❑ Rash
- ❑ Itching
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Recent moles
- ❑ Hives/allergic reactions
- ❑ Loss/thinning of hair
- ❑ Dandruff
- ❑ Warts
- ❑ Other skin problem(s)

Eyes Ears Nose & Throat

- ❑ Eye pain
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Cataracts
- ❑ Ear aches
- ❑ Ear infections
- ❑ Ringing in ears
- ❑ Vertigo or dizziness
- ❑ Sinus infections
- ❑ Nasal obstruction
- ❑ Post nasal drip
- ❑ Nosebleeds
- ❑ Loss of smell/taste
- ❑ Sores in mouth
- ❑ Mercury fillings
- ❑ Jaw pain or clicks
- ❑ Recurrent sore throat
- ❑ Tonsillitis
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Facial pain/tics
- ❑ Headaches

Cardiovascular

- ❑ Chest pain
- ❑ Palpitations
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ Irregular heartbeat
- ❑ Pacemaker
- ❑ Artificial heart valve
- ❑ Stroke
- ❑ Fainting
- ❑ Varicose veins
- ❑ Deep leg pain
- ❑ Cold hands or feet
- ❑ Swelling of limbs
- ❑ Anemia
- ❑ Easy Bruising

Respiratory

- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Emphysema

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- ❑ Asthma
- ❑ Wheezing
- ❑ Coughing blood
- ❑ Phlegm in throat

Muscle Bone & Joints

- ❑ Neck pain
- ❑ Back pain
- ❑ Arthritis
- ❑ Bursitis
- ❑ Joint pain or stiffness
- ❑ Artificial joint
- ❑ Muscle pain
- ❑ Muscle weakness

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Reflux or heartburn
- ❑ Constant hunger
- ❑ Ulcer
- ❑ Indigestion
- ❑ Abdominal pain or cramping
- ❑ Bloating
- ❑ Gall stones
- ❑ Liver disease
- ❑ Jaundice
- ❑ Intestinal parasites
- ❑ Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Chronic laxative use
- ❑ Rectal burning/pain
- ❑ Hemorrhoids
- ❑ Blood in stool

Neurological

- ❑ Anxiety
- ❑ Depression
- ❑ Irritability
- ❑ Emotional problems
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Dizziness
- ❑ Seizures/Epilepsy
- ❑ Concussion
- ❑ Lack of coordination
- ❑ Extremity numbness
- ❑ Extremity tingling
- ❑ Paralysis

Infections

- ❑ Strep throat
- ❑ Mononucleosis
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Sexually transmitted disease

Urinary

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Incontinence
- ❑ Pain on urination
- ❑ Waking at night to urinate
- ❑ Urinary tract infection
- ❑ Blood in urine
- ❑ Kidney stones

Male Reproductive

- ❑ Prostate problem
- ❑ Impotence
- ❑ Sores on genitals
- ❑ Discharge
- ❑ Testicular Mass
- ❑ Testicular pain
- ❑ Infertility/low sperm count
- ❑ Hernia
- ❑ Low Libido

Female Reproductive

- ❑ Irregular periods
  - ❑ Heavy
  - ❑ Light
  - ❑ Clots
- ❑ Painful periods
- ❑ Vaginal Discharge
- ❑ Low Libido
- ❑ PMS
- ❑ Sore breasts with menses
- ❑ Infertility
- ❑ Vaginal sores
- ❑ Date of last Pap?_________
- ❑ Irregular?_______
  If yes, date?___________

Age of first menses? ________

Do you practice birth control?
Y ○ N ○

Type _______________

- ❑ Currently pregnant?
  Y ○ N ○
- ❑ Currently Breastfeeding?
  Y ○ N ○

Number of:

- ❑ Pregnancies ___________
- ❑ Abortions _____________
- ❑ Miscarriages___________
- ❑ Births ______________

Breasts

- ❑ Lumps
- ❑ Tenderness
- ❑ Nipple discharge

Do you do breast self-exams?
Y ○ N ○

Menopausal Y ○ N ○

Age of last menses_________

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Personal Habits and Lifestyle

What would you rate your current stress level? Mild Moderate High Severe
What do you feel are your main causes of stress?____________________________

Do you smoke? Y ○ N ○ If yes, how many per day? ________________________
Were you a previous smoker? Y ○ N ○ If yes, how long ago did you quit?______

Do you use recreational drugs? Y ○ N ○
Have you in the past? Y ○ N ○ is yes, what?___________________

How frequently do you move your bowels? _________ Per day or per week?___

How many hours of sleep do you get on average? ___________________________

Do you feel refreshed in the morning? Y ○ N ○

How many hours do you work each day? ________________________________

Do you exercise? Y ○ N ○ If yes, how often?______________________________

What do you do for exercise? (indicate activity, frequency, intensity and duration)
____
____

Do you have pets in the house? Y ○ N ○ Type?_______________________

Do they sleep with you on the bed? Y ○ N ○ In the room? Y ○ N ○

Have you travelled outside of North America recently? Y ○ N ○
Where to?____
Did you feel sick during/after the trip? Y ○ N ○
What symptoms did you experience? ____

Diet

Non Vegetarian ❒ Vegetarian ❒ Vegan ❒ For how long? _______

All allergies/intolerances/sensitivities:
____
____
____
____

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How many cups/bottles/glasses do you drink, on average, per day?

Coffee	Milk 2%	Fruit Juice
Tea	Skim Milk	Soft Drinks (diet)
Water	Beer	Soft Drinks (regular)
Herbal Tea	Wine	Vegetable Juice
Milk 1%	Liquor	Other

Please check "✓" the source of your drinking water.

Tap (city)		Well		Bottled (spring)		Filtered		Distilled	

Diet Diary:

Please list, in the spaces provided, every food/beverage item that you put in your mouth (excluding gum, but inclusive of EVERY OTHER food item) for a 7 day period. Please take note of any physical symptoms or sensitivities that you may experience during the course of a given day. Please take special note of gas, bloating, bowel movements, heartburn and/or any other irregularity.

***Please bring in a copy of your most recent bloodwork and/or any other relevant tests you have had done if possible. Although helpful to have this information for your first appointment, it is not crucial; so if you do not have any recent results or are unable to obtain them, your first appointment will not be impeded. Additionally, below is a Release of Information Form for our clinic. It is extremely helpful to have your consent to this information, so it can be used to access recent medical testing, after discussing with your Naturopathic Doctor. This form is optional.**

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Diet Diary

	Breakfast	Lunch	Dinner	Snacks	Notes

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Release of Information Form

I hereby authorize that confidential information about myself, and any relevant aspects of my assessment and/or treatment may be exchanged between:

Dr. MaryAnne Hembroff ND

Dr. Dara Morden ND

Dr. Melanie Leppelmann ND

Dr. Mindy Campbell ND

Dr. Jason Bachewich ND

Dr. Jessica Beatty ND

Dr. Heather Cardona HD

Dr. Eduardo Barreto HD

Dr:________________________ Clinic:________________________.

Dr. phone #:____________________ Dr. fax#:____________________

Patient Name:____________________ D.O.B:____________________

I understand that all information involved will be kept confidential from persons not authorized above.

I also understand that this authorization will remain valid for periods of six months or until I specifically withdraw my authorization by written request.

Signed: ______________________________
(Patient)

Signed: ______________________________
(Doctor)

Date:______________________________

Req:____.