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

Informed Consent

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
Homeopathy, developed in the 1700's, is based on the principle of "like cures like". A remedy is selected, which in its crude form would produce in a healthy individual the same symptoms found in a sick person suffering from the specific disease. Minute amounts of natural substances (plant, animal, mineral) are used to stimulate the body's innate ability to heal. Homeopathy is a powerful tool and effects healing on a physical and emotional level.

As Homeopathic Medicine is a holistic approach to health, lifestyle is considered relevant to most health problems. Your homeopathic doctor will help you identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment. Your homeopathic doctor will take a thorough case history and do a full physical examination. If required, the physical may include specific examinations such as 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 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 need to proceed with caution in treatment. It is very important that you inform your homeopathic 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 Homeopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs

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 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 homeopathic doctor will answer any questions that I have to the best of his/her ability. I understand that results are not guaranteed. I do not expect the homeopathic doctor to be able to anticipate and explain all risks and complications. I will rely on the homeopathic 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.

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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

Homeopathic Doctor: _______________________

X _______________________________________
Signature of patient
or legal guardian

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***We require **48 hours notice for cancellation** of your appointment so your time may be filled by someone on the waiting list.
If you do not call by 5:30pm **two business days** prior to cancel or reschedule, you will be charged for the full cost of the appointment.***

PEDIATRIC INTAKE FORM

Today's Date: ______________________________
Child's Name: ______________________________
Child's Age: ________ Date of Birth: ______________
Child's Height: ______________ Weight: __________________
Male ❐ Female ❐ Grade Level: _____________
Referred by: ______________________________
Name and relation of individual who is filling out this form: __________________________
How did you hear about us? Friends ❐ Family ❐ Presentation ❐ Website ❐
Newspaper ❐ Other: ______________________________

Contacts (in order of preference)

Name and relation to child: ______________________________
Phone: (home) __________________________ (work) ______________________________
Phone: (cell or other) ______________________________
Address: ______________________________

Name and relation to child: ______________________________
Phone: (home) __________________________ (work) ______________________________
Phone: (cell or other) ______________________________
Address: ______________________________

Whom does the child live with? ______________________________

Child's Other Health Care Providers

Provider's name: ______________________________
Designation: ______________________________
Address (if available): ______________________________
______________________________ Phone: ______________________________

Provider's name: ______________________________
Designation: ______________________________
Address (if available): ______________________________
______________________________ Phone: ______________________________

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Health Concerns

Please list the child's health concerns in order of importance.

1. Primary health concern: ____
____

At what age did this condition/illness begin: ______________________________
What do you think might have caused this condition? _______________________
____
____

What other (possibly unrelated) events occurred around the time the condition began? _________
____
____

What, if any, medications or supplements have been used to treat this condition and what was their effectiveness? ____
____

Other health concerns:
2. ____
3. ____
4. ____
5. ____

Prenatal Health and History

What was the health of the parents at the time of conception?
Mother: ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown
Father: ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown

What was the health of the mother during pregnancy?
❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown

What was the emotional state of the mother during pregnancy?
❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown

How was the mother's diet during pregnancy?
❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown

Did the mother receive medical care during pregnancy? ❒Yes ❒No ❒Unknown
What was the mother's age at the time of the child's birth?_______________________
How many previous pregnancies and births did the mother have? __________________
What was the mother's occupation during pregnancy? ___________________________

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Did the mother experience any of the following during pregnancy?
❒ Bleeding ❒ High blood pressure ❒ Nausea ❒ Vomiting
❒ Diabetes ❒ Thyroid problems ❒ Physical or emotional trauma
❒ Other: ____

Did the mother use any of the following during pregnancy?
❒ Tobacco ❒ Alcohol ❒ Recreational drugs: ______________________
❒ Prescription medications: ______________________
❒ Over-the-counter medications: ______________________
❒ Vitamins and/or supplements: ______________________
❒ Other: ____

Were any of the following interventions used during pregnancy?
❒ Ultrasound ❒Amniocentesis ❒ Chorionic Villi Sampling ❒ Triple Screen
❒ Maternal Serum Screening ❒ Other: ______________________

Birth History

Term length: ❒ Pre-term (37 weeks or less): __________ weeks
❒ Full-term (38-42 weeks): __________ weeks
❒ Post-term (more than 42 weeks): __________ weeks

Location of birth: ❒ Hospital ❒ Home ❒ Birthing Center ❒ Other: ______________

Type of birth: ❒ Vaginal ❒ C-section

Types of Intervention:
❒ Induced labour ❒ Use of forceps ❒ Epidural/Anesthesia ❒ Episiotomy
❒ Other: ____

Were there any complications during delivery (e.g., breech delivery)? ______________
____

Length of labour: __________ Weight of infant at birth: ______________________
APGAR score (0 to 10): 1minute _______ 2 minutes _______ 5 minutes: ______________

Did the child experience any of the following at or shortly after birth?
❒ Jaundice ❒ Rashes ❒ Seizures ❒ Birth injuries: ______________________
❒ Infections: ____
❒ Difficulties with feeding: ______________________
❒ Birth defects: ______________________
❒ Other: ____

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Dietary History

How was the infant fed?
❒Breast fed ❒ Formula (milk/soy/other): ____________________
❒Other: ____________________
How long was the infant fed this way? ____________________
Did the infant have any reactions to what they were being fed? ____________________
____

What foods were introduced before 6 months? (Please list the approximate month that each food was introduced, as well as any reactions that may have occurred).
____
____
____

What foods were introduced between 6 and 12 months? Were there any reactions to these foods?
____
____
____

Did the child ever experience Colic? ❒Yes ❒No
If yes, how severe was the colic? ❒Mild ❒Moderate ❒Severe

Please list any food allergies or intolerances that the child has: ____________________
____
____
____

Does the child have any dietary restrictions (vegetarian/vegan, religious, etc.)?
____
____
____

Describe the child's usual diet on a typical day:
Breakfast: ____________________
Lunch: ____________________
Dinner: ____________________
Snacks: ____________________
Beverages (include total quantity): ____________________

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Please describe the child's eating habits (e.g., good appetite, picky eater, etc.):
____
____
____

Medical History

Has the child ever experienced any of the following illnesses?
❒ Rubella ❒ Mumps
❒ Measles ❒ Chickenpox
❒ Whooping Cough ❒ Asthma
❒ Scarlet Fever ❒ Polio
❒ Rheumatic Fever ❒ Other: ____________________________________

Has the child ever experienced any of the following conditions?
❒ Diaper Rash ❒ Cradle Cap ❒ Diarrhea ❒ Constipation ❒ High fever
❒ Heat or cold intolerance ❒Trouble with bedwetting ❒ Frequent colds
❒ Ear infections
If they have has ear infections, how many and how often? ____________________________

Has the child received any of the following vaccinations?
❒ DPT ❒ MMR ❒ HIB ❒ Polio ❒ TB ❒ Flu
❒ Smallpox ❒ Pneumovaccine ❒ Chickenpox
❒ Other: ____

Did the child have any adverse reactions to, or chronic illness, following vaccination? ________
____
____

Has the child ever been hospitalized? ❒Yes ❒No
If yes, for what reason? ____
____
How long was the child in the hospital or under care? ______________________________
____

Has the child ever had any significant physical or emotional traumas? ____________________
____
____

Please list any medications and/ or supplements the child is currently taking: ______________
____

____

Does the child have any known drug allergies? ❒Yes ❒No
If yes, please list drug allergies: ____________________________________
____
____

Health and Development

How was the child's health in the first year?
❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown

How is the child's health now? ❒Poor ❒Fair ❒Good ❒Excellent ❒Unknown

At what age did the child first:
Sit up ______________ Crawl ______________ Walk _______________ Talk _______________
At what age did the child begin teething? ____
Were there any difficulties associated with teething?____

Sleep Patterns

What time does the child usually go to bed? ____
What time does the child usually wake in the morning? ______________________________

Does the child nap during the day? ❒Yes ❒No
If yes, what time(s) do they nap? ____

Does the child have nightmares? ❒Yes ❒No
If yes, how often do they have nightmares? ____

Does the child have any problems associated with sleeping? ❒yes ❒no
If yes, what kind of trouble do they have (e.g., trouble falling asleep, trouble waking up, etc.)? ____
____

Social Patterns

Is the child in: ❒school ❒daycare ❒home care ❒other: ___________________________

How would you describe the child's behaviour at school?__________________________________
____
____

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How would you describe the child's behaviour at home? ______________________________
____
____

What are the child's interests and favourite activities? ________________________________
____

What, if any, recreational activities are the child involved in?___________________________
____

How would you describe the child's temperament/personality? ___________________________
____

Is there anything that you would want to change? ____________________________________

Does the child exercise regularly? ❒Yes ❒No
How much and how often do they exercise? ____
____

How much television does the child watch? ________ hours a day/week.

How often does the child read (not for school), **or** How often does someone read to the child?
❒ Daily ❒ Several times a week ❒Weekly ❒ Less than weekly

Family History

Please indicate if a close relative (parent, grandparent, sibling) has had any of the following:

Condition	Relative	Condition	Relative
❒ Allergies		❒ Seizures	
❒ Anemia		❒ Stroke	
❒ Arthritis		❒ Diabetes	
❒ Asthma		❒ Eczema	
❒ Birth Defects		❒ Glaucoma	
❒ Bleeding Disorder		❒ Kidney Disease	
❒ Cancer		❒ Psoriasis	
❒ Hay Fever		❒ Depression	
❒ High Blood Pressure		❒ Tuberculosis	
❒ Juvenile Arthritis		❒ Mental Illness	

❒ I don't know the family medical history

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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			

Do either of the parents of the child have a chronic illness? ❐Yes ❐No
If yes, please describe: ____
____

Environment

Are there any pets in the home? ❐ Yes ❐No
If yes, what type and how many? ____
____

Does anyone in the child's household smoke? ❐Yes ❐No

How is the child's home heated? ____

Do you know of any toxins or other hazards that the child is regularly exposed to? ❐yes ❐no
If yes, please describe: ____
____
____

How would you describe the emotional climate of the child's home? ____________________
____

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____
____

Does the child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)? ____
____
____

Is there anything that you feel is important that has not been covered?___________________
____
____
____
____
____
____

Diet Diary:

On the following page, you will find a Diet Diary. Please list, in the spaces provided, every food item that the child puts into their mouth (excluding gum, but inclusive of EVERY OTHER food item) for at least a 7 day period. Please take note of any physical symptom or sensitivities that they may experience during this exercise and note them in the 'notes' section provided.

If at any time, you have questions or concerns, please feel free to contact the office by phone at (204) 943-6079.

Diet Diary

Breakfast							
Lunch							
Dinner							
Snacks							
Notes							

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