

## **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.

### **Traditional Chinese Medicine (TCM)**

TCM includes acupuncture, as well as botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of small disposable, sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes Moxa (a compressed herb), Cupping Therapy or Guasha is used over the skin at or near specific points on the body in order to stimulate the body's energy. Botanical formulas may be given in the form of pills, tinctures, herbal extract powders or decoctions (strong teas) to be taken internally or used externally as a wash, poultice, salve or fomentation.

### **Bowen Therapy**

Bowen is a soft tissue relaxation technique that enhances the body's innate ability to restore and heal itself. The Bowen technique relieves muscle tension and restores normal lymphatic flow without deep muscle work. The treatment is long lasting and the effects profound.

### **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.

### **Physical Medicine**

This includes the use of various hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation, therapeutic ultrasound and heating lamps for treating musculoskeletal and neurological problems. Hydrotherapy refers to the use of hot and cold-water applications to improve circulation and stimulate the immune system.

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. Your naturopathic doctor will take a thorough case history; do a full physical examination, BIA Analysis and urine analysis. If required, the physical may include specific examinations such as gynecological, breast, rectal, prostate or genital exams.

## 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 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. 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, accidental burning of the skin from the use of Moxa or Cupping
- Muscle strains, sprains or disc injures from spinal manipulation
- The potential for stroke in neck manipulation  
(Tests will be done to screen for this possibility. Clinical research has shown that stroke-like occurrences are rare, occurring approximately 1 in 1.5 million manipulations).

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 naturopathic 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 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):

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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.



## PATIENT INTAKE FORM

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

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

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

E-mail: \_\_\_\_\_

Male  Female  Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Marital Status: \_\_\_\_\_ 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   
Newspaper  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?

**Medications**

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.

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**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:

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**Vaccinations (please check)**

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Flu Shot    |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella)        | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Chicken Pox                          | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Polio                                | <input type="checkbox"/> Other _____ |

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

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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
- 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 of hair
- Thinning hair

- Dandruff
- Other skin problem(s)

**Eyes Ears Nose & Throat**

- Eye pain
- Eye strain
- Blurry vision
- Impaired 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
- 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

### Female Reproductive

- Irregular periods
  - Heavy
  - Light
  - Clots
- Painful periods
- PMS
- Sore breasts with menses
- Infertility
- Vaginal sores

- Vaginal discharge

Date of last Pap \_\_\_\_\_

Irregular? \_\_\_\_\_

If yes, date? \_\_\_\_\_

Age of first menses \_\_\_

Menopausal Y  N

Age of last menses \_\_\_\_\_

Currently pregnant? Y  N

Currently Breastfeeding?

Y  N

Do you practice birth control?

Y  N

Type \_\_\_\_\_

Number of:

• Pregnancies \_\_\_\_\_

• Abortions \_\_\_\_\_

• Miscarriages \_\_\_\_\_

• Births \_\_\_\_\_

### Breasts

- Lumps
- Tenderness
- Nipple discharge

Do you do breast self-exams?

Y  N

### 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

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

Diet: Non Vegetarian  Vegetarian  Vegan  For how long? \_\_\_\_\_

Known Food Allergies/Intolerance:

\_\_\_\_\_

Known Environmental Allergies/Sensitivities:

\_\_\_\_\_

\_\_\_\_\_

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	
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**Diet Diary:**

Please list, in the spaces provided, every food item that you put in your mouth (excluding gum, but inclusive of EVERY OTHER food item) for at least 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.

Diet Diary


Breakfast

Lunch

Dinner

Snacks

Notes