Naturopathic Treatment Informed consent

Naturopathic medicine and care is a unique primary health care system that combines standard medical diagnostics and knowledge with traditional, natural and gentle therapies. The goal is to understand the individual, address the underlying cause and improve health and well-being.

I, _____, understand that the form of medical care is based on naturopathic principles and practices.

I will completely disclose and inform my Naturopathic Doctor of all my health concerns and conditions, allergies, medications, supplements and medical interventions.

I will inform my Naturopathic Doctor if I suspect or become pregnant and/or if I am breastfeeding.

I understand that my identity will be protected and kept confidential.

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 release to others without my consent, unless required by law.

I understand that I may look at my medical record and can request a copy by paying a fee.

I understand that the Naturopathic Doctor will answer any questions that I have to the best of their ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications.

I understand that although the naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to:
- Aggravation of pre-existing conditions and symptoms
- Allergic reactions to supplements or botanical prescriptions
- Pain, bruising, fainting or puncturing or an organ with acupuncture needles

I understand that fees and supplements are to be paid for at the time of the consultation.

I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice.

PATIENT CONSENT
- I have read and understand the above-stated policies and information
- I intend this consent form to cover the entire course of treatment
- I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time (written or verbal format)

Patient Name: _____ Date: _____

Patient Signature: _____

Naturopathic Doctor: _____

INTAKE FORM
GENERAL PATIENT INFORMATION

Date: _____

Name: _____ Age:_____ Date of birth:_____ Sex: F / M
Address:_____ City:_____ Postal Code:_____
Home phone:_____ Cell or other phone:_____

May we leave messages relating to your visits? Y / N Which phone number? _____

How did you find out about naturopathic services at the centre? If referred, please indicated from whom _____

Email address: _____

Would you like to receive our electronic health newsletter? Yes No

Person to notify in case of emergency: _____

Phone number: _____ Relationship: _____

Other health care providers (name and phone number):

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

HEALTH CONCERNS
What is the main reason that you are here for today? _____

What are your health concerns or health goals, in order of importance to you:

Concern	**When did it start**	**Any treatments and the result**
1		
2		
3		
4		
5		

How would you describe your general state of health? Poor Fair Good Excellent

If you are female, are you currently pregnant? Yes No (Please circle one)

Allergies

Do you have any hypersensitivity or allergy to any drugs? _____

Do you have any food allergies or intolerances? _____

Do you have any environmental sensitivity? _____

MEDICAL HEALTH HISTORY

Current medications (prescription, over the counter, birth control)

Medication	Dose per day	What purpose	Date when started

Current Supplements or Herbs

Supplement or Herbs	Dose per day	What purpose	Date when started

Check if you have used any of the following:

☐ Anti-depressants	☐ Epidurals
☐ Antacids	☐ Flu vaccines
☐ Anti-histamines	☐ Hormone therapy
☐ Blood thinners	☐ Laxatives
☐ Chemotherapy	☐ Pain relievers (aspirin)
☐ Cortisone (or other steroids)	☐ Sleeping pills
☐ Diuretics	☐ Thyroid medications
☐ Drugs for arthritis	☐ Vaccination for foreign travel

Any adverse events or allergic reactions to any of the above? Yes No (Please circle one)

List all hospitalizations, surgeries and accidents

Description	Year	Outcome

Date of last physical exam: _____

FAMILY HEALTH HISTORY (Grandparents, parents, siblings, children—insert where applicable)

	Who & Age		Who & Age
Allergies		High blood pressure	
Arthritis		High cholesterol	
Asthma		Heart disease	
Cancer		Mental illness	
Depression		Osteoporosis	
Drug abuse or alcoholism		Stroke	
Diabetes		Thyroid problems	

PERSONAL HEALTH HABITS

Height: ____ Weight: ____ Weight 1 year ago: ____ Maximum weight: _____When? _____

Smoker: Yes / No # of years smoking ____ Packs/day: ____ Quit? If so, year stopped: _____

Alcohol use: Yes / No Type: _____ Frequency: _____

Recreational drug use: Yes / No Type: _____ Frequency: _____

Sleep

How many hours of sleep do you get a night? _____
Do you have difficulty falling asleep? Yes / No
Do you have difficulty staying asleep? Yes / No
Do you wake up feeling rested? Yes / No

Regular exercise: Yes / No Type: _____ Duration: _____ Frequency: _____

On a scale of 1 to 10, with 10 being the highest, please rate your average ENERGY level:_____

On a scale of 1 to 10, with 10 being the highest, please rate your average STRESS level: _____

What are 3 major contributors to STRESS in your life?

1. _____
2. _____
3. _____

Diet (typical day)

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Fluid intake: _____

Coffee: Yes / No _____ cups/day Tea: Yes / No _____ cups/day Water: ____ cups/day

Do you have any dietary restrictions? Yes / No If so, please specify _____

Toxin exposure

Do you live near power lines? Yes / No
Do you have mercury dental fillings? Yes / No
Have you ever lived in a house more than 50 years old? Yes / No
Have you been exposed to mould, lead paint, heavy metals or other toxic substances? Yes / No

REVIEW OF SYSTEMS: Circle N for conditions you have NOW; P for those you've had in the PAST

SKIN

Rash	N P	Colour change	N P
Hives	N P	Lump	N P
Psoriasis/eczema	N P	Itchiness	N P
Dryness	N P	Warts/moles	N P
Cancer	N P	Excessive perspiration	N P

HEAD

Headache	N P	Migraine	N P
Dandruff	N P	Head injury	N P
Oily/dry hair	N P	Hair loss	N P

NOSE

Frequent colds	N P	Nosebleeds	N P
Congestion	N P	Post nasal drip	N P
Nasal polyps	N P	Seasonal allergies	N P

EYES

Dryness	N P	Blurry vision	N P
Double vision	N P	Cataracts	N P
Glaucoma	N P	Styes	N P
Eye strain	N P	Discharge	N P
Itchiness	N P	Dark under eyes/eyelids	N P

MOUTH

Canker sores	N P	Cold sores	N P
Sore throat	N P	Gum disease	N P
Dentures	N P	Cavities	N P
Loss of taste	N P	Hoarseness	N P

RESPIRATORY

Cough	N P	Tuberculosis	N P
Shortness of breath	N P	Bronchitis	N P
Wheezing	N P	Pneumonia	N P
Asthma	N P		

CARDIOVASCULAR

High blood pressure	N P	Rheumatic fever	N P
Low blood pressure	N P	Murmur	N P
Arrhythmias	N P	Palpitations	N P
Edema or swelling	N P	Chest pain	N P

URINARY TRACT

Incontinence	N P	Pain with urination	N P
Frequent urinary infections	N P	Kidney stones	N P
Urgency	N P	Discharge/blood	N P

GASTROINTESTINAL

Heartburn/reflux	N P	Frequent bowel movements	N P
Indigestion	N P	Diarrhea/constipation	N P
Bloating	N P	Hemorrhoids	N P
Nausea or vomiting	N P	Gall bladder disease	N P
Blood or mucous in stool	N P	Liver disease	N P
Change in appetite	N P	Ulcers	N P
Itching around anus	N P		

MUSCULOSKELETAL

Weakness	N P	Arthritis	N P
Stiffness	N P	Leg cramps	N P
Tremors	N P	Pain	N P

NERVOUS SYSTEM

Paralysis	N P	Sciatica	N P
Tingling/numbness	N P	Carpal tunnel syndrome	N P
Seizures	N P	Fainting	N P

MENTAL/EMOTIONAL

Depression	N P	Anger/irritability	N P
Suicide	N P	High-strung/tense	N P
Anxiety	N P	Fear/panic	N P
Eating disorder	N P		N P

MALE SYSTEM

Testicular pain/swelling	N P	Sexually active	N P
Hernia	N P	S.T.D.	N P
Discharge	N P	Prostate disease/problems	N P
Impotence	N P	Last prostate exam	

FEMALE SYSTEM

Menses			
Age of first menses		Heavy menstrual bleeding	N P
Duration of menses		Menstrual cramping	N P
Length of cycle		PMS	N P
		Clots in menstrual blood	N P

Reproduction			
Number of pregnancies		Hysterectomy	N P
Number of live births			
Miscarriage	N P		
Abortions	N P		
Date of last PAP smear			
Any abnormal PAP smear? If so, when?	N P	Sexually active	N P
STI/STD	N P	Healthy libido	N P
Menopausal? If so, age of last menses	N P	Bone density test	N P
Vaginal dryness	N P	Mammography	N P
Pain with intercourse	N P	Self-breast examination	N P

Do you feel there is anything else important that has not been covered?

Welcome to St. George Wellness Centre!