

## *Statement Of Acknowledgement And Consent To Examination And Treatment By Naturopathic Medicine*

Naturopathic medicine uses non-invasive methods of assessing the bodily functions and the use of natural therapeutics for correction. Even the gentlest therapies have the complications in certain physiological conditions such as pregnancy, lactation, in patients who are very young or very old, or in people taking many medications. Some therapies must be used with caution in certain diseases such as diabetes, lung, heart, liver or kidney disease. It is very important that you are completely honest in informing your ND of any disease process currently going on in you body, if you are on prescription medication or over-the-counter drugs. If you are pregnant, suspect that you're pregnant or breastfeeding, please advise your ND immediately.

There are some slight health risks to treatment of Naturopathic Medicine. These include, but are not limited to:

- Aggravation of pre-existing conditions and symptoms.
- Allergic reactions to supplements or botanical preparations.
- Pain, fainting, bruising or injury from venipuncture or acupuncture.

In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your co-operation in signing this statement of acknowledgement and in so doing:

1. You understand that I am a Naturopathic Doctor, and not a conventional medical doctor; that I use non-invasive, natural methods of assessment and treatment of body dysfunctions, That any treatment you receive is not mutually exclusive from any other treatment or advice you may now be receiving or may receive in the future from another licensed health care provider.
2. You understand that methods I may use have a proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.
3. You understand that I am required by my licensing board to perform a physical examination as deemed necessary on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is deemed acceptable.
4. You understand that treatment and/or referral to other health practitioners is based on the assessment of your health, revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.
5. You understand I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended.
6. You are not an agent of any private or government agency attempting to gather information without so stating your intentions.
7. You understand that while changes in dietary habits are not an absolute prerequisite for treatment, failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.
8. You are accepting or rejecting this care of your own free will.



Address: \_\_\_\_\_ City: \_\_\_\_\_  
Province: \_\_\_\_ P/C: \_\_\_\_\_

Phone: H - (\_\_\_\_) \_\_\_\_-\_\_\_\_ W - (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Ext: \_\_\_\_  
Where can we leave a message? H W

Email: \_\_\_\_\_

Date of Birth: (dd/mm/yyyy) \_\_\_\_\_ Age: \_\_\_\_ Sex: F / M

How did you hear about our clinic? \_\_\_\_\_

**Other Health Care Providers:**

Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Phone: \_\_\_\_\_

**Emergency contact: Name:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Main Health Concerns**

Rank your health concerns in order of importance.

When did it begin?

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |

**General Information**

How would you rate your current health status? Excellent Good Fair Poor

Current weight: \_\_\_\_\_ Ideal Weight: \_\_\_\_\_  
Maximum Weight: \_\_\_\_\_ When: \_\_\_\_\_

What do you usually eat and drink for:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

Do you have any food allergies or intolerances?

Do you have any dietary restrictions? (religious, vegan, vegetarian, etc.)

How many antibiotic treatments have you received?

0 - 5 times    6 - 13 times    more than 13 times

Do you get regular screening tests from another doctor? (Pap, physical, blood work)    Y/N

Date of last physical exam: \_\_\_\_\_

List any medications/supplements that you have taken or are currently taking.

(P = past / C = current)

Starting Age	P/C	Medication/Supplement	Illness	Adverse Reactions

If known, please list the immunizations that you have received:

DPT (diphtheria, pertussis, tetanus)	H.influenza B	Hepatitis A
Tetanus booster	"flu shot"	Hepatitis B
MMR (measles, mumps, rubella)	Polio	Small pox

**Hospitalizations:**

Year	Operation/Illness

**Lifestyle information**

How often do you do the following?:

Smoke Cigarettes \_\_\_\_\_ Drink Coffee/tea \_\_\_\_\_  
 Drink Alcohol \_\_\_\_\_ Drink Water \_\_\_\_\_  
 Use Recreational Drugs \_\_\_\_\_ Which one(s): \_\_\_\_\_

Indicate the emotional climate of your home:      Very stable    Stable    Stressful    Very Stressful  
 Comments: \_\_\_\_\_

Indicate if any of the members living in your household smoke:    Yes/No

How many hours per week do you exercise?    None    1 - 3 hrs    4 - 6 hrs    more than 6 hours

How many hours of sleep, on average, do you get each night?  
 Less than 6    6 - 8 hrs    more than 8 hrs

How many hours do you work outside the home per week?  
 None    1 - 8 hrs    8 -16 hrs    16-35 hours    35-40 hours    more than 40 hours

If sexually active, please answer the following two questions:

Form of contraception used:

Birth Control Pill      Condom    Diaphragm      IUD    Sponge    Cervical Cap  
 Other \_\_\_\_\_

**Family Health History**

Indicate if anyone in your family has had any of the following health problems:

Health Problem	Relationship to the patient	Age of onset
Hypertension		
Cancer		
Diabetes		
Asthma		
Allergies		
Heart Problems		
Other		

***Review of systems***

**Y= yes, currently    P= in the past    N= no, never**

<b>SKIN</b>			<b>EYES</b>		
Acne, boils	Y	P	N	Cataracts	Y P N
Psoriasis	Y	P	N	Glaucoma	Y P N
Eczema/rash	Y	P	N	Pain	Y P N
Night sweats	Y	P	N	Redness	Y P N
Change in mole	Y	P	N	Blurred vision	Y P N
Colour/texture changes	Y	P	N	Changes in vision	Y P N
Thinning hair	Y	P	N	Floaters (spots in vision)	Y P N
Temperature changes	Y	P	N	Double vision	Y P N
Dryness	Y	P	N	Bothered by sun	Y P N
Excessive sweating	Y	P	N	Glasses/contacts	Y P N
Lumps	Y	P	N	Discharge/tearing	Y P N
Easy bruising/slow healing	Y	P	N		
Nail changes	Y	P	N		
Itching	Y	P	N		
<b>NOSE</b>			<b>HEAD</b>		
Discharge	Y	P	N	Headache	Y P N
Polyps	Y	P	N	Dizziness	Y P N
Itchy	Y	P	N	head injury	Y P N
Sinus infection	Y	P	N		
Post-nasal drip	Y	P	N	<b>NECK</b>	
Frequent colds	Y	P	N	Enlarged glands	Y P N
Nose bleeds	Y	P	N	Thyroid issues	Y P N
Hay fever	Y	P	N	Pain/stiffness	Y P N
Stuffiness	Y	P	N		
<b>THROAT/MOUTH</b>			<b>EARS</b>		
Sore throat	Y	P	N	Changes in hearing	Y P N
Difficulty swallowing	Y	P	N	Hearing aid	Y P N
Bad breath	Y	P	N	Earaches	Y P N
Cavities	Y	P	N	Ear infection	Y P N
Changes in taste	Y	P	N		
Sore tongue	Y	P	N		
Times per day brushing teeth					
Last visit to dentist					
<b>GASTROINTESTINAL</b>			<b>RESPIRATORY</b>		
Flatulence	Y	P	N	Frequent infections	Y P N
Burping	Y	P	N	Pneumonia	Y P N
Bloating	Y	P	N	Cough	Y P N
Diarrhea	Y	P	N	Yellow/green phlegm	Y P N
Constipation	Y	P	N	Wheezing	Y P N
Blood in stools/black stools	Y	P	N	Asthma	Y P N
Grey stools	Y	P	N	Spitting up blood	Y P N
Stomach ache	Y	P	N	Shortness of breath	Y P N
Abdominal cramping	Y	P	N	Bronchitis	Y P N
Changes in appetite	Y	P	N	Tuberculosis exposure	Y P N

Lack of appetite	Y	P	N	Pain	Y	P	N
# of bowel movements/day				Last chest Xray			
Vomiting	Y	P	N				
Nausea	Y	P	N				
Heartburn	Y	P	N	<b>URINARY</b>			
Sour taste in mouth	Y	P	N	Blood in urine	Y	P	N
Food intolerances/allergies	Y	P	N	Urinary tract infection	Y	P	N
Gallbladder removed	Y	P	N	Urgency	Y	P	N
Hemorrhoids	Y	P	N	Incontinence	Y	P	N
Changes in bowel habits	Y	P	N	Kidney stones	Y	P	N
Indigestion	Y	P	N	Frequency at night	Y	P	N
				Difficulty urinating	Y	P	N
				Change in frequency	Y	P	N
<b>FEMALE REPRODUCTIVE</b>				<b>MALE REPRODUCTIVE</b>			
Menstrual cramps	Y	P	N	Pain in testicles	Y	P	N
PMS	Y	P	N	Changes in scrotum	Y	P	N
Periods regular	Y	P	N	Discharge	Y	P	N
Heavy flow	Y	P	N	Sores	Y	P	N
Pain during intercourse	Y	P	N	STD	Y	P	N
Vaginal discharge	Y	P	N	Sexual difficulties	Y	P	N
Vaginal itchiness	Y	P	N	Hernia	Y	P	N
Yeast infection	Y	P	N	Breast changes	Y	P	N
Sexual difficulties	Y	P	N				
STD	Y	P	N				
Breast self-exams	Y	P	N	<b>MUSCLES/SKELETON</b>			
Uterine fibroids	Y	P	N				
Breast tenderness	Y	P	N	Back pain	Y	P	N
Nipple discharge	Y	P	N	Joint pain/stiffness	Y	P	N
Breast lumps	Y	P	N	Arthritis	Y	P	N
Age of first menses				Broken bones	Y	P	N
Length of cycle				weakness	Y	P	N
Length of period				Spasms/cramps	Y	P	N
Age of menopause				Joint swelling	Y	P	N
<b>PERIPHERAL VASCULAR</b>				<b>CARDIOVASCULAR</b>			
Varicose veins	Y	P	N	High blood pressure	Y	P	N
Cold extremities	Y	P	N	Palpitations	Y	P	N
Swelling in hands or legs	Y	P	N	Irregular heartbeat	Y	P	N
Aching legs	Y	P	N	Coronary artery disease	Y	P	N
Numbness	Y	P	N	Fatigue with exertion	Y	P	N
Ulcers on extremities	Y	P	N	Murmur	Y	P	N
				Congenital heart condition	Y	P	N
				Chest pain	Y	P	N
<b>ENDOCRINE</b>				<b>EMOTIONAL</b>			
Diabetes	Y	P	N	Anxiety	Y	P	N
Excessive thirst	Y	P	N	Low mood	Y	P	N
Excessive hunger	Y	P	N	Depression	Y	P	N

Excessive sweating	Y	P	N	Panic attacks	Y	P	N
Fatigue	Y	P	N	Insomnia	Y	P	N
Low blood sugar	Y	P	N	Rage	Y	P	N
Heat/cold intolerance	Y	P	N	Mood swings	Y	P	N
Hormone therapy	Y	P	N	Phobias/fears	Y	P	N
				Nightmares	Y	P	N

Have you travelled outside of Canada in the past five years?      Y                      N  
 Where? \_\_\_\_\_

How motivated are you to change lifestyle factors if necessary?  
 1      2      3      4      5      6      7      8      9      10

Is there anything you would like me to know that has not been covered?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

***THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INTAKE FORM!***

***I LOOK FORWARD TO WORKING WITH YOU.***