Nature Doctors
Naturopathic Family Medicine Inc.
7-1200 Waverley St
Winnipeg, MB 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 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.

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.

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:
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;

I. 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;

II. 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;

III. 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: _____

Date of Consent:_____

Homeopathic Doctor: _____

X _____
Signature of patient
or legal guardian

***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.***

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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?

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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.

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 adverse effects from them? If yes, please explain.

_____

_____

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 or 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

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- ❑ 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

Urinary

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

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 ○

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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 ○

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:
_____

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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 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.

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Diet Diary

	Breakfast	Lunch	Dinner	Snacks	Notes