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: _____
_____

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_____

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.

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Diet Diary

	Breakfast	Lunch	Dinner	Snacks	Notes