

## **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.

### **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**

Homeopathic Medicine seeks to stimulate the body's defense mechanisms and processes so as to prevent and treat illnesses. It is a curative system of medicine that works to restore the body's state of health, vigor and balance by using and enhancing the body's own healing, defensive and recuperative powers.

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. They will do a thorough case history and a complaint-oriented physical examination. If required, (and upon client consent) the physical may include specific testing or examinations such as BIA, urine analysis, gynecological, breast, rectal, prostate or genital exams,

## **Declaration and Consent to Treatment**

Even the gentlest therapies have their complications. Certain conditions propose higher risk, 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. To ensure your safety, 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. Although rare, 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

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 or 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 their 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):



Who do you live with? \_\_\_\_\_ 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  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?

## Medication

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:

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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 symptoms from them? If yes, please explain.

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**Review of Symptoms**

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**

- |   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Cravings    | <input type="checkbox"/> Chronic Chills or fever |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Night sweats            |
| <input type="checkbox"/> Change in thirst   | <input type="checkbox"/> Weight loss | <input type="checkbox"/> Sweat easily            |
|   | <input type="checkbox"/> Poor sleep  | <input type="checkbox"/> Allergies               |

- Cancer
- Diabetes

**Skin and Hair**

- Dryness
- Rash
- Itching
- Eczema
- Psoriasis
- Acne
- Recent moles
- Hives/allergic reactions
- Loss/thinning of hair
- Dandruff
- Warts
- Other skin problem(s)

**Eyes Ears Nose & Throat**

- Eye pain
- Eye strain
- Blurry 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
- Low Libido

- Date of last Pap? - \_\_\_\_\_
- Irregular? \_\_\_\_\_  
 If yes, date? \_\_\_\_\_

- Pregnancies \_\_\_\_\_
- Abortions \_\_\_\_\_
- Miscarriages \_\_\_\_\_
- Births \_\_\_\_\_

**Female Reproductive**

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

Age of first menses? \_\_\_\_\_

Do you practice birth control?

Y  N

Type \_\_\_\_\_

Currently pregnant?

Y  N

Currently Breastfeeding?

Y  N

Number of: \_\_\_\_\_

**Breasts**

- Lumps
- Tenderness
- Nipple discharge

Do you do breast self-exams?

Y  N

Menopausal Y  N

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

**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

Have you in the past? Y  N  is yes, what? \_\_\_\_\_

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**

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

All allergies/intolerances/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/beverage item that you put in your mouth (excluding gum, but inclusive of EVERY OTHER food item) for 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.

**\*Please bring in a copy of your most recent bloodwork and/or any other relevant tests you have had done if possible. Although helpful to have this information for your first appointment, it is not crucial; so if you do not have any recent results or are unable to obtain them, your first appointment will not be impeded. Additionally, below**

is a Release of Information Form for our clinic. It is extremely helpful to have your consent to this information, so it can be used to access recent medical testing, after discussing with your Naturopathic Doctor. This form is optional.



Diet Diary


Breakfast

Lunch

Dinner

Snacks

Notes

# Nature Doctors

Naturopathic Family Medicine Inc.

7-1200 Waverley St.

Winnipeg, MB, R3T 0P4

phone: (204) 943-6079 fax: (204) 489-3128

## Release of Information Form

I hereby authorize that confidential information about myself, and any relevant aspects of my assessment and/or treatment may be exchanged between:

Dr. MaryAnne Hembroff ND

Dr. Jason Bachewich ND

Dr. Dara Morden ND

Dr. Cory Storm ND

Dr. Melanie Leppelmann ND

Dr. Lori Mae Janzen ND

Dr. Erin Wiebe ND

Dr. Janice Fyfe ND

Dr. Aminder Singh ND

Dr: \_\_\_\_\_ Clinic: \_\_\_\_\_

Dr. Phone#: \_\_\_\_\_ Dr. Fax#: \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B \_\_\_\_\_

PHIN#: \_\_\_\_\_ MHSC#: \_\_\_\_\_

I understand that all information involved will be kept confidential from persons not authorized above.

I also understand that this authorization will remain valid for periods of six months or until I specifically withdraw my authorization by written request.

Signed: \_\_\_\_\_  
(Patient)

Signed: \_\_\_\_\_  
(Doctor)

Date: \_\_\_\_\_

Requesting: \_\_\_\_\_