

Informed Consent to Treatment

General Information

This form applies to patients of Priority Massage and Health – Naturopathic Medicine. By consenting to treatment, your naturopathic doctor will have access to your file and personal information.

Though gentle, naturopathic therapies have complications associated with certain conditions. It is **essential** to be complete in informing your doctor of your current state of physical and mental health, if you are on prescription, over-the-counter or recreational drugs, or if you suspect you are pregnant or are currently breastfeeding.

There are some minor risks associated with naturopathic therapies which include but are not limited to: bruising, pain or injury from venipuncture or acupuncture, fainting, organ puncture from acupuncture, aggravation of pre-existing symptoms and conditions, allergic reactions to botanicals or supplements, muscle sprains, strains or disc injury from spinal manipulation. The utmost care will be taken to prevent such outcomes.

Patient Consent to Treatment

1. This is to acknowledge that I have been informed and understand that any advice or treatment that I receive as a patient at this clinic is not mutually exclusive from any other treatment I am currently receiving or may in the future receive from another licensed health care provider.
2. I understand that I may seek and/or continue to receive medical care from another healthcare provider qualified to practice in Ontario.
3. I understand that no one at this clinic is suggesting I refrain from seeking advice from another qualified health care provider.
4. I understand that my Naturopathic Doctor (ND) keeps a record of services provided to me, and this record is kept confidential, only to be released to others if directed by myself or if required by law. I may request to see this record at any time and have a copy of this record by paying a fee.
5. I understand that my ND reserves the right to determine if my health concerns fall out of the scope of her practice, in which case an appropriate referral may be recommended.
6. I understand that services at this clinic are not covered by OHIP, and I will be paying for fees at the time of the appointment; including fees for the visits, prescriptions, services and tests.
7. I understand that of my own free will, I would accept or reject the treatment protocol recommended by this clinic.
8. I understand that therapies recommended to me will be explained in full by my doctor, and that my questions will be answered as best as possible, in a manner which I can comprehend.
9. I understand that the results are not guaranteed. I do not expect my ND to anticipate all risks and complications, but rely on her to utilize appropriate judgment in my best interests, based on the facts and findings then known.
10. I understand that 24 hours notice is required for visit cancellation or change of appointment, or I will be charged the full cost of a visit.
11. I understand that my naturopathic doctor may prescribe to me medicines or devices, and that I may purchase them from my naturopathic doctor, a pharmacy, a health food store, or a medical supply company of my choice.

I voluntarily consent to treatment at Priority Massage and Health – Naturopathic Medicine using the diagnostic and therapeutic procedures mentioned except for (please list treatments you do NOT want to receive below):

I have read, understand and agree to the above statements.

I understand I am free to withdraw my consent to discontinue treatment at any time, informing the clinic in a written or verbal format.

Patient Name: _____

Parent/Guardian Signature if under 18: _____

Patient Signature: _____



Priority Massage & Health
NATUROPATHIC MEDICINE

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Naturopathic Doctor

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Please help us provide you with the highest standard of care by carefully completing this intake form. Identify anything you don't understand with a question mark. All information is strictly confidential. Please PRINT CLEARLY.

Confidential Pediatric Health Record



Personal Information

Date: _____

Child's Name: _____ Age: _____ Birth Date: _____

Gender: _____

Who is completing this form? _____ Relationship to Child: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone (Home): _____ (Work): _____

Email: _____

Where may we leave messages regarding your child's visits? _____

Family Physician: _____

Phone number: _____ Fax number: _____

Health Insurance Number (e.g. OHIP): _____

In case of emergency contact: _____

Address: _____

Phone number: _____ Relationship: _____

How did you hear about the clinic? _____

Has your child seen a Naturopathic Doctor before? Yes No

If yes, for what ailment(s)? _____

Are any other members of your family being treated at this clinic? Yes No

Current History

Please list the reasons for your child's visit today and when the concerns began:

1. _____
2. _____
3. _____
4. _____

Has anything changed recently or become worse? _____

Any religious affiliations or beliefs relevant to your child's health care and treatment?

How would you describe your child's current state of health? Excellent Good Fair Poor

Does your child have any dietary restrictions? Yes No
If yes, which ones and why (religious or otherwise)?

Has your child ever been prescribed an Epi-pen? Yes No
Reason: _____

Please list all of your child's known allergies (medications, food, pollen etc.):

Medication and Supplement History

History of antibiotic use (when approximately): _____

How long: _____

For what condition(s): _____

Please list all supplements, herbs and medications your child is currently taking:

Medication/supplement	Dosage	Started	Reason

Early Life History

Please check relevant conditions:

Mother's pregnancy

- | | |
|---|--|
| <input type="checkbox"/> Uncomplicated | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Physical/emotional trauma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Smoking/alcohol/drug use |
| <input type="checkbox"/> Early labour | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Excessive vomiting | <input type="checkbox"/> Other _____ |

Medications during pregnancy: Yes No _____

Supplements during pregnancy: Yes No _____

Birth History

Birth weight: _____ Weeks: _____

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Full term | <input type="checkbox"/> Vaginal |
| <input type="checkbox"/> Premature | <input type="checkbox"/> C-section Reason: _____ |
| <input type="checkbox"/> Past term | |

Mother's age at child's birth: _____

Birth complications or interventions used? Describe: _____

Post-natal Complications

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Infections |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Cardiac | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Gastrointestinal | |

Nursing

Was your child breastfed? Yes No If so, how long? _____

Difficulty nursing? Yes No _____

Formula used? Yes No If so, what age? _____

When were solids introduced? _____ 1st foods: _____

Vaccination History

Is your child vaccinated? Yes No

If yes, were all boosters given? Yes No

Vaccine	Age received	Date(s) of immunization(s)	Reactions/side effects (ie fever)
Hep A			
Hep B			
HiB (influenza)			
Polio			
MMR (measles, mumps, rubella)			
DPT (diphtheria, pertussis, tetanus)			
Small pox			
Varicella			
Tetanus booster			
Meningococcal			
Pneumococcal			
"flu" shot			
Other			

Please indicate if your child had any hospitalizations, surgeries or serious injuries:

Hospitalization/Surgery	When (age)	Complications?

Injuries:

Injury	When (age)	Long-term effects?

General Health History (Please check relevant and circle: C=current, P=past)

- | | |
|--|--|
| <input type="checkbox"/> Bleeds/bruises easily C/P | <input type="checkbox"/> Peculiar tastes/smells C/P |
| <input type="checkbox"/> Change in appetite C/P | <input type="checkbox"/> Poor appetite C/P |
| <input type="checkbox"/> Chills C/P | <input type="checkbox"/> Poor sleep C/P |
| <input type="checkbox"/> Cravings C/P | <input type="checkbox"/> Strong thirst C/P |
| <input type="checkbox"/> Fatigue C/P | <input type="checkbox"/> Sudden energy drop (when in day?) C/P |
| <input type="checkbox"/> Fevers C/P | <input type="checkbox"/> Weight gain C/P |
| <input type="checkbox"/> Night sweats C/P | <input type="checkbox"/> Weight loss C/P |

Skin, Hair and nails (Please check relevant and circle: C=current, P=past)

- | | |
|--|---|
| <input type="checkbox"/> Dandruff C/P | <input type="checkbox"/> Pimples C/P |
| <input type="checkbox"/> Dryness C/P | <input type="checkbox"/> Psoriasis C/P |
| <input type="checkbox"/> Eczema C/P | <input type="checkbox"/> Rashes C/P |
| <input type="checkbox"/> Itching C/P | <input type="checkbox"/> Recent moles C/P |
| <input type="checkbox"/> Loss of hair C/P | <input type="checkbox"/> Ulcerations C/P |
| <input type="checkbox"/> Loss of nails C/P | <input type="checkbox"/> Other skin, hair or nail concerns? |
| <input type="checkbox"/> Nail changes C/P | _____ |
| <input type="checkbox"/> Nail fungus C/P | |

Head, Eyes, Ears, Nose and Throat (Please check relevant and circle: C=current, P=past)

- | | |
|---|--|
| <input type="checkbox"/> Blurry vision C/P | <input type="checkbox"/> Hay fever C/P |
| <input type="checkbox"/> Colour blindness C/P | <input type="checkbox"/> Headaches C/P |
| <input type="checkbox"/> Concussion/head injury C/P | <input type="checkbox"/> Jaw clicks or pain C/P |
| <input type="checkbox"/> Dental cavities C/P | <input type="checkbox"/> Mercury tooth fillings C/P |
| <input type="checkbox"/> Discharge from ear C/P | <input type="checkbox"/> Neck pain C/P |
| <input type="checkbox"/> Ear infections C/P | <input type="checkbox"/> Night blindness C/P |
| <input type="checkbox"/> Earaches C/P | <input type="checkbox"/> Nose bleeds C/P |
| <input type="checkbox"/> Eye pain C/P | <input type="checkbox"/> Poor hearing C/P |
| <input type="checkbox"/> Eye strain C/P | <input type="checkbox"/> Recurrent sore throats C/P |
| <input type="checkbox"/> Eyeglasses C/P | <input type="checkbox"/> Ringing in ears C/P |
| <input type="checkbox"/> Facial pain C/P | <input type="checkbox"/> Sores on lips or tongue C/P |
| <input type="checkbox"/> Frequent colds C/P | <input type="checkbox"/> Stuffiness C/P |
| <input type="checkbox"/> Gum problems C/P | <input type="checkbox"/> Tooth pain C/P |
| <input type="checkbox"/> Other _____ | |

Lungs and Breathing (Please check relevant and circle: C=current, P=past)

- | | |
|---|---|
| <input type="checkbox"/> Asthma C/P | <input type="checkbox"/> Difficulty breathing C/P |
| <input type="checkbox"/> Bronchitis C/P | <input type="checkbox"/> Phlegm (colour: _____) |
| <input type="checkbox"/> Cough C/P | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Coughing blood C/P | |

Abdomen and Digestion (Please check relevant and circle: C=current, P=past)

- Abdominal pain C/P
- Bad breath C/P
- Blood in stool C/P
- Constipation C/P
- Diarrhea C/P
- Gas C/P
- Green/Gray stool C/P
- Hepatitis C/P
- Indigestion C/P
- Nausea C/P
- Rectal itching C/P
- Vomiting C/P
- Other _____

Genito-Urinary (Please check relevant and circle: C=current, P=past)

- Bed wetting C/P
- Decreased flow C/P
- Distinctive or odd colour C/P
- Frequent urination C/P
- Other _____
- Pain on urination C/P
- Rash on genitals C/P
- Sores on genitals C/P
- Urgency C/P

Brain, Nervous System and Emotions (Please check relevant and circle: C=current, P=past)

- ADHD C/P
- Anxiety C/P
- Areas of numbness C/P
- Autism C/P
- Concussion C/P
- Depression C/P
- Dizziness C/P
- Lack of coordination C/P
- Has your child ever had treatment for emotional problems? _____
- Any other neurological or psychological concerns? _____
- Loss of balance C/P
- Muscle weakness C/P
- Poor memory C/P
- Quick temper/irritable C/P
- Seizures C/P
- Susceptible to stress C/P
- Talks about/attempted suicide C/P

Interaction with other children

- Very good
- Average
- Poor

Behaviour

- Excellent
- Variable
- Disruptive
- Other _____

Immune System/Infections (Please check relevant and circle: C=current, P=past)

- Chicken pox
- Diphtheria
- Frequent colds/flu
- Hay fever
- Allergies _____
- Anaphylaxis _____
- Hypersensitivities _____
- Measles
- Mumps
- Rheumatic fever
- Rubella
- Scarlet fever
- Strep infection
- Urinary tract infections
- Whooping cough

Household

How long has your child lived at this present address? _____

Where has your child lived previously? _____

Please describe location, if old or new building, i.e., new construction, older construction, damp or moldy etc. _____

Who lives in the home with your child? _____

Are there any pets in your child's home? Yes No _____

Is there specialized air filtration at home? Yes No

Does your child live in the city? Yes No

Do any of your child's hobbies involve toxic materials? Yes No

Is your child currently exposed to second hand smoke? Yes No

What does your child use for drinking water? Bottled Filtered Tap water

Family Health History

Please indicate each relevant condition for blood relatives only.

- | | | |
|--|--|---|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Gout | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Addiction | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> HIV | <input type="checkbox"/> Rubella |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Amnesia | <input type="checkbox"/> Influenza | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Learning disabilities | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Cancer: type(s) | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stroke |
| _____ | <input type="checkbox"/> Lupus | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Celiac disease | <input type="checkbox"/> Malaria | <input type="checkbox"/> Sunstroke |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cold sores | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Eye problems | <input type="checkbox"/> Obesity | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Parasites | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Gall stones | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Genital herpes | <input type="checkbox"/> PID | <input type="checkbox"/> Yellow fever |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Pleurisy | |
| <input type="checkbox"/> Gonorrhea | | |

Any other condition(s) not listed:

Indicate which of the above conditions have affected your child's relatives:

Family member	Age (if alive)	Age at death	Condition
Mother			
Father			
Brother			
Brother			
Sister			
Sister			
Maternal grandmother			
Maternal grandfather			
Maternal aunts/uncles			
Paternal grandmother			
Paternal grandfather			
Paternal aunts/uncles			

I do not know my family history

Is there anything else I should know about your child?

Thank you for completing this extensive health record for your child, your time is appreciated.