Priority Massage & Health
NATUROPATHIC MEDICINE

Dr. Kristina Kastelanac, ND
Naturopathic Doctor

172 Wortley Road
London, Ontario N6C 3P7
519.642.7469

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: _____

Patient Signature: _____

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CONFIDENTIAL SENIOR INTAKE FORM

(Please print clearly)

Name:_____ Date:_____
Date of Birth: YY/MM/DD_____ Age_____Sex: M F
Address:_____
_____
_____
Email Address:_____
Telephone number: Home: _____Work:_____
May we leave a message at these numbers? Y N
Emergency Contact: Name:_____Number:_____
Occupation:_____ Marital Status:_____
How did you hear about the Clinic? _____

Please list all other Health Care Providers: (include name, title and phone number)

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

Have you ever had previous Naturopathic Care? Y N

Please list your major health concerns in order of importance:

1.
2.
3.
4.

Do you have any ALLERGIES? (include medicines, environmental, foods etc)

_____
_____
_____
_____
_____

List all past Hospitalizations, Surgeries, Accidents and Major Illnesses: (include dates)

_____
_____
_____
_____
_____
_____
_____

Please list all PRESCRIPTION medications:

Name of medication	Dose	Frequency	Side effects?

Please list all NON PRESCRIPTION medications that you take on a regular basis:
(including vitamins, minerals, herbs, homeopathics, over-the-counter etc.)

Name of medication	Dose	Frequency	Side effects?

Have you had all the standard vaccinations? Y N

How many times have you been treated with Antibiotics? _____

Please indicate if a close relative (parents, siblings, grandparents, aunts, uncles) has any of the following:

☐ Anemia	☐ Eczema	☐ Glaucoma
☐ Seizures/epilepsy	☐ Thyroid problems	☐ Hypertension
☐ Heart disease	☐ High cholesterol	☐ Diabetes
☐ Asthma	☐ Alcoholism	☐ Psychiatric illness
☐ Cancer	☐ Arthritis	☐ Other _____

Are you currently following any special diets? Y N _____
Have you ever smoked? Y N
Have you ever used recreational drugs? Y N

What is your current weight?_____ Maximum weight_____

Do you exercise regularly? Y N What do you do for exercise, how much, how often?
_____
_____
_____
_____

Do you have a history of falls? Y N Please explain below:
_____
_____
_____

Have you had any memory impairment? Y N Please explain below:
_____
_____
_____

Have you noticed any recent weight loss? Y N Please explain below:
_____
_____
_____

Do you require any walking or hearing aids? Y N Please explain below:
_____
_____
_____

Do you wear dentures? Y N

Do you live on your own? Y N

Do you suffer from depressed moods or depression? Y N

Do you have support from friends and family? Y N Please explain below:
_____
_____
_____
_____

Please list the two most stressful events in your life

1. _____
2. _____

SYSTEMS REVIEW

Below is a list of symptoms which may or may not seem relevant to your current health concerns. Please answer completely as a detailed health history is necessary to develop a personalized health plan. The relevant issues brought up by this questionnaire will be discussed during your appointment.

Please check (√) **"C"** if you currently have the symptom or **"P"** if you have had it in the past 6 months.

Skin	**C**	**P**
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

Head	**C**	**P**
Tension headaches		
Migraine headaches		
Head Injury		
Dizziness		
Other		

Eye	**C**	**P**
Impaired vision		
Use of contact lenses/ glasses		
Eye pain		
Tearing		
Dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Light Sensitivity		
Itching		
Redness		
Discharge		
Blind spot		
Other		

Ears	**C**	**P**
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

Nose & Sinuses	**C**	**P**
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

Mouth & Throat	**C**	**P**
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Other		

Neck	**C**	**P**
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

Respiratory	**C**	**P**
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Pain on breathing		
Shortness of breath		
Positive tuberculin test		
Last TB test		
Last chest x-ray		
Other		

Cardiovascular	**C**	**P**
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitations, fluttering		
Last ECG		
Other		

Breasts	**C**	**P**
Do you perform self breast exams?		
Lumps		
Pain (or tenderness)		
Nipple discharge		
Last mammogram		
Other		

Gastrointestinal	**C**	**P**
Vomiting		
Heartburn		
Change in appetite		
Nausea		
Frequency of Bowel Movements per day	1 2	3+
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stools		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Other		

Blood/Lymphatic	**C**	**P**
Anemia		
Easy bleeding/ bruising		
Past transfusions		
Lymph node swelling		
Other		

Please check (√) **"C"** if you currently have the symptom or **"P"** if you have had it in the past 6 months.

Urinary	**C**	**P**
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

Musculoskeletal	**C**	**P**
Broken bones		
Muscle spasms/cramps		
Weakness		
Joint swelling		
Backache		
Other		

Peripheral vascular	**C**	**P**
Deep leg pain		
Cold hands/ feet		
Varicose veins		
Leg cramps		
Extremity numbness		
Extremity swelling		
Extremity ulcers		
Other		

Neurologic	**C**	**P**
Fainting		
Seizure/ Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of balance		
Speech problems		
Other		

Endocrine	**C**	**P**
Heat/ cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive sweating		
Diabetes		
Low blood sugar		
Other		

Emotional	**C**	**P**
Depression		
Extreme anger		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual difficulties		
Drug abuse		
Psychiatric care		
Psychological counselling		
Other		

Male Reproductive	**C**	**P**
Hernia		
Testicular mass		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease		
Discharge of sores		
Sexually active		
Circle sexual preference: Heterosexual/ Homosexual/ Bisexual		
Last prostate exam:		
Last PSA level:		
Other		

Female Reproductive	**C**	**P**
Age of first menses:		
Last menstrual period:		
Number of days of menses:		
Length of cycle:		
Bleeding between periods		
Irregular cycles		
PMS		
Heavy flow		
Painful menses		
Menopause		
Age of onset:		
Hormone therapy		
Last gynecological exam:		
Number of pregnancies:		
Number of live births:		
Number of miscarriages:		
Number of abortions:		
Difficulty conceiving		
Vaginal discharge		
Vaginal itching		
Sexually active		
Pain during intercourse		
Circle sexual preference: Heterosexual/ Homosexual/ Bisexual		
Other		