TAUNTON CHIROPRACTIC
AND HEALTH CENTRE

Statement Of Acknowledgement And Consent To Examination And Treatment By Naturopathic Medicine

Naturopathic medicine uses non-invasive methods of assessing the bodily functions and the use of natural therapeutics for correction. Even the gentlest therapies have the complications in certain physiological conditions such as pregnancy, lactation, in patients who are very young or very old, or in people taking many medications. Some therapies must be used with caution in certain diseases such as diabetes, lung, heart, liver or kidney disease. It is very important that you are completely honest in informing your ND of any disease process currently going on in your body, if you are on prescription medication or over-the-counter drugs. If you are pregnant, suspect that you're pregnant or breastfeeding, please advise your ND immediately.

There are some slight health risks to treatment of Naturopathic Medicine. These include, but are not limited to:

- Aggravation of pre-existing conditions and symptoms.
- Allergic reactions to supplements or botanical preparations.
- Pain, fainting, bruising or injury from venipuncture or acupuncture.

In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your co-operation in signing this statement of acknowledgement and in so doing:

1. You understand that I am a Naturopathic Doctor, and not a conventional medical doctor; that I use non-invasive, natural methods of assessment and treatment of body dysfunctions, That any treatment you receive is not mutually exclusive from any other treatment or advice you may now be receiving or may receive in the future from another licensed health care provider.
2. You understand that methods I may use have a proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.
3. You understand that I am required by my licensing board to perform a physical examination as deemed necessary on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is deemed acceptable.
4. You understand that treatment and/or referral to other health practitioners is based on the assessment of your health, revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.
5. You understand I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended.
6. You are not an agent of any private or government agency attempting to gather information without so stating your intentions.
7. You understand that while changes in dietary habits are not an absolute prerequisite for treatment, failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.
8. You are accepting or rejecting this care of your own free will.
9. You understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectations and what I can provide are not in agreement.

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10. You understand that all fees, for services, tests and supplements are payable at the time of the appointment by the patient or the guardian. Any special financial arrangements may be made clear in advance.

I understand that my ND will answer any questions that I have to the best ability, in a manner which I can understand. I understand that results are not guaranteed. I do not expect my ND to be able to anticipate and explain all risks and complications. I will rely on my ND to exercise the best judgement in my best interests, based on the facts and findings known at that time. With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above, except for (please list):

Privacy Consent

All discussions/treatments are completely confidential and private. If you are receiving treatment from other practitioners within Taunton Chiropractic, your file may be discussed in order to provide continuity and quality of care. Your medical records will only be released outside of this clinic with your written permission.

I intend this consent form to cover the entire course of treatment present for my present condition. I understand that I am free to withdraw consent and to discontinue participation in these procedures at any time in written or verbal format.

I _____ have read and understood the statements above.

_____ _____
(Signature of patient or guardian) (Date)

Naturopathic Doctor (please print):_____

Signature of ND conducting patient care:_____

Adult INTAKE FORM

Dr. Christine Ordanis BSc., ND
Taunton Chiropractic and Health Centre
905-440-4444

Personal Information

Surname: _____ First name: _____

Preferred name/nickname: _____

Address: _____Suite #_____
City: _____
Province: _____ P/C: _____

Phone: H) _____ W) _____ Ext: _____
C) _____ Other)_____

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Where can we leave a message? H W C O

Email:_____

Date of Birth: (dd/mm/yyyy) _____ Age: _____ Sex: F / M

How did you hear about our clinic?_____

Other Health Care Providers:

Name: _____ Occupation:_____
Phone: _____
Name: _____ Occupation:_____
Phone: _____
Name: _____ Occupation:_____
Phone: _____

Emergency contact: Name: _____

Relationship: _____**Phone:** _____

Main Health Concerns

Rank your health concerns in order of importance. When did it begin?

1._____ _____

2._____ _____

3._____ _____

4._____ _____

5._____ _____

6._____ _____

General Information

How would you rate your current health status? Excellent Good Fair Poor

Current weight: _____lbs Ideal Weight: _____ lbs

Maximum Weight: _____lbs When:_____

What do you usually eat and drink for:

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Breakfast:_____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages:_____

Do you have any food allergies or intolerance's?

_____

Do you have any dietary restrictions? (religious, vegan, vegetarian, etc.)

_____

How many antibiotic treatments have you received?
0 – 5 times 6 – 13 times more than 13 times
Do you get regular screening tests from another doctor? (Pap, physical, blood work) Y/N
Date of last physical exam: _____
List any medications/supplements that you have taken or are currently taking.
(P = past / C = current)

Starting Age	P/C	Medication/Supplement	Illness	Adverse Reactions

If known, please check the immunizations that you have received:

☐	DPT (diphtheria, pertussis, tetanus)	☐	H.influenza B	☐	Hepatitis A
☐	Tetanus booster	☐	"Flu shot"	☐	Hepatitis B
☐	MMR (measles, mumps, rubella)	☐	Polio	☐	Small pox
☐	Other: _____	☐	Other:_____	☐	Other:_____

☐ ☐

☐**Hospitalizations:**

Year	Operation/Illness

Lifestyle information

How often do you do the following?:
Smoke Cigarettes _____ Drink Coffee/tea_____
Drink Alcohol _____ Drink Water _____
Use Recreational Drugs _____ Which one(s): _____

Indicate the emotional climate of your home: Very stable Stable Stressful Very Stressful

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Comments:

_____
_____
_____
_____

Indicate if any of the members living in your household smoke: Yes/No

How many hours per week do you exercise? None 1 – 3 hrs 4 – 6 hrs more than 6 hours

How many hours of sleep, on average, do you get each night?
Less than 6 6 – 8 hrs more than 8 hrs

How many hours do you work outside the home per week?
None 1 – 8 hrs 8 –16 hrs 16-35 hours 35-40 hours more than 40 hours

Form of contraception used:
Birth Control Pill Condom Diaphragm IUD Sponge Cervical Cap None
Other: _____

Family Health History

Indicate if anyone in your family has had any of the following health problems:

Health Problem	**Relationship to the patient**	**Age of onset**
Hypertension		
Cancer		
Diabetes		
Asthma		
Allergies		
Heart Problems		
Other		

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Review of systems **Y= yes, currently P= in the past N= no, never**

SKIN				**EYES**			
Acne, boils	Y	P	N	Cataracts	Y	P	N
Psoriasis	Y	P	N	Glaucoma	Y	P	N
Eczema/rash	Y	P	N	Pain	Y	P	N
Night sweats	Y	P	N	Redness	Y	P	N
Change in mole	Y	P	N	Blurred vision	Y	P	N
Colour/texture changes	Y	P	N	Changes in vision	Y	P	N
Thinning hair	Y	P	N	Floaters (spots in vision)	Y	P	N
Temperature changes	Y	P	N	Double vision	Y	P	N
Dryness	Y	P	N	Bothered by sun	Y	P	N
Excessive sweating	Y	P	N	Glasses/contacts	Y	P	N
Lumps	Y	P	N	Discharge/tearing	Y	P	N
Easy bruising/slow healing	Y	P	N				
Nail changes	Y	P	N				
Itching	Y	P	N				
NOSE				**HEAD**			
Discharge	Y	P	N	Headache	Y	P	N
Polyps	Y	P	N	Dizziness	Y	P	N
Itchy	Y	P	N	Head injury	Y	P	N
Sinus infection	Y	P	N				
Post-nasal drip	Y	P	N	**NECK**			
Frequent colds	Y	P	N	Enlarged glands	Y	P	N
Nose bleeds	Y	P	N	Thyroid issues	Y	P	N
Hay fever	Y	P	N	Pain/stiffness	Y	P	N
Stuffiness	Y	P	N				
THROAT/MOUTH				**EARS**			
Sore throat	Y	P	N	Changes in hearing	Y	P	N
Difficulty swallowing	Y	P	N	Hearing aid	Y	P	N
Bad breath	Y	P	N	Earaches	Y	P	N
Cavities	Y	P	N	Ear infection	Y	P	N
Changes in taste	Y	P	N				
Sore tongue	Y	P	N				
Times per day brushing teeth							
Last visit to dentist							
GASTROINTESTINAL				**RESPIRATORY**			
Flatulence	Y	P	N	Frequent infections	Y	P	N
Burping	Y	P	N	Pneumonia	Y	P	N
Bloating	Y	P	N	Cough	Y	P	N
Diarrhea	Y	P	N	Yellow/green phlegm	Y	P	N
Constipation	Y	P	N	Wheezing	Y	P	N
Blood in stools/black stools	Y	P	N	Asthma	Y	P	N
Grey stools	Y	P	N	Spitting up blood	Y	P	N
Stomach ache	Y	P	N	Shortness of breath	Y	P	N
Abdominal cramping	Y	P	N	Bronchitis	Y	P	N
Changes in appetite	Y	P	N	Tuberculosis exposure	Y	P	N
Lack of appetite	Y	P	N	Pain	Y	P	N
# of bowel movements/day				Last chest Xray			
Vomiting	Y	P	N				
Nausea	Y	P	N				

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Heartburn	Y	P	N	**URINARY**			
Sour taste in mouth	Y	P	N	Blood in urine	Y	P	N
Food intolerances/allergies	Y	P	N	Urinary tract infection	Y	P	N
Gallbladder removed	Y	P	N	Urgency	Y	P	N
Hemorrhoids	Y	P	N	Incontinence	Y	P	N
Changes in bowel habits	Y	P	N	Kidney stones	Y	P	N
Indigestion	Y	P	N	Frequency at night	Y	P	N
				Difficulty urinating	Y	P	N
				Change in frequency	Y	P	N
FEMALE REPRODUCTIVE				**MALE REPRODUCTIVE**			
Menstrual cramps	Y	P	N	Pain in testicles	Y	P	N
PMS	Y	P	N	Changes in scrotum	Y	P	N
Periods regular	Y	P	N	Discharge	Y	P	N
Heavy flow	Y	P	N	Sores	Y	P	N
Pain during intercourse	Y	P	N	STD	Y	P	N
Vaginal discharge	Y	P	N	Sexual difficulties	Y	P	N
Vaginal itchiness	Y	P	N	Hernia	Y	P	N
Yeast infection	Y	P	N	Breast changes	Y	P	N
Sexual difficulties	Y	P	N				
STD	Y	P	N				
Breast self-exams	Y	P	N	**MUSCLES/SKELETON**			
Uterine fibroids	Y	P	N				
Breast tenderness	Y	P	N	Back pain	Y	P	N
Nipple discharge	Y	P	N	Joint pain/stiffness	Y	P	N
Breast lumps	Y	P	N	Arthritis	Y	P	N
Age of first menses				Broken bones	Y	P	N
Length of cycle				weakness	Y	P	N
Length of period				Spasms/cramps	Y	P	N
Age of menopause				Joint swelling	Y	P	N
PERIPHERAL VASCULAR				**CARDIOVASCULAR**			
Varicose veins	Y	P	N	High blood pressure	Y	P	N
Cold extremities	Y	P	N	Palpitations	Y	P	N
Swelling in hands or legs	Y	P	N	Irregular heartbeat	Y	P	N
Aching legs	Y	P	N	Coronary artery disease	Y	P	N
Numbness	Y	P	N	Fatigue with exertion	Y	P	N
Ulcers on extremities	Y	P	N	Murmur	Y	P	N
				Congenital heart condition	Y	P	N
				Chest pain	Y	P	N
ENDOCRINE				**EMOTIONAL**			
Diabetes	Y	P	N	Anxiety	Y	P	N
Excessive thirst	Y	P	N	Low mood	Y	P	N
Excessive hunger	Y	P	N	Depression	Y	P	N
Excessive sweating	Y	P	N	Panic attacks	Y	P	N
Fatigue	Y	P	N	Insomnia	Y	P	N
Low blood sugar	Y	P	N	Rage	Y	P	N
Heat/cold intolerance	Y	P	N	Mood swings	Y	P	N

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Hormone therapy	Y P N	Phobias/fears	Y P N
		Nightmares	Y P N

Have you travelled outside of Canada in the past five years? Y N
Where?_____

How motivated are you to change lifestyle factors if necessary?
1 2 3 4 5 6 7 8 9 10

Is there anything you would like me to know that has not been covered?

_____

_____

_____

_____

_____

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INTAKE FORM!

I LOOK FORWARD TO WORKING WITH YOU.