## Adult Medical Questionnaire

**Name:**________________________________________**Date:** __________________________

**Date of birth:**__________________________(M/D/Y) **Age:**_____ **Sex: M F**

**Full Address:** ______________________________________________________________

**E-mail Address:** ____________________________________________________________

**Home/cell Number:**______________________ **Work:** ________________________

**May I leave messages relating to your visits? Y / N**

**Occupation:** _________________________

**Marital Status: S M D W Sep. No. children:**____**Names:**_________________________

**Emergency contact Name:** ____________________________________________________

**Phone number:**___________________ **Relation:**__________________________

**How did you hear about my services**? __________________________________________

**Other health care providers you are seeing**:

| 1.______________________ | 2.______________________ | 3.______________________ |
|---|---|---|
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| Tel: (__________)____________ | Tel: (__________)____________ | Tel: (__________)____________ |

**What are your health concerns, in order of importance to you:**

1. ________________________________Onset:_______________Cause:________________
2. ________________________________Onset:_______________Cause:________________
3. ________________________________Onset:_______________Cause:________________
4. ________________________________Onset:_______________Cause:________________
5. ________________________________Onset:_______________Cause:________________

**What treatments or regimes are you following:**

1. ________________________________Onset:_______________Result:_______________

2. ________________________________Onset:_______________Result:_______________

3. ________________________________Onset:_______________Result:_______________

4. ________________________________Onset:_______________Result:_______________

5. ________________________________Onset:_______________Result:_______________

**If you are female, are you currently pregnant? Yes No (Please circle one)**

**Medical History**

**How would you describe your general state of health? Excellent Good Fair Poor**

**Please indicate any other medical diagnoses, serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.**

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**Do you have any allergies (medicines, environmental, diet, etc.)?**

___________________________________________________________________________

**Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)**

___________________________________________________________________________

___________________________________________________________________________

**How many times have you been treated with antibiotics?** ___________________________

**Do you have all of your childhood immunizations? Y N**
**Other immunizations:** _________________
**Other**______________________________________________________________________

**Do you get regular screening tests done by another doctor? (pap, blood tests, etc.)? Y / N**

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

**Have you lost weight? How much?**_______**Have you gained weight? How much**?________

**Family History: Indicate if a relative (parent, child, sibling) has had any of the following:**

| | Please indicate which family member |
|---|---|
| Allergies | |
| Asthma | |
| Heart Disease | |
| High Blood Pressure | |
| Cancer | |
| Diabetes | |
| Depression | |
| Other Mental Illness | |
| Drug Abuse/Alcoholism | |
| Kidney Disease | |
| Other | |

**Hobbies:**___________________________________________________________

**Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Y N**

**Do you exercise regularly? Y N**

**What do you do for exercise, how much, how often?**

_______________________________________________________________

**Do you take vacations? Y N**

**How would you describe the emotional climate of your home?**

_______________________________________________________________

_______________________________________________________________

**How stressful is your work, or other aspects of your life? How well do you handle these stresses?**

_______________________________________________________________

_______________________________________________________________

**Have you been a victim of abuse? Y N**
**Have you ever self harmed or attempted suicide? Y N**
**Is there anything that you feel is important that has not been covered?**

_______________________________________________________________

_______________________________________________________________

**Have you seen a Naturopathic Doctor before? Y N**

**Confidential Documentation of Personal Medical History - For file use only unless authorized by you.**

# Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history, perform a physical examination, and possibly request blood and urine samples. If your case requires, the physical may include more specific examinations such as breast, gynecological, rectal, prostate or genital exams.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking, and any known allergies. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to the following:

**I understand (please check the boxes to indicate you understand):**

- q Some patients experience allergic reactions to certain foods, supplements and herbs.
- q Aggravation of pre-existing symptoms
- q Pain, bruising or injury from acupuncture or chinese massage.
- q Fainting or puncturing of an organ with acupuncture needles.
- q Muscle strains and sprains or disc injuries from spinal manipulation.
- q There is a very small potential for stroke in neck manipulation.

**Additionally, I understand (please check the boxes to indicate you understand):**

- q I understand that any treatment or advice provided to me by any of the above. Naturopathic Doctors is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from another licensed health care provider.
- q I understand that I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. Dr. Ashley Nelson,
  N.D. has not suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.
- q I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications.
- q 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 without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy. I have read and understood the privacy policy of Georgian Family Chiropractic.
- q I understand that I may purchase any recommended medicines or supplements from the online Fullscript dispensary, Georgian Family Chiropractic dispensary OR any pharmacy/retail store of my choice.
- q I understand the fee schedule.
- q I am free to withdraw my consent and to discontinue treatment at any time.

As the patient, you are responsible for the total charges incurred (visit fees plus any supplements, tests or medicinal substances) for each visit. If you have private health coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. Most insurance companies **do not** cover the supplements that I prescribe and dispense.

Consultation fees are based on the amount of time spent with the Naturopathic Doctor and are typically scheduled as an initial visit, follow-up visits as required. The length of the second visit can vary if the doctor feels more time is required to review lab results, special testing results, physical therapy, counseling, or for other reasons. Additional time is also scheduled after a long absence from care (1 year or more).

**I require a minimum of 24hrs notice to cancel or reschedule an appointment. Initial appointments require 48 hrs cancellation/rebooking. Missed appointments may be subject to a $50 fee if the require amount of time has not been provided.**

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition.

**Patient Name (please print):** ______________________________________

**Signature of Patient or Guardian:**__________________**Date:** ________________

## Patient Consent Form for Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important while providing you with quality naturopathic care. Georgian Family Chiropractic understands the importance of protecting your personal information. We am committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

**Our privacy policy outlines what Dr. Ashley Nelson ND is doing to ensure that**:

- Only necessary information is collected about you;
- I only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopaths of Ontario.

**How Dr. Ashley Nelson ND Collects, Uses and Discloses Patients' Personal Information**

Dr. Ashley Nelson ND understands the importance of protecting your personal information. Outlined below is how Dr. Ashley Nelson ND is using and disclosing your information. Dr. Ashley Nelson ND will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for goods and services
- To process payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse and reporting diseases and individuals who may be an imminent threat to harm themselves or others

To use for educational and research purposes by Dr. Ashley Nelson ND (this includes case summaries, photographs, lab results and other pertinent medical information). Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

**PATIENT CONSENT**

I have reviewed the above information that explains how Dr. Ashley Nelson ND will use my personal information and the steps that Dr. Ashley Nelson ND is taking to protect my information. I agree that Dr. Ashley Nelson ND can collect, use and disclose personal information as set out above in the information about Dr. Ashley Nelson ND privacy policies.

| ____________________ | ____________________ | __________ |
|---|---|---|
| **Signature** | **Print name** | **Date** |