Dr. Anna Kolomitseva
Naturopathic Doctor

Madison Clinic Naturopathic Intake Form

Section 1: Registration Information

Name:			Today's date:
How would you prefer to be addressed?:			
Address:			
City:	Province:		Postal Code:
Home phone:	Work phone:		
E-mail:			
Date of Birth:	Age:		Gender: □ Male; □ Female
Occupation:		Hrs per Week:	
Emergency Contact:		Phone:	
Please Check One: □ Married/ □ Partnership/ □ Separated/ □ Divorced/ □ Widowed/ □ Single			
Live with: □ Spouse/ □ Partner/ □ Parents/ □ Children/ □ Friends/ □ Alone/ □ Other ______________			
In the event that we are unable to reach you in person by phone, please indicate where it is appropriate for us to leave messages: □ Home message machine/ □ At work/ □ Never leave messages / □ E-mail			
How did you hear about Dr. Anna Kolomitseva, ND?			
What time of day do you prefer: □ Mornings / □ Afternoon / □ Evenings / □ No Preference			
Would you like to receive weekly health articles specific to your goals by email? □ Yes/ □ No			

Section 2: Health Overview

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

1.)________________________________ 2.)________________________ 3.)_________________________

4.)________________________________ 5.)________________________ 6.) _________________________

Is this your first visit to a Naturopathic Doctor? □ Yes/ □ No If No, please specify:_______

Other Health Care Providers

Family Physician's name and phone number: ____

Are you seeing a medical specialist?: □ Yes/ □ No If Yes, for what reason?:____________________

Current Medications & Supplements

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics etc.). If possible, also list dosage information and how long you have been taking the medication as well as the brand.

Medication/ Supplement	Dosage	Start Date	Purpose

Allergies

Please list all known allergies (medications, environmental, chemical, food etc.):

____

Section 3: Health History

Current Health Status

Your weight today:________ Height:______
Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months or more?_________
Are you pregnant? □ Yes/ □ No
List current health problems for which you are being treated:_________________________________
____

Hospitalizations, Surgeries, Imaging

Do you get regular screening tests done by another doctor (Pap, Blood tests, DRE etc?) □No □Yes
Please list any hospitalizations, surgeries, X-rays, and other imaging scans that you have had:
____________________________Year:__________ ___________________________Year:__________
____________________________Year:__________ ___________________________Year:__________

Personal and Family Health History

Please circle all the conditions that apply to **"Self"** if it relates to you.

For family members, please circle:
Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child(**C**).

Please circle **Past** if the condition is resolved, or **Current** if it is on-going and current

	Relation (please circle)	Date Resolved			Relation (please circle)	Date Resolved
Alcoholism/ Drug addiction	Self F M S G C	Past/Current		High blood pressure	Self F M S G C	Past/Current
Allergies	Self F M S G C	Past/Current		Heart Disease	Self F M S G C	Past/Current
Anemia	Self F M S G C	Past/Current		Hepatitis	Self F M S G C	Past/Current
Arthritis	Self F M S G C	Past/Current		Headaches	Self F M S G C	Past/Current
Asthma	Self F M S G C	Past/Current		Kidney disease	Self F M S G C	Past/Current
Cancer	Self F M S G C	Past/Current		Stroke	Self F M S G C	Past/Current
Diabetes	Self F M S G C	Past/Current		TB	Self F M S G C	Past/Current
Eczema	Self F M S G C	Past/Current		Osteo arthritis	Self F M S G C	Past/Current
Epilepsy	Self F M S G C	Past/Current		Depression/ Other mental illness	Self F M S G C	Past/Current

□ I do not know my family medical history

Section 4: Goals For Your Health

What expectations do you have for your visit with me today?

What long term goals and expectations do you have from working with me?

Please list any limitations to care that I must be aware of: (ie: extended benefit health care coverage; work restrictions (hours/ shift work), language, physical etc.…)

Declaration of Informed Consent to Treatment

Naturopathic doctors utilize non-invasive methods for assessment of bodily function and natural therapeutics for correction of imbalances. Naturopathic doctors (NDs) are not medical doctors (MDs) and utilize different modalities of treatment. Therefore, if standard medical treatment (drugs, surgery, etc.) is necessary, it must be obtained from a medical doctor. As part of your care, Dr. Anna Kolomitseva ND will conduct a thorough case history and perform any necessary physical examinations, including more specific examinations such as breast, gynecological, rectal, prostate or genital exams with your consent. Specific blood and/or urine laboratory samples may be used as part of your treatment work-up.

Your signature is required before any treatment is rendered. Your signature acknowledges that:

- Naturopathic care may take some time and immediate results are not always seen;
- No guarantee has been made with respect to any treatment, action, or medical advice given, because many factors are important in determining actual results;
- Diagnosis, treatment and/or referral to other health care professionals are based upon the assessment of conditions revealed through personal history, interview, physical assessment and laboratory testing;
- Health risks associated with treatment by naturopathic medicine include but are not limited to: allergic reactions to certain supplements and herbs, pain/bruising/injury/fainting/puncturing of an organ with acupuncture needles, bruising/blistering/pain from cupping, aggravation of pre-existing symptoms. Vitamin B12 injection risks: injections site reactions (pain, redness, swelling, irritation, itching), digestive upset, muscle cramps, irregular heartbeat, infection. Contraindications: allergy to cobalt, Leber's disease, pregnancy, kidney disease, megaloblastic anemia;
- You are at liberty to seek or continue medical care from a physician or surgeon or other healthcare provider qualified to practice in Ontario;
- To clarify existing protocol, you understand that you may email Dr. Anna ND at dr.anna@aknd.ca. All questions are to be written in a yes/no format and kept to one to two lines. For all other questions, you will hold them until the next scheduled appointment;
- You understand that you may withdraw your consent at any point in treatment;

- You confirm that you are not an agent of any private, local, provincial, or federal agency attempting to gather information without stating.

Fee Schedule

- You accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered (by the end of each visit), unless prior arrangements have been made;

- The clinic will provide a receipt for naturopathic services rendered, supplements purchased and laboratory testing at the end of the visit;

- No alteration to the amount incurred and/or date of the visit will be made, without exceptions;

- Naturopathic medicine is covered by most extended health benefits. If you are using your benefits for naturopathic care, please ensure to check with your insurance prior to booking an appointment;

- You understand that the consultation fee is for the time you spend with the Naturopathic Doctor and does not include supplements/herbs, labs or remedies suggested;

  - **Initial visit**: $176 (50-60 min)

  - **First follow-up**: $123 (30-45 min)

  - **Short Follow-ups:** $86 (15-30 min)

  - **Vitamin B12 Injection:** $19

- You realize that fee schedule is posted within the clinic and may be subject to change in the future

24 Hour Cancellation Policy

- Please understand our time is important;

- Cancelling an appointment within short notice deprives other patient of opportunity to see Dr. Anna ND;

- A 24 hours notice is required to cancel or reschedule a Naturopathic appointment. Any cancellations given less than 24 hours notice will result in a full fee for any appointment missed or cancelled.

I ______________________________(patient's name) hereby authorize and give my informed consent to Dr. Anna Kolomitseva, ND to provide naturopathic medical consultation, assessment and/or treatment to me. I intend this informed consent to apply to all my present and future naturopathic care.

I take full responsibility for all fees I incur during my naturopathic care.

_________________________ _________________________

Signature of Patient Date