

ORANGE MEADOW MEDICAL SERVICES

CONSENT FOR CLINICAL NOTES DISCLOSURE

I, _____ consent to release to
_____ Insurance Company my
clinical notes and details of treatment/s I received, administered to me
by Orange Meadow Medical Services.

Patient's signature _____

Date _____

NATUROPATHIC DIAGNOSES

NAME: _____ DOB: _____

LEVEL OF VITALITY

excellent good average poor

LEVEL OF HEALTH _____

GENERAL DIAGNOSIS _____

PEDIATRIC DIAGNOSIS _____

LIFESTYLE THERAPY DIAGNOSIS

anxiety disorder PTSD depression sleep disorder fears sexual problems
 OCD history of abuse cancer survivor

substance abuse aggression debilitating physical condition

Other _____

LEVEL OF PAIN OR DISABILITY _____

DIET balanced unbalanced poor fat intake poor nutrition
excess CHO consumption excess supplements vegetarian vegan

TRADITIONAL CHINESE MEDICINE DIAGNOSIS

Qi Def
Stag

Blood Def
Cong

Yin Def
XS

Yang Def
XS

LV -- GB HT -- SI SP -- ST LU -- LI KD -- UB PC -- TH CV -- GV

AYUVREDIC DIAGNOSIS / DOSHA

VATA: Balanced - *Vikruty* PITTA: Balanced - *Vikruty* KAPHA: Balanced - *Vikruty*

PHYSICAL FITNESS ASSESSMENT

very fit fit for their age average poor fitness disabled

PROGNOSIS

excellent good poor can not be established at this point

IMMEDIATE GOAL OF THIS TREATMENT _____

LONGTERM GOAL PROJECTION _____

ESTIMATED TREATMENT TIME

expected recovery: few days a week few months over a year no full recovery

Treatment Modalities & Prescription Protocols

NAME: _____ DOB _____

GENERAL DIAGNOSIS _____

DATE	MODALITY	ASSESSMENT	PRESCRIPTION
1			
2			
3			
4			
5			
6			
7			
8			

TCM Traditional Chinese Medicine
Hx Initial case history

As a practitioner of Naturopathic medicine and a registered ND, Helen Cohen is qualified by the Ministry of Health of Ontario to perform the following controlled acts and modalities: communicating a diagnosis, prescribing drugs for therapeutic purposes, practicing **homeopathic medicine**, **Asian medicine & acupuncture**, **clinical nutrition**, **lifestyle counselling**, and **botanical (herbal) medicine**.

INFORMED CONSENT TO NATUROPATHIC TREATMENT OF THE MINOR

I, _____ understand that the naturopathic doctor, Helen Cohen, is providing naturopathic services to _____ who is my

_____ within her scope of practice. I hereby consent for Dr. Cohen, ND to examine and treat my child for the conditions I will discuss with her including assessments, examinations and techniques, which may be recommended by her.

I acknowledge and understand that the naturopathic doctor must be fully aware of my existing medical conditions. I have completed my child's medical history form as provided by Dr. Helen Cohen, ND and disclosed to her all of the medical conditions affecting my child. It is my responsibility to keep Dr. Cohen, ND updated on my child's medical history. The information I have provided is true and complete to the best of my knowledge.

I do not authorize Dr. Cohen, ND to release or obtain information pertaining to child's condition(s) and/or treatment to/from my other caregivers or third party payers without my prior knowledge.

I have read the above noted consent and I have had the opportunity to question the contents and my child's therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment options discussed with me and such additional treatment as proposed by my child's naturopath from time to time, to deal with my child's present and future complaints and health problems for which I am seeking treatment for my child. I understand that at any time I may withdraw my consent and treatment will be stopped.

DATE _____

SIGNED _____

PATIENT ATTENDANCE SHEET

Patient's Name _____

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SIGNED _____

Naturopathic Treatment Intake Form

Please Note. This detailed intake form has many questions that may or may not pertain to your condition. Please feel free to answer only those questions you feel are important for your specific health concerns. *Any questions that you would rather discuss in person can be marked-off for future discussion.*

NAME _____ Date _____

Address _____

Phone: Home _____ mobile _____

Date of birth _____ Occupation _____

When was the **last time** you visited your family doctor or a specialist? _____

The name of that doctor _____

What **health conditions** required that visit? _____

Please, describe the **most troubling symptoms** you are experiencing right now or in the past month

List all the **medication** you are currently taking by their proper names _____

HEALTH HISTORY

Are you a vegetarian? _____ vegan _____ do you consume: animal fat _____ butter _____ margarine _____
vegetable oil _____ whole milk/dairy _____ skinned milk/dairy _____ fresh vegetables _____ avoid certain
foods? _____ How often do you take vitamins? _____

Do you follow a specific diet? _____

indicate if condition is present (N) or past (P)

- Adenitis
 Allergies (indicate type): _____
 Anemia (indicate type): _____
 Anxiety disorder
 Arthritis (indicate type): Osteo _____ Rheumatoid _____ Gout _____ Psoriatic _____ Other _____
 Asthma
 Autoimmune disease _____
 Bipolar disorder
 Cancer (indicate the type): _____
 Cervical dysplasia ((indicate degree): _____
 Chemical sensitivities
 Chronic fatigue
 Concentration problems
 Constipation
 Cough
 Crohn's disease
 Dental problems _____
 Depression
 Diabetes (indicate type): _____
 Diarrhea
 Digestive problems (Type): _____
 Diverticulitis
 Dizziness/vertigo
 Ear infection/s
 Environmental sensitivities _____
 Eating disorders: Appetite excessive _____ Anorexia _____ Other _____
 Endometriosis
 Epstein-Barr virus
 Eyesight problems
 Fibrocystic breast disease
 Food Allergies (Type): _____
 Frequent headaches
 Frequent upper respiratory tract infections/colds/sore throats
 Gallstones /Kidney stones
 Gynecological problems _____
 Hearing problems _____
 Heartburn
 Hemorrhoids
 Heart disease (indicate type): _____
 Hepatitis (indicate type): _____
 HIV positive
 Hypertension (high blood pressure)
 Hypoglycemia (low blood sugar)
 Infertility: Primary _____ Secondary _____
 Injuries (indicate the type): _____
 Irritable bowel syndrome
 Leucorrhea (Candidiasis)
 Memory problems
 Menopausal symptoms _____

- Menstrual irregularities _____
 Migraine headaches _____
 Numbness (indicate location): _____
 OCD _____
 Painful intercourse _____
 Paranoid disorder _____
 Phobic states (indicate type): _____
 PMS symptoms _____
 Pneumonia _____
 Prostatitis _____
 PTSD _____
 Rashes (indicate type): _____
 Schizophrenia _____
 Seizures (indicate type): _____
 Shingles _____
 Shortness of breath _____
 Sleep problems _____
 STD _____
 Stomach aches _____
 Stroke _____
 Substance abuse: Food _____ Alcohol _____ Other _____
 Sudden weight change: Loss _____ Gain _____ When _____
 Tumours _____
 Ulcers: Stomach _____ Duodenal _____
 Ulcerative colitis _____
 Urinary tract infections (indicate type): _____
 Uterine fibroids _____

Hospitalization

Date and reason: _____

Surgeries

Date and reason: _____

Your Current Weight _____ Height _____

I have filled out this form by myself Yes _____ No _____

I am a relative _____ Guardian _____ and filled this form out on behalf of _____

SIGNATURE _____

ORANGE MEADOW MEDICAL CARE

Consent to Acupuncture Treatment

Please read attentively before signing

Date: _____ / _____ / _____

I _____, hereby request and
consent to Acupuncture Treatment by a qualified Acupuncture
Practitioner.

I have had the opportunity to discuss with the Acupuncture Practitioner and/ or with the other officer or clinic personnel the nature and purpose of acupuncture care and other procedures. I understand that the results are not guaranteed.

I acknowledge that I understand the nature of the treatment, the expected benefits of the treatment, and the material risks and side effects of the proposed treatment.

I have read the above consent. I acknowledge I have discussed with my Acupuncture Practitioner the purpose of the acupuncture treatment in general and my treatment in particular as well as the contents of this Consent. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient's Name

Signature of Patient

ORANGE MEADOW MEDICAL CARE

GENERAL HEALTH QUESTIONNAIRE

Please circle correct answer, sign and date this form

Patient's name _____

Date of Birth _____ (DD/MM/YY)

Address _____ Telephone _____

Occupation _____

Family Doctor: _____ tel: _____

1. Do you take any regular medicine? _____

2. Have you ever had cancer? Yes No

3. Do you have diabetes? Yes No

4. Do you have high/low blood pressure? Yes No

5. Do you have any form of heart disease? Yes No

6. Do you have high cholesterol levels? Yes No

7. Do you smoke? Yes No

If answered yes, how many cigarettes per day? _____

8. For women: could you be pregnant? Yes No

9. Do you have any other major health problems? Yes No

If yes, please specify _____

10. Have you ever had any surgery in the past? Yes No

11. Do you have any joint pain? Yes No

12. Do you have any joint pain(arthritis) Yes No

13. Have you ever had a broken bone? Yes No

14. Do you have numbness in your limbs? Yes No

15. Do you have any allergies? Yes No

16. Neck pain _____

17. Shoulder/Elbow/Hand pain _____

18. Hip/Knee/Foot pain _____

19. Other medical condition _____

PATIENT ATTENDANCE SHEET

Patient's Name _____

ORANGE MEADOW MEDICAL CARE

Consent to Massage Therapy

Patient Name: _____

Date of Birth: _____ / _____ /
DD MM YYYY

I, the undersigned, give my full and voluntary consent to Massage Therapy by a qualified Massage Therapist at Orange Meadow Medical Care Inc.

I acknowledge that I understand the nature of the treatment, the expected benefits of the treatment, and the material risks and side effects of the proposed treatment. I also understand that alternative treatment is available.

I further comprehend the likely consequences of not having the treatment.

I remain free to withdraw my consent in writing at any time and the treatment shall cease at such time.

Signature

Date

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone # _____

Address: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? Yes No

Did a health care practitioner refer you for massage therapy? Yes No

If yes, please provide their name and address. _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- high blood pressure
- low blood pressure
- chronic congestive heart failure
- heart attack
- phlebitis / varicose veins
- stroke/CVA
- pacemaker or similar device
- heart disease

is there a family history of any of the above? Yes No

Respiratory

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema

is there a family history of any of the above? Yes No

Infections

- hepatitis
- skin conditions
- TB
- HIV
- herpes

Other Conditions

- loss of sensation, where?
- diabetes, onset: _____
- allergies/hypersensitivity to what?

- type of reaction: _____
- epilepsy
- cancer, where?

- skin conditions, what?

- arthritis

is there a family history of arthritis?
Yes No

Head/Neck

- history of headaches
- history of migraines
- vision problems
- vision loss
- ear problems
- hearing loss

Women

- pregnant, due: _____
- gynaecological conditions, what? _____

Overall, how is your general health?

Primary Care Physician:

Address:

Current Medications:

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) Yes No
what? _____

condition it treats: _____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No
what? _____
where? _____

Are you currently receiving treatment from another health care professional? Yes No
If yes, for what? _____

What is the reason you are seeking massage therapy?
Please include the location of any tissue or joint discomfort.

Surgery – date _____
nature: _____

Injury – date _____
nature: _____

Notes:

Date of initial Health History: _____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____

PATIENT ATTENDANCE SHEET

Patient's Name _____