DR. ALLISON
GALAN
NATUROPATHIC DOCTOR

INFORMED CONSENT TO TREATMENT
(Must be signed prior to first appointment)
(Page 1 of 2 Consent)

Naturopathic medicine is the treatment and prevention of diseases through assessment of the individual as a whole. Taking into consideration the physical, mental, emotional, and spiritual aspects of an individual's health. Our goal is to utilize natural approaches to stimulate the body's inherent healing capacity and intervene using non-invasive approaches as much as possible.

It is important to notify your Naturopathic Doctor immediately of any diagnosed diseases or ongoing investigations, further, it is important to include a comprehensive list of all other active and past medical interventions (medications, surgeries, alternative therapies etc.) Advise your Naturopathic Doctor immediately if you are pregnant, breastfeeding or suspect you are pregnant.

As a patient, information regarding your diagnosis, treatment (and or alternative courses of action), material effects, costs, expected benefits, risks, and side effects will all be communicated during treatment. Further, information regarding the consequences of not having the diagnosis and/or treatment acted upon will be relayed within a reasonable timeframe.

1. I understand that Dr. Allison Galan, ND. is a Naturopathic Doctor, and will practice only within the scope as outlined in .

2. I understand that any advice given to me, as a patient, by Dr. Galan is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.

3. I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in Alberta.

4. I understand that the Naturopathic Doctor reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.

5. I understand that I am accepting or rejecting this care by my own free will.

6. I understand the Naturopathic Doctor is NOT suggesting to me to refrain from seeking the advice of another health care provider. Further, I am free to withdraw my consent and discontinue treatment at anytime.

7. I understand that the services offered here are not covered by Alberta Healthcare, and that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.

8. I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the cancellation fee, which is the FULL AMOUNT.

9. I understand that any therapies recommended will be explained to me in full by the naturopathic doctor, and that I will give consent to treatment based on informed consent.

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10. I understand that any risks associated with treatment will be thoroughly explained to me before starting the treatment.

Some of the general health risks associated with naturopathic medical interventions include:

- Some patients may experience allergic reactions to certain supplements or herbs
- Some patients may develop pain, bruising, or injury from venipuncture, or acupuncture, or parental therapy
- Rare risks for acupuncture include fainting, puncturing an organ, or burns from moxa or cupping
- Muscle strains, sprains and disc injuries from spinal manipulation
- There is a small potential for stroke with spinal neck manipulation

Screening tests will always be conducted, and safety procedures (ie. Clothing, safety gear, proper positioning and technique) will be implemented to minimize risks. Further, staff is trained in Emergency safety procedures as well as obtaining CPR and First aid certification.
Please be advised that by signing you are agreeing to the allowing Dr. Galan, N.D to treat your healthcare in an integrated way using the knowledge gained at an accredited institution.

I _____(print name) have read, understood and agree to the above statements.

Signature_____ Date_____

Please proceed to completing the Naturopathic intake form. We look forward to working with you in your Naturopathic care.

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NATUROPATHIC INTAKE FORM

The details of this form are required to gain a comprehensive understanding of your specific needs. Please fill out each section to the best of your ability. Any information provided is strictly confidential.

Registration Information

Name: _____ Today's Date: _____
(First) (Middle) (Last) dd / mm / yy

Date of Birth: ___/___/___ Age: _____
dd/ mm / yy

How do you identify your gender identity (please check all appropriate boxes)

☐ Female ☐ Male ☐ Transgender _____ ☐ Alternative

☐ Prefer not to answer

Home Address: _____

Town/ City: _____ Postal Code: _____

Home Telephone: ( ) _____ Work: ( ) _____

May we leave messages on your home phone relating to your visits? (Please circle) Y N

Emergency contact: _____ Phone:( )_____

Email Address: _____

How did you find out about our Naturopathic Services?

- ☐ Referral Whom may we thank? _____
- ☐ Newspaper/ magazine / flyer
- ☐ Yellow pages
- ☐ Other _____

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Family Physician: _____ Phone:( )_____
Other Health Care Provider(s):
Name: _____ Specialty_____
Phone: ( )_____
Name: _____ Specialty: _____
Phone: ( )_____

Have you ever consulted (Please check all that apply):

☐ Naturopath ☐ Acupuncturist ☐ Nutritionist/Dietician

☐ Councilor

Do you have extended medical coverage, if so, what services are covered?
_____

Chief Health Concerns

What are your health concerns and/or goals, in order of importance to you:
1. _____
2. _____
3. _____
4. _____
5. _____

List any other concerns you may want to discuss:
_____
_____
_____
_____
_____
_____
_____
_____
_____

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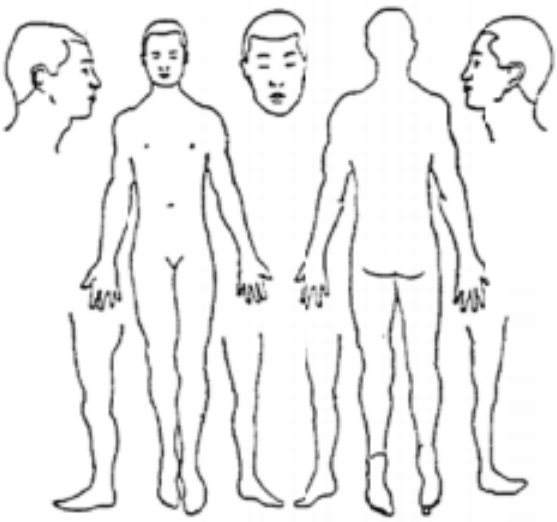
Indicate Painful or distressed areas:



Medical History

How would you describe your general state of health? (Please circle the correct response)
Excellent Good Fair Poor

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? Please list with approximate dates:

_____
_____
_____
_____

Do you have any allergies (medicines, environmental, foods)?

_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

_____
_____
_____
_____

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Please list any past prescription medications:

_____

_____

Approximately how many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (Please check all that apply)

☐ Laxatives
☐ Diet pills
☐ Antacids
☐ Aspirin/Tylenol/Advil

☐ Caffeine - form and amount/day_____
☐ Alcohol - how much/day or week_____
☐ Recreational drugs - what and how often_____

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus)
☐ Hepatitis A
☐ "Flu"
☐ MMR (measles, mumps, rubella)
☐ Smallpox
☐ Haemophilus influenza B
☐ Tetanus booster
☐ Hepatitis B
☐ Polio

Please indicate any adverse reactions you may have had to past immunizations:

_____

_____

(Please circle the following correct responses)

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

Are you currently pregnant? Y N Due date _____

Are you currently lactating? Y N

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Family Health History (√ - present or 'P' - past):
Indicate if a close relative (parent, grandparent, sibling) has, or has had any of the following:

☐ Allergies	☐ Endometriosis	☐ Osteoporosis
☐ Artificial Heart Valve	☐ Gallstones	☐ PMS
☐ Arthritis	☐ Heart Disease	☐ Rubella
☐ Asthma	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Cancer (type_____)	☐ Kidney Disease	☐ Skin Disease
☐ Diabetes	☐ Mental Illness	☐ Stroke
☐ Eczema	☐ Multiple Sclerosis	☐ Tuberculosis

Any other medical conditions?

_____
_____
_____

Diet and Lifestyle

Do you have food allergies or intolerance's? Please list:

_____
_____
_____

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

_____
_____

Describe a typical day's diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages (total amount) _____

Occupation(s) _____
_____

Hobbies _____
_____
_____

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Do you exercise regularly? (Please circle the following correct responses)
Y N

What type of exercise, how much, how often?
_____
_____
_____

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

How stressful is your work, or other aspects of your life? How do you manage stress?
_____
_____
_____

Environment

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe:
_____
_____
_____

Are you particularly sensitive to perfumes, gasoline, other vapors (such as new furniture, carpets or paint?)
_____
_____

Is there anything that you feel that is important that hasn't been covered?
_____
_____
_____
_____