urban wellness
HOLISTIC HEALTHCARE

Dr. Ashley Chauvin, ND
Patient Intake and Consent Form

Last Name: _____ First Name: _____ Date: (MM / DD / YR)

Birth Date: (MM / DD / YR) Preferred Pronoun: He/She/They

Occupation: _____ Work: (___)_____

Address: _____

_____

Home Phone: (___)_____Cell: (___)_____ Email:_____

May we leave messages regarding your visit? Y / N

Can we email you our quarterly newsletter about upcoming courses and events: Yes/No

Emergency Contact:

Name (last, first): _____ Relationship:_____

Phone number(s): (___)_____ (___)_____

Primary Healthcare Provider (Family Physician/Specialist):

Dr._____ Phone: (___)_____

Other healthcare providers you are currently seeing:

_____

_____

_____

When was the last time that you had a medical check-up? _____

If you are female, are you currently pregnant? Y / N

Please list your chief complaints in order from *most to least important*:

1. _____
2. _____
3. _____

Past major illnesses/hospitalizations (please indicate date):

_____

_____

_____

Allergies (medical, environmental, food etc.):

_____

_____

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Medications (Current & Past, please include prescription and over-the-counter):

_____

_____

_____

Supplements (vitamins, herbs etc.):

_____

_____

_____

Who may we thank for referring you to our clinic?

_____

_____

_____

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Naturopathic medicine is the treatment and prevention of diseases by natural means. NDs (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 ND will take a thorough case history, perform a physical examination, including breast exam.

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.

Because in some therapies must be used with caution with particular conditions (such as pregnancy, lactation, kidney disease and heart disease), it is very important that you inform your ND immediately about any disease process you are suffering from, as well as any form of medication, drug or supplement you are taking as well as any changes to medications or remedies.

There are slight health risks associated with treatment by naturopathic medicine, including:

- Aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your ND of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parental (IV) therapy.
- Fainting or puncturing of an organ with acupuncture needles

I have read all of the foregoing information and I understand that: the ultimate responsibility for my health is my own; I will be seeing a Naturopathic Doctor (ND), not a Medical Doctor (MD); the Naturopathic Doctors at Urban Wellness work within the Naturopathic scope of practice; any advice or treatments given to me as a patient of Urban Wellness is not mutually exclusive from any advice or treatment that I have received in the past, receive now, or receive in the future from any other licensed healthcare practitioner; I am at liberty to seek or continue medical care from any other healthcare provider; No healthcare provider or employee under the direction of the Urban Wellness has made the recommendation to me to refrain from seeking or following the advice of another healthcare provider.

I understand that a record will be kept of the health services provided to me, and that it will be kept confidential and will not be released to others unless so directed by myself unless the law requires it. I understand that I may look at my medical record at anytime, and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential. I understand that the practitioner will answer any questions I may have to the best of their ability. I understand that the clinic does not guarantee treatment results. I do not expect the ND to be able to anticipate and explain all risks and complications. I will rely on the ND to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures recommended by the ND. I intend this consent form to cover the entire course treatment of my present condition. I understand naturopathic services are not covered under OHIP. I agree to pay for all services rendered. I understand that I am free to withdraw my consent and to discontinue my participation in these procedures at any time

Patient Name: (Please print name): _____

Signature of Patient or Lawful Representative: _____Date:_____

Signature of ND: _____