Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

Naturopathic Medicine Informed Consent – Male Fertility

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

We would like to take this opportunity to welcome you to Lakeside Natural Health Centre. This clinic utilizes the principles and practices of Naturopathic medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Your ND will conduct a thorough case history and may perform a physical exam, specific blood and/or urinary laboratory tests as part of the treatment work-up. It is very important that you inform your Naturopathic Doctor of any medical concerns or medication and supplements you may be taking. Please advise your ND if you are pregnant, suspect you are pregnant or if you are breastfeeding. 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. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine including acupuncture. By signing this form you acknowledge your understanding of the associated risks and accept full responsibility for any fees incurred during care and treatment and grant permission to proceed. Possible side effects include, but not limited to; aggravation or pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture.

Privacy of your personal information is an important part of providing you with quality Naturopathic care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. Our privacy protocol complies with privacy legislation and standards of our regulatory body, the College of Naturopaths of Ontario.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers. I understand that I may look at my medical records at any time and can request a copy of my file with a fee of $0.10 per page. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect Naturopathic doctors to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name (Please print name): _____
Signature of Patient or Guardian: _____ Date: _____
Naturopathic Doctor: _____ ND Signature: _____

The vision of Lakeside Natural Health Centre is to provide true integrative health care. Given our commitment to this best-patient practice, we will communicate with your other practitioners at our clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.
I welcome professional dialogue regarding my case between members of my health care team at Lakeside Natural Health Centre (please circle): Yes / No
Signature: _____

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Billing Authorization Form

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Credit Card on File:

Client's Name: _____

Name as it appears on the credit card: _____

Type of credit card (please circle): MasterCard / Visa

Card Number: _____

Expiration Date (month/year): _____

Cancellation Policy:

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours' notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with our clinic policy.

I, _____, authorize Lakeside Natural Health Centre to process the above credit card as "Signature on File" for any balance due on my account past 30 days and for any appointments not cancelled in accordance with Lakeside Natural Health Centre's cancellation policy. I understand that a receipt will be promptly sent to me upon any charges.

Patient / Cardholder's Signature: _____ Date: _____

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Naturopathic Medicine – Male Fertility Intake Form

Please complete the following form to provide us with the background information we require to ensure you receive comprehensive care. It should take 15 – 20 minutes.

Contact Information:

Name _____
Date of Birth M_____D_____Y_____
Gender (circle) ____Male / Female_____ Age_____
Health Card # _____
Address _____
_____

Occupation _____
Home # _____
Work # _____
Cell # _____
Email _____
Emergency Contact _____
Emergency Contact # _____
Health Card # _____

YES / NO Can we send you our monthly newsletter and new event listings via email? Your email address will not be shared.

How did you hear about Lakeside Natural Health Centre? _____

Health Care Providers:

Medical Doctor _____
Phone # _____
Fax # _____

Specialist _____
Phone # _____
Fax # _____

Fertility Specialist _____
Phone # _____
Fax # _____

Fertility Specialist _____
Phone # _____
Fax # _____

Other Health Care Providers:

Type of Provider _____
Name _____
Phone # _____

Type of Provider _____
Name _____
Phone # _____

Health Concerns (List in order of importance):

1. _____
2. _____
3. _____
4. _____

Medical and Lifestyle Information:

General Information:

General state of health (circle one): excellent good fair poor
How many times have you taken antibiotics in the last 5 years? _____
How often do you exercise? _____ / week
How many hours of sleep do you get per night? _____
Do you wake up during the night? (circle one): YES / NO If so, how often? _____ Reason for waking? _____
How often do you spend a day doing the following? Driving_____ Watching TV_____ Reading _____ On the computer _____ Working _____
Weight _____ Height _____ Weight 1 year ago _____
What do you value in your life? _____
Have you experienced any other trauma or loss in your life? _____
Are you on a restricted diet? YES / NO
If yes, please describe the type of diet: _____

Energy level: _____ / 10 (0 – no energy, 10 – abundance of energy)
Were you frequently given antibiotics as a child? (circle) YES / NO
What is your exercise routine? _____
Do you wake feeling rested? YES / NO
Have you ever been on a restricted diet? YES / NO

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Fertility Information:

How long have you been trying to conceive? _____

Have you received a diagnosis regarding your fertility (eg. Low sperm count, poor sperm quality/motility, low testosterone)? YES / NO

Please explain: _____

_____

Have you had any of the following lab testing or cycle monitoring related to your fertility? Please check

☐ Blood test ☐ Semen analysis, If so how often? _____ ☐ DNA Testing ☐ Other (Please explain):

_____

Have you had any of the following? Please check

☐ Testosterone ☐ Erectile dysfunction ☐ Vasectomy ☐ Prostatitis

_____

Have you ever used and of the following? Please check

☐ Cholesterol medication ☐ Propecia ☐ Thyroid medication ☐ aerobic steroids ☐ Anti-depressants

☐ Blood pressure medication

_____

Do you have children? YES / NO If yes, what are their ages? _____

Please describe any other treatments you have tried related to your fertility: _____

_____

_____

Is there anything else you would like us to know pertaining to your fertility? _____

_____

Please check the following that apply to you:

☐ Cancer	☐ Diabetes	☐ Surgeries	☐ Depression	☐ HIV
☐ High blood pressure	☐ Seizures	☐ Other major illness	☐ Asthma	☐ Autoimmune disorders
☐ Heart Disease	☐ Hepatitis	☐ Venereal disease	☐ Allergies	☐ Other
☐ Rheumatic fever	☐ Thyroid Disease	☐ Arthritis	☐ Alcoholism	☐ Significant trauma (falls, auto accidents, other)
☐ Low blood pressure	☐ Digestion problems	☐ Mood swings	☐ Sleep	
☐ Frequent illness	☐ Anxiety			

Please circle the number that indicates your level of stress: (0 – no stress, 5 – moderate stress, 10 – extremely stressful)

Family members	0	1	2	3	4	5	6	7	8	9	10	Job Related	0	1	2	3	4	5	6	7	8	9	10
Financial	0	1	2	3	4	5	6	7	8	9	10	Spiritual	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10	Relationship	0	1	2	3	4	5	6	7	8	9	10

Allergies or Food sensitivities: Please indicate any allergies (environmental/medicines) and/or serious food sensitivities

Allergy / Sensitivity	Severity of reactions

Medications/Supplements: Please list all current medications/supplements/homeopathics and over-the-counter medications

Medication/Supplement	Dose/Length of use	Condition it is treating

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Do you use any of the following? (please check each one that applies to you):

Substance	✔	How often / How long / How much / How many / What Brand / Type
Alcohol		
Ant-acids		
Artificial sweeteners		
Cigarettes		
Coffee		
Diet pills		
Laxatives		
Mercury fillings		
Metal implants		
Pain relief medication		
Pop		
Recreation Drugs		
Resin fillings		
Tea		
Other		

Screening Tests: Please check which of the following screening test you receive

Test	✔	How often	Date of last test
Blood glucose			
Blood work ups			
Breast exam			
CBC (complete blood count)			
Cholesterol			
Dental check up			
DEXA scan			
Digital rectal exam (men)			
Hearing			
Mammogram			
PAP smear (women)			
Physical exam			
Prostate			
Vision			
Other			

Family History: Please check and indicate which family member

Illness	✔	Family member/s and age	Complications/Severity
Allergies			
Asthma			
Cancer			
Depression			
Diabetes			
Family history unknown			
Heart Disease			
High blood pressure			
Infertility			
Kidney disease			
Other			
Other mental illness			
Post-partum depression			

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Check off any of the following if they are a CURRENT or RECURRING symptom:

General:

- ☐ Change in appetite
- ☐ Chills
- ☐ Sweat easily
- ☐ Weight Gain
- ☐ Peculiar tastes or smells
- ☐ Poor sleep
- ☐ Fevers
- ☐ Strong thirst
- ☐ Weight Loss
- ☐ Sudden decrease in energy
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Bleed or bruise easily

Skin and Hair:

- ☐ Rashes
- ☐ Itching
- ☐ Loss of hair
- ☐ Recent moles
- ☐ Ulcerations
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Dryness
- ☐ Skin Cancer
- ☐ Change in hair or skin texture

Head, Eyes, Ears, Nose and Throat:

- ☐ Headaches
- ☐ Glasses
- ☐ Blurry vision
- ☐ Ringing in ears
- ☐ Jaw clicks
- ☐ Head or neck problems
- ☐ Night blindness
- ☐ Cataracts
- ☐ Sinus problems
- ☐ Gums bleed easily
- ☐ Concussions
- ☐ Eye pain
- ☐ Ear aches
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Eye Strain
- ☐ Colour blindness
- ☐ Poor hearing
- ☐ Teeth problems
- ☐ Recurrent sore throats
- ☐ Sores on lips, tongue or mouth

Respiratory:

- ☐ Difficulty breathing
- ☐ Bronchitis
- ☐ Coughing blood
- ☐ Pain with a deep breath
- ☐ Other
- ☐ Cough
- ☐ Asthma
- ☐ Pneumonia
- ☐ Production of mucus

Cardiovascular:

- ☐ High blood pressure
- ☐ Dizziness
- ☐ Chest pain
- ☐ Blood clots
- ☐ Swelling of hands
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Varicose veins
- ☐ Cold hands and feet
- ☐ Swelling of ankles/feet
- ☐ Irregular heartbeat

Gastrointestinal:

- ☐ Indigestion
- ☐ Constipation
- ☐ Vomiting
- ☐ Rectal pain
- ☐ Blood in stool
- ☐ Gas
- ☐ Nausea
- ☐ Laxative use
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Bad breath
- ☐ Abdominal pain or cramps

Genito-urinary:

- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Wake at night to urinate
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Impotency
- ☐ Unable to hold urine
- ☐ Other
- ☐ Pain on urination
- ☐ Frequent urinary tract infections

Musculoskeletal:

- ☐ Neck pain
- ☐ Hand / wrist pain
- ☐ Knee pain
- ☐ Hip Pain
- ☐ Muscle weakness
- ☐ Back pain
- ☐ Shoulder pain
- ☐ Foot / ankle pain
- ☐ Muscle pain
- ☐ Other joint or bone problems

Neuropsychological:

- ☐ Loss of balance
- ☐ Poor memory
- ☐ Depression
- ☐ Concussion
- ☐ Susceptible to stress
- ☐ Quick temper
- ☐ Anxiety
- ☐ Dizziness
- ☐ Seizures
- ☐ Lack of coordination

Lakeside Natural Health Centre

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AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL TO LAKESIDE NATURAL HEALTH CENTRE

(Please send a copy of this form back with records)

Section 1:

(Patient to complete Section 1 and 3 of this form)

To: Dr.(MD): _____ **From: Patient:** _____
(please print) (please print)

Fax No#: _____ **Date of Birth**: _____

Address: _____ **Address:** _____

_____ _____

_____ _____

Telephone: _____ **Telephone:** _____

Section 2:

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _____

Laboratory Results _____

Imaging Results _____

Other _____

Section 3:

I _____ **give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.**

Signature of patient: _____

Requesting Practitioner: _____

Date: _____