

For your first ADULT (16+) patient consultation:

As requested, please find attached naturopathic intake materials and additional information. Please fill out and return all completed forms, including informed consent, to Dr. Jasper PRIOR to your first appointment.

Please list, in detail, any supplements and medications that you are currently taking, including name brands, name of supplement, dose, and how long you have been taking it. If you are taking a lot of supplements, you may wish to bring the bottles along to your appointment.

Please indicate any special diets that you are currently adhering to. Refer to the Diet Diary to log your diet for 3-days (at any time shortly before your initial the appointment).

I am also attaching the "*Authorization for Release of Medical Information*" form -- this form is optional to you and may be filled out and sent back to me ASAP, at which time I can forward to your doctor(s). The purpose of this form is to release recent test results from your doctor(s) to your naturopathic file -- I use this information to help reach a diagnosis, and in order to better understand your health concerns. This is only done if I have your consent, and is not mandatory, but strongly encouraged.

If you have any other pertinent health information on hand please feel free to forward along as well.

NEW: You have the option of a 1.5-hr or 1-hr initial adult consultation. Be aware that part of an initial consultation (60- or 90-min.) may include a complaint-oriented physical exam. Please note, at this time I do not perform gynecological or prostate exams but can refer you to another practitioner that does.

At the first visit you may be given a wellness plan (diet, lifestyle and/or supplemental recommendations) and/ or referred for further testing. Please note, I do not collect blood samples on-site.

Payment is requested at the conclusion of the visit (we take cash, cheque, debit, e-transfer, Visa and Mastercard), and you may wish to keep the receipt to forward to your extended benefits health insurance company for reimbursement of naturopathic services.

PLEASE NOTE that initial consults must be conducted face-to-face. Follow-up appointments may be provided via phone for your convenience, depending on your concern. Please read and sign the "*Consent and Waiver of Liability: Electronic Communication*" form if you wish to communicate by email with Dr. Jasper.

Thanks for your interest in naturopathic medicine and I look forward to meeting with you!

--Dr. Jasper

Adult Patient In-take Form**Date filled out:**

Surname: _____ Given Names: _____

Birth date (dd/mm/yyyy): _____ Complete Address: _____

E-mail: _____

Home phone no.: _____ Other phone no.: _____

Phone # to leave messages at?: _____ Occupation(s): _____

Marital status: _____ Children/ dependents: _____

Emergency Contact (Name & Phone): _____

How did you hear about us? _____

Have you seen an ND before? (who, when?) _____

Current health care providers (*please list name & occupation*):

_____Main Health Concerns/ Diagnoses (date of diagnosis):

_____Treatment goals:

_____Current Medications & Supplements (brand, dose, how long taken): _____

_____Allergies/ Sensitivities? (*Foods, animals, environmental, etc.*) _____

Do you smoke tobacco? Have you ever? (When? How much per day? For how long?)

Typical diet: Diet restrictions (e.g. vegetarian, vegan, food allergies)? _____
 Breakfast _____
 Lunch _____
 Dinner _____
 Snacks _____
 Beverages _____

Do you consume any of the following (*How much daily? Weekly?*):

Soda pop		Coffee/Tea		Marijuana	
Candy		Alcohol		Recreational drugs	

Past Medical History (conditions, illness, injury): _____

Hospitalizations/ surgery: _____

FAMILY HISTORY (*please state family member, i.e. mother, grandfather, etc.*):

Allergies		Arthritis	
Digestive problems		Osteoporosis	
Diabetes		Anxiety/ Depression	
High blood pressure		Cancer (what type?)	
Heart attack		Thyroid (low/ high)	
Stroke		Gynecological problems	
High cholesterol		OTHER?	

How do you handle your stress?

Review of Systems – Please circle the best response & elaborate

Y A condition you have NOW and are currently suffering from

P A condition you had in the PAST or intermittently

N A condition you have NEVER had or almost never have

Comments:

GENERAL			
Current age, weight (lbs.), height (in.)			
<i>Are you /might you be pregnant?</i>			
Fatigue (time of day? since when?)	Y	P	N
SKIN			
Rash / Hives (circle one)	Y	P	N
Eczema	Y	P	N
Psoriasis	Y	P	N
Acne / Boils (circle)	Y	P	N
Itching (where?)	Y	P	N
Lumps (where?)	Y	P	N
Dryness	Y	P	N
Night sweats	Y	P	N
Fingernail changes (what kind?)	Y	P	N
Changes in moles	Y	P	N
Skin cancer	Y	P	N
Hair loss/ Hair thinning (circle)	Y	P	N
Dandruff	Y	P	N
Fungal infections	Y	P	N
Warts	Y	P	N
HEAD			
Headache	Y	P	N
Head injury (concussion)	Y	P	N
Dizziness / Vertigo (circle)	Y	P	N
EYES			
Impaired vision	Y	P	N
Glasses / Contacts	Y	P	N
Eye pain	Y	P	N
Tearing / Dryness (circle one)	Y	P	N
Double vision / Floaters (circle one)	Y	P	N
Glaucoma	Y	P	N
Cataracts	Y	P	N
Blurring	Y	P	N
Bothered by sun	Y	P	N
Itching	Y	P	N
Redness	Y	P	N
Discharge	Y	P	N

EARS			
Impaired hearing (Hearing aid?)	Y	P	N
Ear pain	Y	P	N
Tinnitus (ringing in ears)	Y	P	N
Itching	Y	P	N
Discharge (Colour? Odour?)	Y	P	N
Ear Infections	Y	P	N
NOSE and SINUSES			
Stuffiness	Y	P	N
Sinus pain	Y	P	N
Runny nose (Colour?)	Y	P	N
Post-nasal drip	Y	P	N
Number of colds per year?			
Nose bleeds	Y	P	N
MOUTH and THROAT			
Frequent sore throats (>3 per year?)	Y	P	N
Tonsils/ Adenoids removed (circle)	Y	P	N
Sore tongue/ mouth	Y	P	N
Gum problems	Y	P	N
Hoarseness	Y	P	N
Mononucleosis (When diagnosed?)	Y	P	N
Dental cavities (How many silver?)	Y	P	N
Mercury fillings removed (When? #?)	Y	P	N
Dentures/ partial (top / bottom)	Y	P	N
Dental surgeries (what sort, when?)	Y	P	N
Teeth grinding? (Night guard?)	Y	P	N
Loss of taste	Y	P	N
NECK			
Lumps	Y	P	N
Swollen glands	Y	P	N
Goitre (Enlarged thyroid gland)	Y	P	N
Pain/ stiffness	Y	P	N
RESPIRATORY			
Cough	Y	P	N
Sputum / mucus	Y	P	N
Spitting up blood	Y	P	N
Wheezing	Y	P	N
Asthma	Y	P	N
Bronchitis	Y	P	N
Pneumonia	Y	P	N
Pleurisy (Inflammation of lung lining)	Y	P	N
Emphysema	Y	P	N
Difficulty breathing	Y	P	N
Pain on breathing	Y	P	N

Shortness of breath	Y	P	N
Shortness of breath at night	Y	P	N
Shortness of breath on lying down	Y	P	N
Tuberculosis	Y	P	N
Tuberculin Test (Test Result?)	Y	P	N
Last chest x-ray (Date? Results?)	Y	P	N
CARDIOVASCULAR			
Heart disease	Y	P	N
High / Low blood pressure (circle)	Y	P	N
Heart murmurs	Y	P	N
Rheumatic fever	Y	P	N
Chest pain	Y	P	N
Swelling in ankles	Y	P	N
Palpitations, fluttering	Y	P	N
Heart tests (Type? Date? Results?)	Y	P	N
BREASTS			
Lumps	Y	P	N
Pain/ tenderness (When?)	Y	P	N
Nipple discharge	Y	P	N
Breastfeeding	Y	P	N
GASTROINTESTINAL			
Difficulty swallowing	Y	P	N
Heartburn/ Indigestion (circle one)	Y	P	N
Change in thirst (Decreased? Increased?)	Y	P	N
Change in appetite (Decreased? Increased?)	Y	P	N
Any foods you CRAVE? (bread, sugar...)			
Nausea	Y	P	N
Vomiting	Y	P	N
Bowel movements (Per day or per week?)	Y	P	N
Is this a recent change?			
Blood in stool	Y	P	N
Frequent belching	Y	P	N
Frequent passing gas	Y	P	N
Jaundice (Yellow skin)	Y	P	N
Liver disease (fatty liver, hepatitis)	Y	P	N
Gallbladder disease (gallstones)	Y	P	N
Ulcer	Y	P	N
Crohn's or Ulcerative Colitis (circle)	Y	P	N
Irritable Bowel Syndrome (IBS)	Y	P	N
Food poisoning (when?)	Y	P	N
Parasites / Pinworms (when?)	Y	P	N
Diarrhea	Y	P	N
Rectal bleeding	Y	P	N
Hemorrhoids	Y	P	N
Black, tarry stool	Y	P	N

Abdominal pain	Y	P	N
Hernia (Where?)	Y	P	N
URINARY			
Pain on urination	Y	P	N
Frequent urination (day / night?)	Y	P	N
Urination at night	Y	P	N
Inability to hold urine	Y	P	N
Frequent urinary tract infections	Y	P	N
Kidney stones	Y	P	N
Blood in urine	Y	P	N
Hesitancy (Incomplete urination)	Y	P	N
MALE REPRODUCTIVE			
Testicular masses/ lumps	Y	P	N
Testicular pain	Y	P	N
Are you sexually active?	Y	P	N
Erectile dysfunction	Y	P	N
Prostate enlargement/ infection/ cancer	Y	P	N
Sexually transmitted disease(s)	Y	P	N
Penis discharge/ sores	Y	P	N
FEMALE REPRODUCTIVE			
Age of first period			
Days of bleeding in cycle (How long do you bleed?)			
Length of cycle (e.g. 28-days, 30-days...)			
Bleeding between periods	Y	P	N
Irregular cycles	Y	P	N
Painful menses	Y	P	N
Excessive bleeding	Y	P	N
Clotting (small, med., lg.)	Y	P	N
PMS (What kind?)	Y	P	N
Pain during intercourse	Y	P	N
Low libido / Sexual difficulties	Y	P	N
Sexually transmitted disease (describe)	Y	P	N
Birth control?	Y	P	N
What type, how long?			
Number of pregnancies			
Number of miscarriages			
Uterine or ovarian diagnosis? (fibroids, enometriosis, cysts...)			
Difficulty conceiving	Y	P	N
Last menstrual period?			
Vaginal pain	Y	P	N
Vaginal itching	Y	P	N
Vaginal discharge	Y	P	N
Yeast infections (How many?)	Y	P	N
Last PAP & pelvic (Date, Abnormal findings?)			

MUSCULOSKELETAL			
Joint pain (where?)	Y	P	N
Joint stiffness (where?)	Y	P	N
Arthritis (osteo- or rheumatoid?)	Y	P	N
Broken bones	Y	P	N
Muscle cramps/ spasms	Y	P	N
Muscle weakness	Y	P	N
Joint swelling	Y	P	N
Backache	Y	P	N
PERIPHERAL VASCULAR			
Deep leg pain	Y	P	N
Cold hands and/or feet	Y	P	N
Varicose veins / spider veins (circle)	Y	P	N
Hand and/or feet swelling	Y	P	N
Leg/ foot ulcers	Y	P	N
NEUROLOGIC			
Fainting	Y	P	N
Seizures/ convulsions	Y	P	N
Paralysis	Y	P	N
Numbness/ tingling (where?)	Y	P	N
Loss of memory	Y	P	N
Involuntary movements/ twitching	Y	P	N
Loss of balance	Y	P	N
Speech problems	Y	P	N
ENDOCRINE			
Heat intolerance	Y	P	N
Cold intolerance	Y	P	N
Known thyroid trouble? (Hyper/hypo?)	Y	P	N
Excessive thirst	Y	P	N
Excessive hunger	Y	P	N
Excessive sweating	Y	P	N
Diabetes (Type 1 or Type 2?)	Y	P	N
Low blood sugar (hypoglycemia)	Y	P	N
Hormone replacement therapy	Y	P	N
BLOOD			
Anemia (Low iron in blood)	Y	P	N
Low vitamin B ₁₂	Y	P	N
High cholesterol (last checked?)	Y	P	N
Excessive bruising when injured	Y	P	N
Excessive bleeding when cut	Y	P	N
Blood transfusion	Y	P	N

MEDICATION HISTORY			
Have you taken antibiotics for acne for 1 month or longer?			
Have you, at any time in your life, taken other “broad-spectrum” antibiotics for respiratory, urinary, or other infections for 2 months or longer, or in short courses four or more times in a 1 year period?			
About how many times have you taken an antibiotic in your lifetime?			
Have you taken prednisone or other cortisone-type drugs? (how long?)			
Have you taken heartburn medication? (how long?)			
Do you take aspirin, ibuprofen, naproxen or other NSAID medications? (how often?)			
ALLERGIC HISTORY			
Reaction to vaccine in the past? (Which ones?)			
Have you found black mould in your house? (when?)			
Are you sensitive to scents, smoke or other airborne chemicals? (describe)			
Allergies (List)			
EMOTIONAL and LIFESTYLE			
Depression	Y	P	N
Seasonal Affective Disorder	Y	P	N
Mood swings	Y	P	N
Anxiety or Nervousness	Y	P	N
Phobias (Please list)	Y	P	N
Addictions (Please list)	Y	P	N
Emotional traumas? (When?)	Y	P	N
Sleep problems (Insomnia, waking)	Y	P	N
Do you awake rested?	Y	N	
Hours of sleep per night? (Weekday)	Y	N	
Do you watch TV? (Hours per day)	Y	N	
Do you exercise? (What type, how often)	Y	N	
Do you have pets/ animals (Type?)	Y	N	
Have you ever been treated for drug dependence? (when?)	Y	P	N

3-DAY DIET DIARY

	Day 1:	Day 2:	Day 3:
Breakfast			
Lunch			
Dinner			
Snacks			
Water 1c. = 227ml			
# Bowel Movements			
Energy (1-10)			
Exercise			
Comments			

Informed Consent to Naturopathic Treatment

Naturopathic Doctors are trained to evaluate their patients through interview, physical exams and through various diagnostic tests. 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.

Naturopathic Doctors are regulated by the Board of Directors, of the Manitoba Naturopathic Association, and under strict adherence to the Naturopathic Act. Every Naturopathic Doctor must maintain license through their Association in order to legally practice.

Practitioners of Naturopathic Medicine may employ natural medicines and techniques such as nutritional counselling and nutritional supplements, botanical medicines, Asian medicines & acupuncture, homeopathic remedies, physical medicine (such as Bowen therapy), and lifestyle counselling.

Please check the following therapies listed below that you DO NOT wish to participate in, unless later indicated:

- Clinical nutrition** is counselling on the use of special diets and nutritional supplements to address nutritional deficiencies, treat disease processes, and promote health.
- Botanical medicine** is a plant-based medicine that involves the use of herbs to assist in recovery from injury and disease and to promote general well-being. Herbs may be consumed or applied topically. Some examples include consuming herbs as teas, tinctures, tablets, capsules, creams, compresses, or suppositories.
- Homeopathy** is a form of medicine using highly dilute quantities of naturally occurring plants, animals, minerals and other substances to stimulate the body's healing response. Homeopathy is effective at addressing the whole person, both on a physical and mental/emotional level.
- Acupuncture** refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Moxabustion and cupping are additional Eastern soft tissue techniques that can be employed.
- Physical medicine** refers to the use of hands-on techniques such as soft tissue manipulation (massage, acupressure), and the use of hot or cold applications to specific areas on the body to stimulate circulation (i.e. hydrotherapy).
- The Bowen Technique** is a hands-on technique that involves the gentle manipulation of soft tissues at specific points on the body for the purposes of treating musculoskeletal, neurological and systemic conditions of the individual.
- Lifestyle counselling** involves discussing and reforming daily habits (such as sleep hygiene, exercise regimes, and relaxation techniques), as well as removing risk factors to one's health.

During your initial consultation your Naturopathic Doctor will guide you through a case-taking interview, may perform a physical examination, request a urine sample, and/or recommend any necessary laboratory analyses. You may be referred to an external laboratory or health care practitioner for certain diagnostic testing (e.g. blood tests, saliva testing, imaging studies, etc.)

When necessary, it is the responsibility of the Naturopathic Doctor to refer to other healthcare practitioners for confirmation of diagnosis of an illness, disease, or any physical or mental disorder. Naturopathic Doctors are not trained to dispense prescription medications, perform surgery, or provide psychiatric counselling services.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g. pregnancy, lactation, very young children, or those taking multiple prescription medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform your doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your Naturopathic Doctor immediately.

Dr. Deirdre A.W. Jasper BSc, ND (#074)
#5-414 Westmount Drive, Winnipeg, MB R2J 1P2
T: (204) 256-2273 F: (204) 257-2449 W: www.winnipegnaturopathicdoctor.ca

I recognize the potential risks and benefits of these procedures as described below:

Potential risks (not an exhaustive list): aggravation of pre-existing symptoms, allergic reactions to prescribed herbs and supplements, side effects of natural medicines, inconvenience of lifestyle changes, injury from injections or procedures, fainting or puncturing of an organ with acupuncture needles, or muscular/soft tissue pain from hands-on treatments.

Potential benefits (not an exhaustive list): restoration of health and the body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of illness and disease, assistance in injury and disease recovery, and the prevention of disease and its progression.

Naturopathic Physicians are in no way accountable for the outcome of treatment(s) given in adherence to the Naturopathic Act; they in no way guarantee a "cure" of any illness or disease. Naturopathic Doctors shall provide empathetic, professional, and unbiased care for all patients that request treatment. The Naturopathic Doctor and the patient reserve the right to terminate Naturopathic care/ treatment at any time, as they deem necessary.

I understand that a record will be kept of the health services provided to me. As a patient, I shall provide my Naturopathic Doctor with updated information pertaining to my health to the best of my ability. Information will be gathered solely for the purposes of treatment, and will be kept confidential and shall not be released to other parties without my consent, unless required by law. I understand that I may request any portion of my medical record by paying the appropriate fee.

I understand that all charges are to be paid at the time of the visit unless specific arrangements have been made prior to my scheduled appointment. I understand that a fee may be charged for any missed appointments or late cancellations (less than 24 hours).

With this knowledge, I voluntarily consent to Naturopathic treatments offered or recommended to me by my Naturopathic Doctor, unless omitted as indicated above. I realize my Naturopathic Doctor has made no guarantees regarding cure or improvement of my condition, nor do I expect the Doctor to anticipate and explain all potential risks and complications. I intend this consent to apply to all my present and future Naturopathic care, unless a new agreement has been reached and a new consent form has been signed.

Dated this _____ day of _____, 20_____.

Patient's Signature

Guardian's Signature (under 18 years)

Patient's Name (please print)

Guardian's Name (please print)

Consent and Waiver of Liability: Electronic Communication

Electronic communication is a widely accepted form of communication. While it cannot replace personal encounters between you and your health care provider, it can be a convenient way to exchange information. All electronic communication will be acknowledged in a timely fashion. However, we do not monitor emails when the office is closed for weekends, evenings, statutory holidays and vacations. Please consider our office hours when you are waiting for a reply to your electronic communication. As a general rule, we will respond to patient emails within 3 business days. If you do not receive a response within the designated time period, please assume that your email was not received and call the office to follow up.

I understand and agree that:

- Electronic communication is not an appropriate substitute for clinical examinations. I am responsible for following up on Dr. Deirdre Jasper N.D.'s (Dr. Jasper) electronic communication and for scheduling appointments where warranted;
- Electronic communication is not to be used in emergencies, or when I need information or advice urgently. In case of an emergency, go to your nearest urgent care facility or call 911;
- Electronic communication will not be used for any purpose outside the context of my direct patient-health care provider relationship;
- Electronic communication between me and Dr. Jasper will become part of my confidential patient record;
- This medical practice may use electronic communication to send me health promotion material and other educational resources;
- Electronic communication is a privilege that may be withdrawn at the discretion of Dr. Jasper;
- Electronic communication between Dr. Jasper is only for the residents of Manitoba and is governed by the laws of the Province of Manitoba;
- Electronic communication is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the electronic communication once it has been sent;
- Electronic communication can introduce viruses into a computer system and potentially damage or disrupt the computer;
- Electronic communication can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the physician or patient. Electronic communication senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients. Electronic communication is indelible. Even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or cyberspace;
- Use of electronic communication to discuss sensitive information can increase the risk of such information being disclosed to third parties;
- Emails may be forwarded or referred, as necessary, for diagnosis, treatment, or health care operations, with the permission of the patient;
- Dr. Deirdre Jasper N.D. is not responsible for information loss due to technical failures;
- I will notify the Dr. Jasper of any changes to my electronic communication address;
- I acknowledge Dr. Jasper's right to, upon provision of written or electronic communication notice, withdraw the option of communicating through email;

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I hereby authorize Dr. Deirdre Jasper, N.D. to disclose my personal health information to me via the following:

Email address (print clearly): _____

Mobile number to be used for texting (if applicable): _____

I have read and understood the “**Consent and Waiver of Liability: Electronic Communication**” form and fully acknowledge that sending personal health information via electronic communication is not secure and I fully accept the risks and responsibility involved with this. I hereby waive any and all claims against Dr. Deirdre Jasper N.D. in connection with the disclosure of my personal health information via email.

Name of Patient (print): _____

Signature of patient (or guardian/ legal representative): _____ Date: _____

Relationship to patient (if signed by guardian/ representative): _____

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***PLEASE NOTE THAT THIS DOCUMENT DOES NOT INDICATE A TRANSFER OF PATIENT CARE!**

Authorization for Release of Medical Information

Patient's Name: _____	Date of Birth: _____
Address: _____	City: _____
Prov/ State: _____	Postal Code/ Zip: _____
MH Reg/ Health ID #: _____	PHIN #: _____
Date of Request: _____	Date Needed: ASAP

I authorize Dr. Jasper to **OBTAIN** information from:

(Practitioner's info here:)

Name of Provider or Facility

Address

City, Prov/ State, Postal Code/ Zip

HCP's Fax # (include area code) Tel #

TYPE OF RECORDS REQUESTED:

Signature of Patient or Representative: _____

Relationship of Representative to Patient: _____

Date: _____