Patient Consent Form

Congratulations for making a commitment to your health by coming in for a naturopathic assessment at Ritacco Chiropractic. I hope that you enjoy your experience as we work together to help you achieve your full health potential.

Naturopathic Medicine is a unique and comprehensive approach to improving health and treating illness. As primary health care practitioners, our goal is to provide safe and effective health care to each patient in a compassionate and efficient manner. In order to assess your individual condition, your Naturopathic Doctor will take a thorough case history, perform a screening physical exam, and laboratory tests. Therapeutics include clinical nutrition and supplementation, botanical medicine, acupuncture, and Traditional Chinese Medicine, homeopathy and lifestyle counseling. Further detailed information on the assessment/treatments used by Naturopathic Doctors can be provided on request (either through verbal or written explanation provided by the Naturopathic Doctor).

Each Person must sign this document prior to the initial visit.

My signature acknowledges that I have been informed and understand that:

1) I am encouraged to create a comprehensive health care team working towards my best interests and continue to seek medical care from other qualified health practitioners (physician, chiropractor, dentist, etc.) as required.
2) I understand that Naturopathic Doctors are required by their licensing boards to perform a screening physical exam on each new patient. This will be adhered to unless the referring practitioner sends a full report to the N.D.
3) I am aware of the slight health risks concerning some treatments, which may include, but are not limited to; aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, fainting, bruising or injury from acupuncture or venipuncture. I have received a full and complete explanation of the treatment or services that I may receive at this office and hereby authorize consent to treatment.
4) I understand that working with a Naturopathic Doctor involves a team-like approach and while appropriate individualized advice regarding obtaining my treatment goals will be provided, I also commit to being responsible for my own health. If I am having difficulty following a treatment plan, I will contact my ND so that we can make the necessary modifications to ensure that I am able to continue to work towards my health and wellness goals.
5) I am aware that I can purchase the products recommended by my Naturopathic Doctor at the location of my choice. I am under no obligation to purchase products from Ritacco Chiropractic. However, if I do purchase products at the clinic, I am aware that they cannot be returned for refund, as they will not be resold. Just as a pharmacy cannot accept returns on pharmaceutical products, we cannot accept returns on nutraceutical products so that we can guarantee that all of our products have been stored in appropriate conditions until they are dispensed.
6) I understand that a record will be kept of health services provided to me. Other health care practitioners within Ritacco Chiropractic may have access to my information as needed for my own benefit. Otherwise, this record will be kept confidential and will not be released to anyone outside this office unless so directed by myself or unless it is required by law.
7) I understand that I may look at my medical record at anytime and that copy of my file will be provided to me, for a fee, upon request. I have reviewed Ritacco Chiropractic's privacy policy and I understand how it applies to me. I agree to Ritacco Chiropractic's collecting, using and disclosing personal information about me as set out in this policy. 8) I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

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

_____ _____
(signature of patient/guardian) (date)

_____ _____
(signature of N.D) (date)

_____ _____
(signature of witness) (date)

Date _____

Ritacco Chiropractic,
800 Bathurst St. Suite 201
Toronto, ON 416.944.0792

Health History Summary

Name _____ Age _____ Date of Birth (y/m/d) _____

Address: _____ Phone: _____(H) _____ (W)

In case of emergency contact _____ Phone: _____ (1)_____(2)

How did you hear about our clinic?

_____

Your Current Health Concerns What is your main reason for coming in today?

_____

_____

List, in order of importance, other health problems that are troubling you:

1) _____ How long? _____
2) _____ How long? _____
3) _____ How long? _____
4) _____ How long? _____
5) _____ How long? _____

What kind of conventional treatment have you received?

_____

_____

Please circle all of the following complementary healthcare practitioners you have seen:

Naturopathic Doctor Chiropractor Acupuncturist Massage Therapist Osteopath Other _____

What was the therapy and what were the results?_____

_____

Last Physician or Health Practitioner seen _____ When _____

When was your last physical exam? _____ Were blood tests done? **Y/N** Blood Type _____

Your Health History What is the general state of your health? **Excellent Good Average Fair Poor**

What is your current level of energy from 1-10 (where 10 is the best you've ever felt)? _____

What is your current approximate weight? _____ One year ago? _____ Ideal weight? _____ Height? _____

Please list the 5 most significant stressful events in your life:

1) _____ Date _____
2) _____ Date _____
3) _____ Date _____
4) _____ Date _____
5) _____ Date _____

Are any of these situations continuing to impact your life? **Y/N** (*if yes, please circle which one*)

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist? **Y/N**

Have you in the past? **Y/N**

Do you have any allergies to any drugs, herbs, foods, animals or other? **Y/N** *If yes, please specify* _____

_____

Have you had any major injuries? **Y/N** *If yes, what happened and when?* _____

_____

Previous surgeries and hospitalizations (include dates)

_____

_____

Please indicate which of the following conditions you have had and indicate “now” (N) or “past” (P)

	N	P		N	P		N	P		N	P
Allergies			Weight Problems			Anemia			Measles		
Asthma			Gallstones			High Blood Pressure			Mumps		
Hayfever			Gout			Stroke			Chicken Pox		
Sinusitis			Thyroid Problems			Cancer			Whooping Cough		
Ear Infections			Speech Problems			Jaundice			Shingles		
Strep Throat			Tooth/Gum Problems			Alcoholism			Diphtheria		
Tonsillitis			Ringing in Ears			Hepatitis			Scarlet Fever		
Mono			Visual Problems			Gas/Bloating			Polio		
Eczema			Fainting			Diarrhea			Rheumatic Fever		
Psoriasis			Poor Memory			Constipation			Small Pox		
Acne			Balance Problems			Hemorrhoids			Malaria		
Warts			Broken Bones			Rectal Bleeding			Pneumonia		
Varicose Veins			Numbness/Tingling			Parasite			Tuberculosis		
Canker Sores			Cold Hands/Feet			Herpes			Child Abuse		
Headaches			Arthritis			STD			Physical Abuse		
Migraines			Epilepsy			Gonorrhea			Sexual Abuse		
Depression			Diabetes			Syphilis			Emotional Abuse		
Miscarriage			Heart Disease			HIV/AIDS			Rape		

Other?_____

Are there any ailments from which you feel you have never been well since?_____

Were you vaccinated? **Y/N** Did you have any adverse reactions (ex: fever)? **Y/N**

Which of the following do you currently use? (Please indicate how much, how often and how long.)

Alcohol _____ Tobacco _____

Hormones _____ Coffee _____

Cortisone _____ Tea _____

Sedatives _____ Laxatives _____

Antacids _____ Recreational Drugs _____

Ritacco Chiropractic
800 Bathurst St. Suite 201 Toronto, ON 416.944.0792

Other Medications? (Please give name, dose, and amount of time on the medication.)

_____ _____ _____

_____ _____ _____

Vitamins/Herbs?

_____ _____ _____

_____ _____ _____

Any other supplementation?

_____ _____ _____

Family History

	Mother	Father	Sibling	Grandparent		Mother	Father	Sibling	Grandparent
Cancer					Kidney Disease				
Tuberculosis					Diabetes				
Heart Disease					Asthma				
Stroke					Depression				
High Blood Pressure					Other (				

General Information Marital Status? **Single Married Divorced Separated Widow Other** _____ Number of Children _____

Who do you currently live with? **Spouse Partner Parents Children Friends Alone**

Are you currently in a happy and supportive relationship? **Very Mostly Somewhat No**

What is your weakest organ system and why? (ex: digestive, immune, etc)_____

_____

Do you exercise? **Y/N** *If yes, what do you do and how often?* _____

Occupation _____ Employer _____

Do you enjoy your work? **Y/N** Do you take vacations? **Y/N**

How often do you get colds, flus, and sore throats in a year? _____

Occupational/Household Is your home damp or moldy at all? **Y/N** Do you have specialized air filtration at home? **Y/N**

Do you work in an office building? **Y/N** Do the windows open? **Y/N**

Do you work in the presence of toxic fumes or chemicals? **Y/N** Do your hobbies involved toxic materials? **Y/N**

Are you currently exposed to second hand smoke? **Y/N**

What do you use for drinking water? *(circle all that apply)* **Tap Water Bottled Water Filtered Water Reverse Osmosis**

Is there anything else you feel I should know about
you?_____

_____

Thank you for taking the time to fill out this lengthy questionnaire. It will be a valuable resource in understanding your health.

Ritacco Chiropractic
800 Bathurst St. Suite
201 Toronto, ON
416.944.0792