ChristineMathesonND.com Christine@ChristineMathesonND.com

BELLY BE WELL PATIENT INTAKE FORM

CONTACT INFORMATION

Today's Date:________________

First Name:____________________________ Last Name: _________________________

Date of Birth (mm/dd/yy): __________________________________ Age____________

Gender__________________

Occupation:____

Do you enjoy your work?____

Full Mailing Address: ___________________________________

____

____

Email Address:____

Home Telephone Number:____

Other Telephone Number:____

May I leave messages relating to your visits? _____________

How did you hear about me? ____

Emergency Contact:

Name:____ Relation:_____________________

Phone Number: ____________________________

Other Healthcare Providers

Name: ______________________________

Specialty:_____________________________ Phone Number:________________________

Name: ______________________________

Specialty:_____________________________ Phone Number:________________________

Reason For Visit

Primary reason for
visit:____

____

If applicable-

When did your first notice it?____

What brought it on?____

Describe any stressors occurring at the
time____

____

What activities provide relief?____

What makes it worse?____

Is this condition getting worse?_____________________________________

interfering with work______sleep______ recreation_________

Have you had massage/bodywork before?__________________________

What type?____

Health History

What are your health concerns or goals, in order of importance to you:

1____
2____
3____
4____
5____

If you are female, are you pregnant?   Yes   No   Trying

Approx. Height:_______________ Approx.Weight:____________

Have you had any unexplained weight changes recently? ________________________

Please list any previously diagnosed medical conditions /year diagnosed:___________

____
____
____

Falls/Injuries to Sacrum/head/tailbone
(describe)____

Please list all of your allergies (medications, foods, pets, environmental,
etc):____
____
____

Please list all prescription drugs, over-the-counter
medications:_____________________

____
____

Please list all natural supplements or herbal medicines:_____________________________

____

____

____

Example of 2 DAY EATING DIARY

Day 1

Breakfast____

Lunch____

Dinner____

Snacks____

Day 2

Breakfast____

Lunch____

Dinner____ _

Vaccinations / Immunization Record (please check all that apply):

Routine Ontario Immunization Schedule

Polio
Hepatitis B
Varicella (Chicken Pox)

Haemophilus Influenza B
Human Papillomavirus (HPV)
MMR (Mumps, Measles, Rubella)
DPT (Diptheria, Pertussis, Tetanus)
Meningococcal C Conjugate (Meningitis)
Pneumococcal Conjugate (Meningitis, Pneumonia)

Additional Vaccines:
Flu Vaccine
Hepatitis A
Tetanus Booster
BCG (Tuberculosis) Other:

Other:

Did any of your vaccines cause adverse reactions? If yes, please describe:

____

____

Family History

Please indicate if a parent, grandparent, child, or sibling has had any of the following health problems: allergies, arthritis, asthma, cancer, depression or other mental illness, diabetes, drug or alcohol abuse, headaches, heart disease, high blood pressure, kidney disease, thyroid disease, neurological conditions, or other genetic diseases:

Health Problem_______________________________Family Member___________________

Health Problem_______________________________Family Member___________________

Health Problem_______________________________Family Member___________________

Health Problem_______________________________Family Member___________________

Health Habits

Diet: Do you have any dietary restrictions?____

____

Exercise: How many times do you exercise per week?______________________________
What types of exercise?____

Sleep: On average, how many hours of sleep do you get per night?_________________
Do you have trouble falling asleep?____
Do you wake up during the night?____

Sex- Are you sexually active? Yes No

If yes, what form of contraception do you use?____

Energy: What is your average energy level from 1 (lowest) to 10 (highest)?____

Stress: What is the biggest source of stress in your life?

____ ____

Hobbies: What are your hobbies?____

Environment:Are you regularly exposed to toxins, smoke, animals, or other hazards? If yes, please describe:____

Tobacco (amount per day):_________________ Past tobacco (years used):_____________

Alcohol (drinks per week) __________________ Beer_______ Wine______ Other_______

Caffeine (drinks per day) ___________________Coffe_______Tea________Cola________

Recreational Drugs What:________________Amount:_________________

Headaches Type:	Past or Present	Numbness in feet or legs when standing	Past or Present
Asthma		Sore heels when walking	
Cold Hands or feet		Anxiety	
Swollen ankles		Depression	
Sinus Conditions Frequent Colds		Sleep Disturbance	
Seizures		Fainting Spells	
Low Back Pain		Muscular Tension: Location:	
Skin Disorders: Type		Varicose Veins Hemorrhoids Location	
Sciatica		Herniated/Bulging Discs	
Painful/Swollen Joints		Artifical/Missing limbs	
High or Low Blood Pressure		Contact Lenses	
Dentures/Partials		Cancer (past or current) Type	

Digestion and Elimination

Do you experience bloating/gas/burps after eating?___________________

What foods trigger this?_________________

How often are your bowel movements?_________________________

Constipation?__________Blood in stool ?_________Mucus in stool?_____

Pain during bowel movements?_____________________________________

Other ____

Emotional & Spiritual

What is your opinion of yourself?____

If possible, please describe the most negative emotion you experience____

When do you most often feel this emotion:_______________________________________

Where are you? ____

Do you pray to or have a spiritual practice

____

On a scale of 1 – 10 (1 being the lesser, 10 the greater) Please rate yourself in each of these qualities: Faith______Hope____Charity____Generosity________ Sense of Humor_______Fear_____Grief_____Sense of Fun_____

What hobbies/ activities provide you with pleasure and accomplishment_____________

____

What changes would you like to achieve in 6 months:____

One Year: ____
____

Female Reproductive Health History

Method of Contraception (circle) pills patch diaphragm injection condoms IUD abstinence rhythm method Fertility Awareness Other:______________

Length of time using method________

Last Pap smear____Results _____ Are you under the treatment for fertility_____________

Describe current treatment to date :_________________
(IUI, IVF,etc)____
____

Menstrual History Review and check as indicated:
Age of First Menses:__________________________

What was this like for you? ____-

Last Menstrual Period:_______________________

Length of Menses____

Are you trying to Conceive_________________________________

Possibility of Pregnancy______________________

Pregnancy History

Number of Pregnancies: Number of Births: Dates:	Complications:	Miscarriages:	Terminations:
Premature Births:	Spotting during Pregnancy	Weak Newborns at Birth	Incompetent Cervix

Briefly describe your experience with:

Pregnancy:____

____

Labor:____

Birthing____

PostPartum:____

Family History of (please circle)

Fibroids Endometriosis PMS Difficult Menopause

Cancer(type)_____________Menstrual Problems ______________

Other_________________________________

Rate your interest in Sex:

High_________Moderate__________Low______________None_________

Do you have or ever had difficulty experiencing orgasms _____________

____

Do you have a history of rape_______trauma_______incest____

If so,-when_______________________________

Did you undergo counselling for this____

What was this like for you _______________________________________

Menopause

Age symptoms began:____________Are they getting worse__________better________________same________

Are you on/ or ever been on hormone replacement therapy?______if so, how long__________________________

Name and dose____

Reason for stopping____Age of Mother at menopause:______ConcernsExperience___________________________

Check the following symptoms that apply to you:

Hot flashes	Insomnia	Fatigue	Memory Loss	Mood Swings
Vaginal Discharge	Dry Vagina	Depression	Anxiety	Irritability
Spotting	Flooding	Irregular Menses	Painful Intercourse	Increased Libido
Decreased Libido	Disturbed Sleep Pattern			

Additional Information you feel important your practitioner should know that is not mentioned here: Is there anything else that you feel is important that you want me to know?

____
____
____
____
____

Informed Consent to Naturopathic Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. The principles and practices of naturopathic medicine and other supportive therapies are used 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 by taking into consideration the physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to promote healing. The naturopathic doctor will conduct a thorough case history and a screening physical exam may be used as well specific laboratory tests being suggested as part of the treatment work-up. Depending on your case, the physical may include, with your consent, more specific examinations such as breast or external genital exams.

With your consent, other practitioners you choose to work with within the Vital Physiotherapy clinic will have access to your case history in order to improve the quality of your care while maintaining complete confidentiality.

It is very important that you inform your naturopathic doctor of any disease you are suffering from, any allergies you have, and any medications or over the counter drugs that you are currently taking. Please advise your naturopathic doctor if you are pregnant, suspect you are pregnant, or if you are breastfeeding.

Statement of Acknowledgement

Printed name ____

As a patient, I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As Vital Physiotherapy is a collaborative health clinic, I give permission for all the practitioners that are working with me at this clinic to communicate about my case for my benefit. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.
I also confirm that I have the ability to accept or reject this care of my own free will and choice 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 UNDERSTAND:

My naturopathic doctor does not guarantee treatment results. My naturopathic doctor will explain to me the exact details of any treatments provided and will answer any questions I may have. Costs above those included in the naturopathic visit fee will be explained prior to engaging in any treatment or diagnostic test that involves additional fees. I am free to withdraw my consent and to discontinue treatment at any time.

Name:____

Signature:__________________________________Date (mm/dd/yy)_____________

The Arvigo ®Techniques of Maya Abdominal Therapy

Patient Confidentiality and Release Form

I understand this modality is not a replacement for medical care. The practitioner does not diagnose medical illness, disease or other physical or mental conditions unless specified under his/her professional scope of practice. As such, the practitioner does not prescribe medical treatment of pharmaceuticals, nor does he/she perform spinal manipulations (unless specified under his/her professional scope of practice). The practitioner may recommend referral to a qualified health care professional for any physical or emotional conditions I may have. I have stated all my known conditions and take it upon myself to keep the therapist/practitioner updated on my health.

Confidentiality of medical and personal information obtained during the course of the practitioner's work is of the utmost importance. HIPAA regulations require all practitioners obtain a signed release form from their client before taking any information about them. The best way to be fully compliant is to obtain this release signature at the initial consultation. Patients can receive a copy of the form they signed (upon request), and the practitioner maintains a copy for their records

I, (name)____

address ____

give my permission, for my practitioner, to take notes including health history/ medical and /or personal information I choose to disclose to him/her. I understand this information may be used for the purpose of practitioner certification and/or may be shared with the Arvigo Institute, LLC for statistical data collection only. All relevant identifying information will not be disclosed, such as name, address, social security number, date of birth.

Patient Signature: ____

Date: _______________

Consent for the Collection, Use, and Disclosure of Personal Information

We understand the importance of protecting the privacy of your personal information and are committed to collecting, using, and disclosing your personal information responsibly. All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. As such, we strive to ensure that:

• Only necessary information is collected about you.
• We only share your information with your consent.
• Storage, retention, and destruction of your personal information complies with existing legislation and privacy protection protocols.
• Our privacy protocols comply with privacy legislation, the standards of our regulatory body, and the law.

We will collect, use, and disclose information about you for the following purposes:

• To assess your health needs and advise you of treatment options.
• To communicate with you and remind you of upcoming appointments.
• To communicate with all other health care providers in your health care team.

• To allow us to efficiently follow-up for treatment, care, and billing.
• To assist in complying with all regulatory requirements and the law, including requirements to advise authorities of child abuse and to report diseases and

individuals who may be an imminent threat to themselves or others.
• To invoice for goods and services, process payments, and collect unpaid accounts.

If a new purpose arises, we will seek your written approval in advance. We will not, under any circumstances, supply your insurer with your confidential medical history. In the event that this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

PATIENT CONSENT:

I have reviewed the above information that explains how my naturopathic doctor will use my personal information. Should the need arise, I agree that my naturopathic doctor can email me and I understand that this is not considered a secure form of communication. I agree that my naturopathic doctor can collect, use, and disclose my personal information for the purposes listed above.

Patient Name____

Patient Signature____

Date (mm/dd/yy)____________________________________

PATIENT HEALTH STATUS SCREENING POLICY AND PROCEDURE

For In-Office Visits with Christine Matheson, ND

It is of utmost importance that patients thoroughly read and sign this document with respect and sensitivity for the reasons it has been created.

Dr. Christine Matheson, ND has created the 'Patient Health Status Screening Policy and Procedure' for the purpose of **controlling and preventing the spread of contagious infections to her other patients, to herself and to her family** therefore she appreciates your respect and compliance.

Because as part of her services, Dr. Matheson provides the Arvigo Techniques of Maya Abdominal Therapy with hands-on treatments through her 'Belly Be Well' Program, she wants to be particularly cautious about avoiding coming into contact with or spreading infection. Dr. Matheson also wants to remain well so she can continue to be

in service to her patients and family and doesn't want to unnecessarily be exposed to contagious conditions.

Dr. Matheson has implemented this policy to clearly outline that **she will not see patients for in-office visits IF they have recently experienced or are experiencing the following signs or symptoms due to an acute, contagious and/or infectious cause, for example:**

- **Cough, cold, flu, fever, sore throat, respiratory infection, bronchitis, pneumonia, viral infection, sinus infection or nasal congestion caused by an acute infection**

Dr. Matheson will most certainly continue to see all patients when they are generally "well" and free of any acute, contagious and/or infectious symptoms.

In the event that a patient is experiencing or has recently experienced an acute, contagious and/or infectious illness, Dr. Matheson can offer the below options in an effort to assist you.

- A **phone consultation** to provide you with health recommendations for your acute health symptoms or to review your other main health concerns
- To **Reschedule the appointment** for once the patient is completely recovered and symptoms have subsided.
- A referral to the patient's family doctor if strongly suggested.

*If a patient is not sure if his/her symptoms are contagious and not sure whether or not he/she should attend an in-office visit, it is strongly advised to contact Dr. Matheson at **christine@christinemathesonND.com** to speak with Dr.Matheson directly to assess his/her patient health status to be on the safe side.

I____ (**print patient name**) have read and understand the above 'Patient Health Status Screening Policy and Procedure' and will respectfully comply with this policy by not attending (or having my child attend) any in-office visits with Dr. Christine Matheson, ND if I (or my child) have **recently experienced or am experiencing the following signs or symptoms due to an acute, contagious and/or infectious cause, for example:**

- **Cough, cold, flu, fever, sore throat, respiratory infection, bronchitis, pneumonia, viral infection, sinus infection or nasal congestion caused by an acute infection**

Please answer the following health status screening questions accurately and honestly;

1. Are you or have you (or your child) recently experienced signs or symptoms due to an acute, contagious and/or infectious cause, for example ; cough, cold, flu, fever, sore throat, sneezing, respiratory infection, bronchitis, pneumonia, viral infection, sinus infection or nasal congestion and sneezing caused by an acute infection?

YES or NO (Circle answer)

2. If you (or your child) have recently experienced signs or symptoms due to an acute, contagious and/or infectious cause, how many days have you (or your child) been completely symptom free? ____________ days

3. If you (or your child) have recently experienced signs or symptoms due to an acute, contagious and/or infectious cause, did you seek medical attention for these symptoms? YES or NO (Circle answer)

If so, please explain further:

____

I respect the seriousness of this health status policy and have answered the above questions accurately and honestly.

Patient Name____

Patient Signature____

Date (mm/dd/yy)______________________________________

Thank you for your cooperation and for respecting the safety of my health, the health of my other patients and family.

THANK YOU FOR TAKING THE TIME TO COMPLETE ALL ABOVE FORMS

Sincerely, Dr. Christine Matheson, ND