Health History Questionnaire

By completely filling out this form you will help us to help you. All answers will be *absolutely confidential*. If you have any questions please ask. Thank you.

Name_____ Age _____ M □ F □ Today's Date _____
Your Care Card Number_____ Birthdate (M/D/Y)_____
Home Address _____
_____ Postal Code _____
Occupation _____
Home Phone _____ Cell Phone _____
Spouse's Name_____ Children (Name/Age)_____
_____
E-mail Address _____
I give permission to be emailed occasionally of specials or new treatments: Yes or No (circle)

Names Of Other Healthcare Providers:
Medical Doctors _____ Naturopathic Physician_____
Chiropractor_____ Others _____

Who referred you to our clinic?
_____

Your Main Health Concern

Why are you coming to our clinic today?

When did your problem(s) begin (be specific)?

Changes in medication(s)?

Your Past Medical History (Please check and date)

□ Cancer	□ Diabetes	□ Venereal Disease
□ High Blood Pressure	□ Seizures	□ Surgeries
□ Heart Disease	□ Hepatitis/Kidney Disease	□ Anemia (All types)
□ High Cholesterol	□ Thyroid Disease	□ Osteoporosis/Osteopenia
□ Rheumatic Fever	□ Asthma	□ Other Major Illness
□ Significant Trauma (auto accidents, falls, other)		(Specify) _____
□ Allergies (drugs, chemicals, foods) (Specify) _____		_____

The Village Clinic

Consent Form for Naturopathic Medicine

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic physicians 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 capacity to heal itself. Your Naturopathic Physician will take a thorough case history, may perform a pertinent physical exam and may suggest lab work or request copies of lab work previously completed by your family physician or specialist.

Please inform your Naturopathic Physician of any disease process you are suffering from and any medications, over the counter drugs and supplements you are taking. Please advise your Naturopathic Physician if you are nursing, pregnant or become pregnant throughout the course of your treatment.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, 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 risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, bruising or injury from injections
- fainting or puncturing of an organ with acupuncture needles

All visits are confidential. We are committed to preserving and safeguarding your right to privacy. A record will be kept of the health services provided to you. The record will be kept confidential and will not be released to others unless so directed by you or if the law requires it.

If required, the Naturopathic Physician may discuss your case with other healthcare providers. I give permission to the physicians and practitioners at The Village Clinic to collaborate on my case. _____
Initial

_____

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

Patient name: (please print) _____

Signature of patient or guardian: _____

Signature of Dr. Maria Fabbro ND: _____

THE VILLAGE CLINIC
be healthy · be vibrant · be your best

Informed Consent for Intravenous Therapy

Dr. Maria Fabbro, ND

Dr. Fabbro provides treatments for her patient which include intravenous vitamin/mineral therapy. It is your right to be informed about the treatments being offered to help you, including the risks and benefits, and alternative options.

1. This treatment is safe and effective medical therapies used worldwide to help deliver improved health outcomes.
2. This treatment involves inserting a needle into a vein and injecting the appropriate formulation.
3. This treatment typically involves a series of 3 to 6 treatments.
4. Alternatives to intravenous therapy included oral supplementation and dietary modification.
5. RISKS of INTRAVENOUS THERAPY include:
    a. discomfort, pain, or bruising at the injection site
    b. infection at the injection site
    c. lightheadedness or fainting
    d. allergic reaction, blood clots Initial: _____
6. BENEFITS of INTRAVENOUS THERAPY include:
    a. direct delivery of nutrients into circulation for the highest bioavailability
    b. higher doses of nutrients can be administered and utilized by cells than by oral route delivery
    c. most effective cellular nutrient replenishment
    d. improved levels of energy and mood, and general functionality Initial: _____

Your signature below means that:

a. you understand the information provided on this form
b. the treatment has been explained to you to your satisfaction
c. you give your informed consent and authorize Dr. Fabbro to treat you with the treatment that you have initialed

Patient signature: _____ Date: _____