



Dr. Greg Sikorski ND
The Natural Element
105, 100 Grand Blvd Cochrane, AB T4C 0S4
403 981 2505 | www.GregND.com

ADULT

ADULT INTAKE FORM

Our health is influenced by many different factors. Your health history provides valuable information to help me understand your current health. Please fill out this form to the best of your ability and bring it with you to your first visit.

GENERAL CONTACT INFORMATION

Name _____ Today's Date: _____
(Last name) *(First name)* *(M/D/Y)*

Birthdate (M/D/Y): _____ Age: _____ Gender: _____

Address: _____
Street *City* *Province* *Postal Code*

Phone (H): _____ (W): _____ (C): _____

E-mail: _____ Alberta Health Card Number: _____

May we leave you a message about your appointment: Y N Preference: Cell Email

Emergency Contact: _____
Name *Phone Number* *Relationship*

Occupation: _____ Number of years: _____ Job Satisfaction (out of 10, 10 =highest) _____

How did you hear about the clinic? Who were you referred by: _____

Medical Doctor: _____ Last Physical Exam: _____
Name *Telephone* *(M/Y)*

PERSONAL MEDICAL HISTORY

What are your health concerns, in order of importance to you? When did they start? Possible causes?

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

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations along with approximate dates:

1. _____
2. _____
3. _____

Do you have any allergies or hypersensitivities to any of the following?

Foods: _____

Medicines: _____

Environment: _____

Other: _____

Please list all prescription and over the counter medications, vitamins or other supplements you are currently taking (including brands):**Please bring medications & supplements to your first appointment**

Please list any other Healthcare Providers you are currently seeing (ie. Chiropractor/Osteopath/Acupuncturist/Specialist):

<i>Name</i>	<i>Phone Number</i>	<i>Reason</i>
<i>Name</i>	<i>Phone Number</i>	<i>Reason</i>
<i>Name</i>	<i>Phone Number</i>	<i>Reason</i>

Please state why you have chosen Naturopathic Medicine:

FAMILY MEDICAL HISTORY

Please indicate if there is a family history of any of the following health problems and indicate which relative:

F: Father M: Mother B: Brother S: Sister C: Children Sp: Spouse
 MGM: maternal grandmother PGM: paternal grandmother MGF: maternal grandfather PGF: paternal grandfather

Condition	Family Member (Age)	Condition	Family Member (Age)
Allergies/ Hay Fever		High Blood Pressure	
Alcoholism/Drug Addictions		High Cholesterol	
Alzheimer's / Parkinson's		Kidney Disease	
Anemia		Liver Disease	
Arthritis		Lupus	
Asthma		Mental Illness	
Autoimmune Disease		Multiple Sclerosis	
Cancer		Myasthenia gravis	
Celiac Disease		Osteoporosis	
Diabetes		Obesity	
Digestive issues		Skin Conditions	
Epilepsy		Stroke	
Fibromyalgia		Syphilis	
Glaucoma		Thyroid Conditions	
Headaches		Tuberculosis	
Heart Disease		Other	

LIFESTYLE HABITS

Do you have any food allergies or intolerances? Please list

Do you have any dietary restrictions? (Religious, Vegetarian, Vegan, etc.)

REVIEW OF SYSTEMS

GENERAL

Height: _____ Weight: _____ Max weight: _____ Weight one year ago: _____

For the following please check the appropriate box. Yes indicating this is a condition you are currently experiencing and Past if you have experienced it in the past. If you've never had the condition, leave it blank.

SKIN/ HAIR/ NAILS

	YES	PAST		YES	PAST		YES	PAST
Frequent rashes	<input type="checkbox"/>	<input type="checkbox"/>	Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Changes in hair growth	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Mole changes	<input type="checkbox"/>	<input type="checkbox"/>	Change in skin texture	<input type="checkbox"/>	<input type="checkbox"/>
Boils	<input type="checkbox"/>	<input type="checkbox"/>	Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Nail changes	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>			

HEAD/ EYES/ EARS/ NOSE/ MOUTH/ THROAT/ NECK

	YES	PAST		YES	PAST		YES	PAST
Impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	Blind spot	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue/mouth	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Impaired hearing	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	Dental cavities	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Mouth ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Blurring	<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste	<input type="checkbox"/>	<input type="checkbox"/>
Light Sensitive	<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Neck Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Goiter	<input type="checkbox"/>	<input type="checkbox"/>
Eye discharge	<input type="checkbox"/>	<input type="checkbox"/>	Nose stuffiness	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain or stiffness	<input type="checkbox"/>	<input type="checkbox"/>

RESPIRATORY

	YES	PAST		YES	PAST		YES	PAST
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Sputum	<input type="checkbox"/>	<input type="checkbox"/>	Pain on breathing	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	SARS	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculin Test	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath (SOB)	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	SOB at night	<input type="checkbox"/>	<input type="checkbox"/>
Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	SOB lying down	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Last Chest-ray: _____		

GASTROINTESTINAL

	YES	PAST		YES	PAST		YES	PAST
Trouble swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Flatulence	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice (yellow skin)	<input type="checkbox"/>	<input type="checkbox"/>	Black, tarry stool	<input type="checkbox"/>	<input type="checkbox"/>
Change in thirst	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disease	<input type="checkbox"/>	<input type="checkbox"/>	Food allergy	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Hernias	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Bowel movements - how often?		
Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Belching	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Is this a change?	Y	N

CARDIOVASCULAR

	YES	PAST		YES	PAST		YES	PAST
Thrombophlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Swelling in ankles	<input type="checkbox"/>	<input type="checkbox"/>
Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Extremity numbness	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Extremity coldness	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cyanosis	<input type="checkbox"/>	<input type="checkbox"/>
Extremity swelling	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Past ECG	<input type="checkbox"/>	<input type="checkbox"/>
Extremity ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Other heart tests	<input type="checkbox"/>	<input type="checkbox"/>
Deep leg pain	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Cold hands/feet	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>			

ENDOCRINE/ IMMUNE

	YES	PAST		YES	PAST		YES	PAST
Heat or cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>	Past transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lymph node swelling	<input type="checkbox"/>	<input type="checkbox"/>
Goiter	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Drug sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	Reaction to vaccine	<input type="checkbox"/>	<input type="checkbox"/>
Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Excessive urination	<input type="checkbox"/>	<input type="checkbox"/>	Easy bleeding or bruising	<input type="checkbox"/>	<input type="checkbox"/>	_____		

MUSCULOSKELETAL

	YES	PAST		YES	PAST		YES	PAST
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasms/ cramps	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Reduced movement	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Joint swelling	<input type="checkbox"/>	<input type="checkbox"/>	Decreased flexibility	<input type="checkbox"/>	<input type="checkbox"/>
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>	Backache	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

URINARY

	YES	PAST		YES	PAST		YES	PAST
Pain on urination	<input type="checkbox"/>	<input type="checkbox"/>	Inability to hold urine	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
Increased frequency	<input type="checkbox"/>	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>	<input type="checkbox"/>	Urgency	<input type="checkbox"/>	<input type="checkbox"/>
Frequency at night	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Hesitancy	<input type="checkbox"/>	<input type="checkbox"/>

PSYCHOLOGICAL/ NEUROLOGICAL

	YES	PAST		YES	PAST		YES	PAST
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety or nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent thoughts	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Tension	<input type="checkbox"/>	<input type="checkbox"/>	Binge eating	<input type="checkbox"/>	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Low Self Esteem	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	PTSD	<input type="checkbox"/>	<input type="checkbox"/>
Loss of memory	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Self Injury	<input type="checkbox"/>	<input type="checkbox"/>
Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	Sadness	<input type="checkbox"/>	<input type="checkbox"/>	Poor Concentration	<input type="checkbox"/>	<input type="checkbox"/>
Loss of coordination	<input type="checkbox"/>	<input type="checkbox"/>	Grief	<input type="checkbox"/>	<input type="checkbox"/>	Memory difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>	Anger	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>

MALE REPRODUCTIVE

	YES	PAST		YES	PAST		YES	PAST
Hernias	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Penile sores	<input type="checkbox"/>	<input type="checkbox"/>
Testicular masses	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	STIs	<input type="checkbox"/>	<input type="checkbox"/>
Testicular pain	<input type="checkbox"/>	<input type="checkbox"/>	Penile discharge	<input type="checkbox"/>	<input type="checkbox"/>	Sexually active	<input type="checkbox"/>	<input type="checkbox"/>

FEMALE REPRODUCTIVE

	YES	PAST		YES	PAST		YES	PAST
Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty conceiving	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal itching	<input type="checkbox"/>	<input type="checkbox"/>
Regular cycles	<input type="checkbox"/>	<input type="checkbox"/>	Sexually active	<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>
Pain during intercourse	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Breast pain or tenderness	<input type="checkbox"/>	<input type="checkbox"/>
Painful menses	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>
Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>	STIs	<input type="checkbox"/>	<input type="checkbox"/>	Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
PMS	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Age menses began: _____			Last menstrual period: _____			Number of live births: _____		
Average number of days: _____			Last PAP - (date): _____			Number of miscarriages: _____		
Length of cycle: _____			Number of pregnancies: _____			Number of abortions: _____		

Is there anything you feel is important that has not been covered?

Thank you for taking the time to complete this form. The information provided will be discussed in further detail during your initial visit. Please bring this completed form with you to your visit or email me a copy to info@GregND.com





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EMAIL/PP

EMAIL CONSENT FORM

Name: _____ E-mail: _____

I hereby acknowledge that I consent to email communications about my care. It is my responsibility to inform Dr. Sikorski if my email address changes. I understand that I am exposing myself to certain risks, which include but are not limited to:

- The privacy and security of email communication cannot be guaranteed.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Backup copies of Email may exist even after sender or recipients have deleted their copy.
- Email senders can easily misaddress an Email or be received by unintended recipients
- Email is easier to falsify than handwritten or signed documents.

Dr. Sikorski will use reasonable means to protect the security and confidentiality of emails. Due to the risks above, Dr. Sikorski cannot guarantee the security and confidentiality of emails and will not be liable for improper disclosure of confidential information that is not caused by Dr. Sikorski's intentional misconduct.

Dr. Sikorski will try to read and respond promptly to emails but cannot guarantee that all Emails will be read and responded to. No one shall use Email for medical emergencies or other time-sensitive matters. It is the patient's responsibility to follow up with Dr. Sikorski if a response has not been received within a reasonable time period.

Please be advised all Emails to or from Dr. Sikorski will be made part of your medical record. It is your responsibility to inform Dr. Sikorski of any types of information you do not want sent by Email. Dr. Sikorski will not forward Emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

I acknowledge that I have read and fully understood this consent. I understand the risks associated with email communications between Dr. Sikorski and myself, and consent to the conditions outlined. In addition, I agree to the instructions for communicating by Email, as well as any other instructions that Dr. Sikorski may impose to using Email.

Signature of Patient or Guardian: _____ Date: _____

PATIENT PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of providing you with quality naturopathic care. Dr. Greg Sikorski understands the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly.

We strive to ensure that:

- Only necessary information is collected about you;
- We only share your information with your written consent;
- Storage, retention, and destruction of your personal information complies with existing privacy legislation and privacy protection protocols of our regulatory body, The College of Naturopathic Doctors of Alberta.

Information is collected, used and disclosed about you for the following purposes:

- To assess your health concerns and advise you of treatment options;
- To establish and maintain contact with you and remind you of upcoming appointments;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up for treatment, care and billing;
- To comply with legal and regulatory requirements;

I have read and understand how Dr. Greg Sikorski will use my personal information and the steps taken to protect my information. I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

Signature of Patient or Guardian: _____ Date: _____



CONSENT

INFORMED CONSENT FORM

Please note that this form must be signed prior to your first appointment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. 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. Your Naturopathic Doctor will take a thorough case history and perform a physical examination. Each patient seeking care in this clinic should understand that the practitioner is a Naturopathic Doctor, not a medical doctor.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

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. Treatments used in this clinic include nutrition, botanical medicine, lifestyle counseling, homeopathy, Traditional Chinese medicine (including acupuncture), hydrotherapy, physical medicine, laboratory testing and supplement recommendations.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by your Naturopathic Doctor prior to manipulating the neck.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

I have been informed and I understand that:

- The clinic does not guarantee treatment results.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.
- I agree to pay my account in full at the time of each visit. I am aware that Alberta Health Care does not cover these fees.

Patient Name (please print): _____

Signature of Patient or Guardian: _____ Date: _____

Naturopathic Doctor: _____



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CANCEL

CANCELTATION POLICY FORM

If I am unable to make a scheduled appointment **I must provide 24 hours advance notice to avoid being charged a missed appointment fee of 100%**. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as any other applicable fees.

Credit Card information: Visa or Mastercard

Patient's Name On Card (please print) _____
First Middle Last

Credit Card Number: _____ Expiration Date: _____ CVC: _____
Month Year 3 digit on back

Patient's Full signature: _____ Today's Date: _____
Month Day Year

Credit card information will only be used in the event that less than 24 hours' notice was not given to The Natural Element, office of Dr. Greg Sikorski ND, by the patient above. If in the event the credit card does not work, the full amount will have to be paid prior to the next scheduled appointment. Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged for their "missed" appointment and future service will be denied until payment is made.