Vis
NATURAL HEALTH CLINIC

Dr. Tanya Rampersad, ND
CNDA Member: 1640

Dr. TANYA RAMPERSAD, N.D. AANP Member 1640

Full name: _____

Birthdate: (d/m/y) _____ Sex: M ☐ F ☐ Ancestry: _____

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____

Cell: _____ Email: _____

Occupation: _____

Employer: _____

Provincial Health Number: _____

Private Insurance Company: _____

Emergency Contact: _____

Relationship to patient: _____ Phone: _____

By providing your email address, you are allowing us to send you emails as a form of communication. Group emails may be sent approximately every 1 - 2 months. If you check below, you will not be notified of changes to policies, pricing, services and locations which happen from time to time. You may visit **drtanyanaturopath.ca/policies** to view most current policies.

☐ I do not wish to receive email correspondences

How did you hear about Dr. Rampersad and/or Vis Natural Health?

(eg. Friend, Google, or flyer): _____

Name of referring person: _____

## Terms of Admission

**Personal:** In signing below, I voluntarily consent to treatment with the understanding that the form of medical care I will receive is based on naturopathic principles, practices and therapies. These may include but are not limited to: nutritional counseling, herbal medicine, homeopathy, injections, counseling, soft & hard tissue manipulation, hydrotherapy, cold laser & infra-red therapy, radio frequency & lab testing. Please note that there are potential risks to any health related treatment as well as benefits. If I do not understand the risk of any treatment, I understand that it is my duty to ask for clarification or more information.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or otherwise permitted or required by law.

**Financial:** I understand that **deposits may be required to hold space for scheduled visits**. To receive package prices, payment must be made for the entire package prior to service. I understand that if I am providing insurance billing information, that I am responsible for all charges whether or not they are covered by my insurance. Money for prepaid packages is non-refundable, however, credit for services yet-to-be delivered may be applied to other services or products offered at Vis Natural Health (credits are calculated on non-package pricing). ****Cancellation or rescheduling of appointments must be done 48 hours prior to the original appointment time to avoid loss of deposit or prepayment. Late cancellations or no-shows will result in missed visit charges and a valid credit card being kept on file for future bookings. In the case of prepaid packages, missed visits and late cancellations will be considered used services.**

By signing below, I affirm that I understand and agree to the above terms and that the information I provide is thorough and correct to the best of my ability.

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature Date

_____
Print Name

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# Present Health Concerns

List your health issues in order of significance along with any diagnosis you've received:

1 _____

2 _____

3 _____

4 _____

Please list any treatments you are currently receiving; including prescription medication, vitamins, mineral, herbs, and homeopathic remedies. Please include dosages for each listing.

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

How would your life be different if the above concerns were not an issue? _____

_____

What will the absence of the above concerns look and feel like? _____

_____

## - Medical History -

Hospitalizations _____

Serious Illnesses/Injuries _____

Date of most recent physical exam _____ Date of most recent blood test: _____

# of general anesthetics/sedations _____

Name of your doctor _____ Location: _____Phone: _____

Current weight _____ Weight one year ago _____ Maximum weight _____

Blood type: A ☐ B ☐ AB ☐ O ☐ Don't know ☐

Family Medical History – include what is known. M = mother's side; P = father's side

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Allergies | M☐ P☐ | Autoimmune Dz* | M☐ P☐ | Diabetes | M☐ P☐ |
| Physical deformities | M☐ P☐ | Heart Disease | M☐ P☐ | Eczema | M☐ P☐ |
| Syphilis | M☐ P☐ | Tumors/growths | M☐ P☐ | Obesity | M☐ P☐ |
| Cancer | M☐ P☐ | Epilepsy / Seizures | M☐ P☐ | Parkinson's | M☐ P☐ |
| Thyroid Condition | M☐ P☐ | Mental Illness | M☐ P☐ | Stroke | M☐ P☐ |
| Tuberculosis | M☐ P☐ | Blood disorder | M☐ P☐ | Osteoporosis | M☐ P☐ |

* Dz = Disease

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Dietary Preferences/Restrictions _____

Sleep Patterns (hours, shiftwork) _____

Relationship Status (please check): S ☐ M ☐ D ☐ W ☐ Significant Other ☐

Do you have children? Yes ☐ No ☐ if so, how many? _____ please list their ages: _____

**Please mark the rows according to your level of satisfaction of each category.**

| | Physical Enviroment | Family & Friends | Spirituality | Fun & Recreation | Health | Significant Other/ Romance | Money | Career | |
|---|---|---|---|---|---|---|---|---|---|
| **5** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | **5** |
| **4** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | **4** |
| **3** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | **3** |
| **2** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | **2** |
| **1** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | **1** |
| **0** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ | **0** |

Smoke? Y ☐ N ☐ How many per day? ____ How many years? ____ tried to quit? Y ☐ N ☐

Drink Alcohol? Y ☐ N ☐ How often? Daily ☐ weekly ☐ infrequently ☐ #/Week _____

Drink coffee? Y ☐ N ☐ How many cups/day? _____

Use recreational drugs? Y ☐ N ☐ How often? Daily ☐ weekly ☐ infrequently ☐

Have surgical or cosmetic implants? Y ☐ N ☐ Please specify: _____

How many times have you been on antibiotics? _____ When was the last time? _____

Have you been vaccinated? Y ☐ N ☐ Any adverse reactions? Y ☐ N ☐

Please list any occupational or environmental hazards _____

How many: root canals # ____ current amalgam (silver) fillings # ____

amalgam fillings removed # _____

Pending dental work Y ☐ N ☐ Nature of the issue _____

Drug, environmental and food allergies/sensitivities _____

Are there any other significant events that you believe have impacted your health?

_____

Please describe your commitment to overcome your current health concern(s) – check one:

- O I am willing to commit fully to the process of seeking wellness
- O I have other priorities that may prevent me from committing myself fully to getting well
- O I have little space in my life to commit effort to getting well.

In what length of time are you expecting or hoping to see significant results? _____

How will you know you have met your wellness goals? _____

_____

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Please check all significant conditions that you currently have or have had in the past:

| | | | |
|---|---|---|---|
| General | ◯ Weight-loss | ◯ Excessive Thirst | ◯ Anemia |
| | ◯ Weight-gain | ◯ Significant drop in Energy/Time of day? | ◯ Heat or Cold Intolerance |
| | ◯ Fevers | | ◯ Unusual tastes or smells |
| | ◯ Chills | ◯ Fatigue | ◯ Bleed or Bruise easily |
| | ◯ Excessive Sweating | | |
| Skin<br>Hair | ◯ Rashes | ◯ Dandruff | ◯ Changes in hair or skin texture |
| | ◯ Itching | ◯ Changes in Moles | |
| | ◯ Eczema or Psoriasis | ◯ Ulcers | ◯ Loss of hair |
| | | ◯ Acne | |
| Head<br>Eyes<br>Ears<br>Nose<br>Throat | ◯ Headaches | ◯ Cataracts | ◯ Poor hearing |
| | ◯ Neck masses | ◯ Corrected vision | ◯ Frequent colds/flu's |
| | ◯ Hay fever | ◯ Ear aches | ◯ Sinus problems |
| | ◯ Eye pain/strain | ◯ Ringing in ears | ◯ Frequent nose bleeds |
| | ◯ Blurry vision | ◯ Mouth pain or sores | ◯ Jaw pain |
| Heart<br>Circulation | ◯ Irregular Heartbeat | ◯ Fainting/Dizziness | ◯ Low blood pressure |
| | ◯ High Blood Pressure | ◯ Cold Hands/Feet | ◯ Chest pains |
| | ◯ Blood Clots | ◯ Swelling in hands/feet | ◯ Varicose veins |
| Respiratory | ◯ Difficulty Breathing | ◯ Coughing up blood | ◯ Bronchitis |
| | ◯ Asthma | ◯ Wheezing | ◯ Pneumonia |
| | ◯ Phlegm | | ◯ Cough |
| Digestion | ◯ Indigestion/heartburn | ◯ Poor/Excess Appetite | ◯ Abdominal pain |
| | ◯ Gas/Bloating | ◯ Change of Appetite | ◯ Rectal pain |
| | ◯ Diarrhea | ◯ Bad Breath | ◯ Hemorrhoids |
| | ◯ Constipation | ◯ Nausea | ◯ Blood in stool |
| | ◯ Parasite Infection | ◯ Vomiting | |
| Genito-Urinary | ◯ Frequent urination | ◯ Increased urgency | ◯ Blood in urine |
| | ◯ Pain on urination | ◯ Decrease in flow | ◯ Sores on genitals |
| | ◯ Unable to hold urine | ◯ Kidney stones | |
| Musculo-skeletal | ◯ Neck pain | ◯ Joint swelling | ◯ Joint pain/stiffness (Ankle, wrist, hip, knee) |
| | ◯ Back pain | ◯ Muscle pain or weakness | |
| | ◯ Hand / foot pain | ◯ Bone pain | |
| Neurological<br>Psychological | ◯ Numbness | ◯ Loss of Balance | ◯ Anxiety |
| | ◯ Dizziness | ◯ Stress | ◯ Difficulty concentrating |
| | ◯ Poor Memory | ◯ Depression | ◯ Seizures |
| Female | ◯ Irregular periods | ◯ Heavy menses | ◯ Painful periods |
| | ◯ Clotted Periods | ◯ Fibroids | ◯ Cysts: Uterus / Ovaries |
| Male | ◯ Urinary hesitance | ◯ Erectile dysfunction | ◯ Prostate disease |
| | ◯ Testicular pain/swelling | ◯ Difficult urination/incomplete voiding | |

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- Packaged services are to be used within 3 months or 90 days of purchase. If the packaged services are not used within this time, credit in service will be granted based on current value of those same or other services.

- Missed appointments and late cancellations will be considered used services from a package.

- The clinic requires 48 hours notice by phone of intent to cancel or reschedule an appointment. If this is not provided, charges will be applied and deposits will be required for future bookings. Less than 48 hours notice will incur a $25 fee, less than 24 hours notice will incur fee for the entire visit that was missed.

- Alberta Health does not cover standard or special laboratory testing, even when blood is drawn through Calgary Lab Services. This means that all tests must be paid for at the time of requisition.

- For reasons of liability and potential misinterpretation or misuse, lab results will not be provided over the phone or via email. A follow-up appointment needs to be booked to go over lab results. Ideally this follow-up is pre-booked so you will know when to expect your test results and we will know whether it has not been processed properly.

- If you are having any problems with any medications or remedies provided, or if you are not sure whether you are having a drug or medication reaction, it is expected you will call us to let us know so we can problem solve and adjust dosing.

- All treatments and therapies come with risks including the failure to perform as expected, discomfort and even more serious risks. If you do not understand the risks inherent in any therapy, please ask for clarification.

- We will not discuss additional, new or ongoing health problems over the telephone or by email. If you cannot make it in and need assistance, you can schedule a telephone consult.

- Our service charges are based on time. If we go over an appointment time, we will ask if you wish to continue and increase the visit length. Your agreement means you are willing to pay for the additional time. If you do not agree, it may be suggested that certain issues be dealt with in subsequent visits.

- We try our best to be diligent, thorough, fair and clear. We are not perfect and are always trying to improve. If you see room for improvement, please let us know.

I, _____, understand and accept the above terms. I hereby agree to pay for missed visits and late cancellations (as specified above).

_____ _____

(Signature) (Date)

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# Visceral Manipulation Informed Consent

Visceral manipulation (VM) is a manual (hands on) technique for assessing and treating organ and glandular function, but can be used to assist with any abnormal line of tension within the body including and not limited to: hard, bony tissues, ligaments, capsules, nervous and neural tissue, arteries and veins. The technique is gentle and minimal and therefore the risks are very small. However, any therapy has potential adverse responses, for VM, these can include:

- Soft tissue tears
- Internal bleeding
- Gallstone dislocation causing gallbladder attack
- Worsening of current malady (aggravation – temporary)
- Creation of new symptoms
- Dislodging of implants (e.g. IUD's)
- Fracture of ribs or bones (i.e. in osteoporosis)
- Miscarriage (in pregnancy)

We will make every attempt to minimize risk and maximize benefits for patients, but it is important to inform the doctor if there has been a change in health status, if there are new/any implants, medical devices, pins, plates, stents or potential pregnancy.

If you do not understand the potential risks and benefits, it is your duty to yourself to seek clarification from the doctor.

I, _____ agree with above statement of personal obligation and understand the above potential risks of manual therapies. I give consent for manual therapies, including Visceral Manipulation (assessment and treatment) administered by Dr. Tanya Rampersad, ND or associates.

_____ _____

Signed Dated

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# Injection Therapy Informed Consent

Sign above to give consent, sign below to deny consent

Injection therapies come with additional benefits like stronger, more dramatic activity of medicines, and improved response rates. They also come with additional considerations and risks. These risks pertain to any time anything is injected beneath the skin and include:

Contamination at the site of injection can lead to infections, which can become systemic involving the whole body. High fevers within 24 to 48 hours of injection may be a sign of systemic infection and should be dealt with promptly through emergency services.

Bruising is a common side effect of injection therapies and is not considered to be serious or life threatening.

Hypersensitivity reactions can occur with repeated exposure. These are immune responses and can vary from minor to severe and life threatening. Minor reactions include swellings or rashes. Severe reactions include anaphylactic reactions, whose symptoms include swellings, anxiety, fainting, GI cramps, difficulty swallowing or breathing. If any of the above occur the first course of action will be diphenhydramine (Benadryl) orally or intramuscularly, and if needed the second course of action will be epinephrine intramuscularly. Regardless of whether recovery is full and complete, due to secondary reactions, it is **ABSOLUTELY NECESSARY THAT THERE IS SAME DAY FOLLOW UP WITH AN EMERGENCY FACILITY**. Any potential sensitivities should be reported to the clinician immediately. All allergies should be listed on the intake form to avoid injecting a potential allergen.

There can be minor and temporary discomfort from injection therapies.

By signing I confirm that I understand the risks and benefits of injection therapies and give consent for such therapies should they be appropriate for my care.

_____
(Print Name)

_____ _____
((Signature) (Date)

---

I **never** want to receive injection therapies.

_____
(Print Name)

_____ _____
(Signature) (Date)