The Conscious Pod
Holistic Solutions for Down Syndrome

Consent to Naturopathic Treatment

Naturopathic medicine uses natural approaches to treat and prevent disease. Naturopaths take into account the unique complexity of a person's circumstances, including physical, mental, emotional, genetic, environmental and spiritual factors. Therapeutic procedures include diet and lifestyle counselling, nutritional supplementation, herbal medicine, homeopathy, aromatherapy, bach and bush flower essences.

Gabi Giacomin's Professional Indemnity Insurance does not cover countries outside Australia. Clients outside Australia are welcome for consultation but would have to pursue legal matters within Australia.

While the chances of experiencing complications from supplements are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to:

- Temporary worsening of symptoms

More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side effects and understand that there may be potential risks or side effects that Gabi Giacomin cannot anticipate. I also understand that there is no guarantee for a specific cure result. I understand that at any time I may withdraw consent to any further treatment. All enquiries: c-pod@outlook.com.

Patient Name________________________________Guardian Signature_______________________

Clinic Policies

All personal and medical information, including pathology tests are kept by Gabi Giacomin at The Conscious Pod. Your information is not released without written consent provided by you unless required by law. All patient information is kept private and confidential.

I consent to discussing my child's case through email if necessary: Yes ☐ No ☐

Fees:

50 minute Skype Consultation: $140.00

I understand that if I miss an appointment or cancel with less than 24 hours notice, I may be charged for the missed appointment.

Guardian Signature____ Date______________________

Witness Signature____________________________ Witness Name___________________________

Welcome!Thank you for taking the time to fill out this extensive questionnaire. Your time and care is appreciated.

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Consent to Audio-Visual Communication

Online audio-visual consultations are an alternative to face-to-face consultations. There are situations where an online audio-visual consultation will enable more convenient and accessible healthcare delivery without compromising patient safety.

Benefits of audio-visual communication

- greater accessibility to specialist practitioner
- patient remains in the comfort of their home
- reduced financial burden for patient
- quick access to natural medicine care
- tests can be obtained from other locations

Risks of audio-visual communication Risks are rare, but the potential for problems during audio-visual communication must be examined:

- quality of image resolution and voice transmission may be poor
- internet connection or equipment may fail leading to delays or interruptions to consultations
- security efforts may be breached and confidential information leaked
- email communication may be lost or unopened

I, the patient, give consent to the following procedures and policy:

1. Information will be collected during Skype consultations and may be used to create a plan of treatment, referral for therapy, recommendation of supplements, education and future appointments. It can include: disclosure of pathology test results, medical images and records and includes audio and video streaming.

2. All efforts will be made to protect patient privacy and no recording of the consultation will occur without the patients prior consent. Patients are not authorised to make recordings of the online audio-video consultation.

3. Appropriateness of audio-visual consulting will be determined by the practitioner prior to the first consultation and subsequent consultations. Internet security software and adequate internet activity is used to secure patient confidentiality.

4. The only parties present during the audio-visual consultation will be the patient, any support person and the practitioner. A parent/ guardian must be present during the entire consultation if it involves a person under 18 years of age.

5. Patients may decline participation in the online audio-visual consultation at any time. If the patient wishes to decline participation in the audio-visual consultation fees still apply. In the unlikely event that the internet isn't working, telephone consultation will be used.

Patient Name____Date of Birth____________________

Guardian Signature_____________________________Relationship to Patient______________Date______

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Pediatric Intake Form (0 - 1 year)

Name:_______________________________________Age: ________DOB__________
Address:____Country:__________
Parent's Name:______________________________Email:______________________
Occupation:_________________________________Phone:_____________________
Emergency Contact:____

What are you child's main health concerns?
1____
2____
3.____
What are your treatment goals and expectations?
____
____
____

Diagnosis: Down Syndrome ☐ Autism ☐ ADD/ ADHD ☐ Other:_________
How do you rate your child's overall health? Poor ☐ Fair ☐ Good ☐ Excellent ☐

Pregnancy

Mother's illnesses during pregnancy

High Blood Pressure ☐ Diabetes ☐ Bleeding ☐ Low iron ☐
Hypothyroidism ☐ Excessive Vomiting/ Nausea ☐ Trauma ☐
Other:____

Substances used during pregnancy

Tobacco ☐ Alcohol ☐ Caffeine ☐
Recreational Drugs ☐ Prescription Medication ☐ Herbal Preparations ☐
OTC Drugs ☐ Other:_________________________________

Interventions used during pregnancy

Ultrasound ☐ Amniocentesis ☐

Term Length of Pregnancy

Pre-term (37 weeks or less) ☐ Full term (38 - 42 weeks) ☐ Post term (42 weeks)

Delivery

C-Section ☐ Vaginal ☐ Jaundice ☐ Colic ☐ Seizures ☐
Heart ☐ NG-tube ☐ ICU ☐ Breastfed ☐ Bottlefed ☐
Respiratory distress ☐

Complications during delivery

Difficult delivery ☐ Long 2nd Stage labour ☐ Breech delivery ☐ Shoulder dystocia ☐

Interventions administered at birth

Vitamin K ☐ Eye Drops ☐ Hepatitis B Vaccine ☐
At birth: Weight ___________ Length _____________ APGAR Scores _______________

Complications after delivery

Jaundice	☐	Rash	☐	Colic	☐	Seizures	☐
Respiratory distress	☐	Birth defects	☐	Bleeding	☐	Fever	☐
Hip Displacement	☐	Scoliosis	☐	Infections	☐	Injuries during birth	☐

Other:____

Feeding

Breast Fed: Yes No How long:________________________________
Bottle Fed: Yes No How long:________________________________

What type of formula was used? (milk, soy, other) ________________________________
Where there any reactions to formula? ____

Introduction of Solid Foods
When? ________________________
First foods in order of introduction

____
Were there any reactions to the foods? constipation, colic, congestion

____

Medication/ Supplements
How many courses of antibiotics has your child had in the past? ________________________

List all medical drugs, vitamins, herbs and supplements being taken at present

____
____
____
____
____
____
____

Family Medical History

Asthma	☐	Chrohn's or Colitis	☐	Kidney Disease	☐	Heart Disease	☐
Allergies	☐	Diabetes	☐	Liver Disease	☐	Osteoporosis	☐
Autoimmune	☐	Eczema	☐	Cancer	☐	Thyroid Condition	☐

Child's Health Condition

Hypothyroid	☐	Hyperthyroid	☐	Anaemia	☐	Constipation	☐
Leukaemia	☐	Heart defect	☐	Seizures	☐	Ear Infections	☐

Sleep Apnoea ☐ Scoliosis ☐ Hearing Loss ☐ Delayed Growth ☐
Reflux ☐ Food Sensitivities ☐
Other ____

Immunisations
Fully vaccinated ☐ Partly vaccinated ☐ No vaccinations ☐
Reaction to vaccination____

Diet
Breakfast:____
Lunch:____
Dinner:____
Snacks:____
What types of food are used? Home-grown organic ☐ Some Organic ☐ No Organic ☐
Are all foods served fresh? Yes ☐ No ☐
List all raw foods your child eats: ____
Water
tap ☐ filtered ☐ distilled ☐ reverse osmosis ☐ spring ☐
amount per day ____
Other Liquids
fruit juice ☐ herbal tea ☐ cow's milk ☐ soft drink ☐

Is your child on a Nutritional Program?
Basic Elimination Diet ☐ Food Rotation ☐ Low Glycemic ☐ GAPS ☐
Other ____

Allergies
Is your child allergic to: Medication ☐ Foods ☐ Environment ☐ Animals ☐
Specific item/ reaction ____

Environmental Toxic Exposure
Has your child been exposed to:
Toxic Chemicals ☐ Solvents ☐ Sprays ☐ Pesticides ☐ Herbicides ☐ Heavy Metals ☐
Please describe: ____
Air quality: Is your child exposed to: smoke ☐ incense ☐ perfumes ☐
Quality of bath water: Municipal tap water ☐ Filtered ☐ Spring ☐
What sort of cleaning products do you use at home? ______________________________
How old is your child's mattress? __________ Quilt? __________ Pillows? __________

Energy Level
Poor ☐ Fair ☐ Good ☐ Excellent ☐
Please describe____

Gross Motor Skills

Rolling Over ☐ Sitting Up ☐ Crawling ☐ Standing ☐

Holding onto furniture ☐ Walking ☐ Kicks Ball ☐ Running ☐

Jumping ☐ Rides Bike ☐

Sleep

Difficulty falling asleep ☐ Does not sleep through the night ☐ wakes unrefreshed ☐

nightmares ☐ sleeps with a light on ☐ talks in sleep ☐ sleep walks ☐

Bedtime ___________ Time wakes _____________ Hours of sleep per night _______________

Naps? ____________ When? _______________ How long? ____________________________

What position does your child sleep in? ____

Temperature

How does your child feel most of the time? Warm ☐ Cold ☐

Bowel Habits

Frequency of stool: times per day _______________ times per week ____________________

Digestion

Bloating ☐ Loss of appetite ☐ History of anaemia ☐ Excessive Gas ☐ Constipation ☐

Undigested food in stool ☐ Difficulty gaining weight ☐ Diarrhoea ☐ Difficulty swallowing

Extremely Narrow Stools ☐ Mucous or Blood in stools ☐ Yellow colour of skin or eyes ☐

Pale clay-coloured stool ☐

Blood tests

DNA test ☐ MTHFR ☐ CDSA ☐ GI Function ☐

Bioscreen ☐ Organic Acids Test ☐ Urine Amino Acids ☐ Hair MineralAnalysis ☐

Gluten ☐ Allergy Panel ☐ Liver Function ☐ Vitamin D ☐

Iron ☐ Reverse T3 ☐ Thyroid Antibodies ☐ Thyroid ☐

Cortisol ☐

Surgery/ Hospitalisation

Reason for surgery/ hospitalisation ____

Hospital ____________________________________ Date ______________________________