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. During your first Skype consultation Naturopath Gabi Giacomin will take a thorough medical history and recommend supplements and laboratory testing.

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_____Patient 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 ☐

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

Patient 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.

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_____

Patient Signature_____Date_____

Ballina, NSW, Australia 2478 **Adult Intake Form** c-pod@outlook.com

Name:_____Age: _____DOB_____
Address:_____Country:_____
Occupation:_____Email:_____
Emergency Contact:_____Phone:_____

What are your main health concerns?
1_____
2_____
3._____
What are your treatment goals and expectations?
_____
_____
_____

How do you rate your overall health? Poor ☐ Fair ☐ Good ☐ Excellent ☐

Medication/ Supplements
How many courses of antibiotics have you 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 ☐

Health History

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 ☐

Water
tap ☐ filtered ☐ distilled ☐ reverse osmosis ☐ spring ☐

amount per day _____
Other Liquids
fruit juice ☐ herbal tea ☐ cow's milk ☐ soft drink ☐
Are you on a Nutrition Program?
Basic Elimination Diet ☐ Food Rotation ☐ Low Glycemic ☐ GAPS ☐
Other _____

Allergies

Are you allergic to: Medication ☐ Foods ☐ Environment ☐ Animals ☐
Specific item/ reaction _____

Environmental Toxic Exposure

Have you been exposed to:
Toxic Chemicals ☐ Solvents ☐ Sprays ☐ Pesticides ☐ Herbicides ☐ Heavy Metals ☐
Please describe: _____
Air quality: Are you 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 mattress? _____ Quilt? _____ Pillows? _____

Energy Level

Poor ☐ Fair ☐ Good ☐ Excellent ☐
Please describe_____

Sleep

Difficulty falling asleep ☐ Do not sleep through the night ☐ wake unrefreshed ☐

Temperature

How do you 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 _____