

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 Giacomini'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 Giacomini 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 Giacomini 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.

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.

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 _____

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 Crohn'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 Mineral Analysis
Gluten Allergy Panel Liver Function Vitamin D
Iron Reverse T3 Thyroid Antibodies Thyroid
Cortisol

Surgery/ Hospitalisation

Reason for surgery/ hospitalisation _____
Hospital _____ Date _____