Trillium Health Clinic

Dr. Michelle Myszko, ND

141 – 3 Wellington St, St Thomas, ON, N5R 2R8 TrilliumHealthClinic.com
Phone: (519) 854 – 3824 DrMichelle@TrilliumHealthClinic.com

NATUROPATHIC MEDICINE INFORMED CONSENT

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.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include dietary modification, nutritional supplementation, lifestyle counselling, botanical medicine, homeopathy, traditional Chinese medicine & acupuncture, hydrotherapy, physical medicine, bioenergetics, reiki, and shamanic healing techniques.

During your initial visits, Dr. Michelle Myszko ND will take a thorough case history, perform a basic/complaint-oriented physical examination, and when indicated refer to Life Labs for laboratory testing.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends dramatically, on the individual and the extent of the illness. Some therapies must be used with caution in certain conditions or diseases such as diabetes, heart/liver/kidney disease, or in young children, those taking multiple medication or pregnancy/lactation. Therefore, it is very important that you inform Dr. Michelle immediately of any disease process that you are suffering from, any medications (prescription or over-the-counter) that you are taking or if you are pregnant, suspect you are pregnant, or you are breastfeeding.

I understand that Dr. Michelle Myszko ND will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above for my child.

Health risks associated with Naturopathic Medicine include, but are not limited to:

- Aggravation of pre-existing symptoms during the healing process
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains or disc injuries from spinal manipulation

The Naturopathic Doctor may prescribe supplements that can be purchased at the clinic or at other local options i.e. health food stores. Most insurance companies do not cover the supplements that we prescribe and dispense. I understand that fees (see fee schedule page 3 & 4) and supplements are to be paid for at the time of the consultation. As the patient, I am responsible for the total charges incurred

for each visit. I understand that a fee will be charged for any missed appointments or cancellations with less than 48 hours' notice.

I understand that a record will be kept of the health services provided for your child. This record will be kept confidential and will not be released to others unless so directed by the parent or guardian unless law requires it. I understand that I may look at my child's medical record at any time, and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

- ☐ I acknowledge that I have read, understand and consent to the above terms of care.

- ☐ I confirm that I am **NOT** an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating.
- ☐ I agree that I will not record any of my visits with an audio or video device, without written permission.

EMAIL CONSENT:
Trillium Health Clinic offers patients the opportunity to communicate by email to support you between visits. If you choose to use email communication, you acknowledge the following:

- Due to the nature of email communication, there are inherent risks concerning privacy
- Emails concerning diagnosis or treatment will be made part of patient's medical record
- Medical advice cannot be given over email. Only clarification and communication regarding appointment times may be given.

- ☐ I consent to use email as a form of communication
- ☐ I do not consent to use email as a form of communication

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent for the collection, use and/or disclosure of your personal information as outlined above. I have reviewed the above information that explains how your clinic will use my personal information, and the steps being taken to protect my information. I agree that Trillium Health Clinic can collect, use and disclose personal information as set out above in the information about the Clinic's privacy policy.

Patient Name (please print):_____

Signature of Parent/Guardian: _____ Date: _____

CONSENT TO TREATMENT
I hereby acknowledge that Dr. Michelle Myszko ND has explained to me the nature of the naturopathic treatment I am to receive including the benefits of the treatment, any risks associated with the treatment and any medical alternatives. I hereby consent to the treatment as set out below for my child.

Patient Name (please print):_____

Signature of Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____

Trillium Health Clinic

Dr. Michelle Myszko, ND

141 – 3 Wellington St, St Thomas, ON, N5R 2R8
Phone: (519) 854 – 3824
TrilliumHealthClinic.com
DrMichelle@TrilliumHealthClinic.com

NATUROPATHIC SERVICES & FEES

INITIAL NATUROPATHIC VISITS: (IN OFFICE, VIRTUAL OR PHONE)	
Foundational Health Consultation (Adult or Child) (90 to 120 mins)	$ 275.00
NATUROPATHIC FOLLOW UP VISITS: (IN OFFICE, VIRTUAL OR PHONE)	
Extended Health Consultation & Reassessment (60 to 80 mins)	$ 240.00
Comprehensive Health Consultation (up to 50 mins)	$ 160.00
Focused Health Consultation (up to 25 mins)	$ 100.00
Acupuncture (25 mins)	$ 90.00
Acute Assessment (up to 15 mins)	$ 50.00
OTHER SERVICES & FEES:	
Email Consults (up to 15 mins)	$ 50.00
Home Visit Travel Fee	$ 60.00
Trillium Preferred Membership	$ 25.00 (+HST)
SHAMANIC & ENERGETIC HEALING SESSIONS:	
Deep Shamanic & Energetic Healing Session	$ 270.00 (HST INCLUDED)
Focused Shamanic & Energetic Healing Session	$ 180.00 (HST INCLUDED)
Couples Shamanic Healing Session	$ 360.00 (HST INCLUDED)
Family Shamanic Healing Session	$ 450.00 (HST INCLUDED)
Shamanic House Clearing & Blessing	$ 250.00 (HST INCLUDED)

***Please note: If you are having financial difficulty, please advise Dr. Michelle prior to your appointment to discuss if a sliding scale rate may be applied to your visit. Prices are subject to change.**

CANCELLATION POLICIES & FEES

Please keep in mind, that I require 48 hours' notice to cancel or reschedule appointments. Any missed appointments are subjected to the following fees:

Missed Appointment	**50% of Visit**

The Initial Naturopathic Visit:

Foundational Health Consultation (Adult or Pediatric)

The Foundational Health Consultation is an in depth initial naturopathic medicine appointment. In this thorough investigation, we will explore all aspects of your health including detailed health history, stress, lifestyle, diet, emotional states, how your body is functioning, your wellbeing and more. Dr. Michelle will take the guess work out of what is going on with your body and help you get the results you have been struggling to achieve. Dr. Michelle will assess, create and explain your individualized treatment program, with an action plans that include all aspects of your health. The Foundational health consultation is very thorough, so your appointment may vary from 90 mins – up to 2hrs. Please bring a list of all current medications.

The First Follow up Visit:

The first follow up visit, is always a **Comprehensive Health Consultation**, which allows time to do necessary physical exams, ask further questions, explain treatment plans and any therapeutic treatments (including acupuncture or other therapies).

Comprehensive Health Consultation

The Comprehensive Health Consultation is the standard follow up visit to continue healing your health goals and exploring deeper. In this visit Dr. Michelle is able to reassess the whole health picture, provide remedies, modify treatment programs or provide therapeutic tools like acupuncture, BIE or other healing modalities. Don't worry we will address all your concerns, track progress and continue the phases of your treatment programs in these visits.

Phone Consults or Emails

Occasional emails to answer brief questions about current prescriptions or brief symptoms that may have developed from a new prescription are included as a courtesy service to my patients. But when patients have a new health concerns that cannot wait until the next follow up visit and requires detailed answers via email or phone, then an Acute Assessment visit will be scheduled (fee). This includes creating a new prescription and answering detailed questions. This is based on Dr. Michelle's discretion and availability.

Acupuncture

Acupuncture visits will solely focus on maximizing time and benefit for acupuncture treatments based on the current treatment plan. The initial acupuncture assessment and schedule will be created during your initial visit or a Comprehensive Health Consultation and will be scheduled weekly for 6 – 8 weeks. During the acupuncture visits, we will briefly chat about how you are feeling and how the previous acupuncture treatment was and proceed to your relaxing acupuncture treatment. During these visits Dr. Michelle will not be addressing **new issues** or creating **new prescriptions**. After the 6 – 8 weeks a formal acupuncture reassessment will occur during a Comprehensive Health Consultation. For long term acupuncture treatment plans, approximately every 4 weeks, a Comprehensive Health Consultation and acupuncture will be scheduled to reassess acupuncture treatments, new symptoms/issues, to create new prescription recommendations, and an acupuncture treatment, if time permits.

Trillium Preferred Membership

Members will receive 15% discount off supplements purchased at Dr. Michelle's online dispensary or in-office for 1 year. This membership is sharable with family members of the same household who are also patients or Dr. Michelle and must use the same account.

Home Visit Travel Fee:
Home visits are available, but are limited to individuals with special circumstances (Including severe illness, weakness or frailty, or other mobility issues). This service is only available for Foundational Health Consultation, Extended or Comprehensive Health Consults and for those who qualify based on Dr. Michelle's discretion and availability. The fee includes travel time for up to 30 minutes or 40 km away from the office. My new location is wheelchair accessible to in person visits are available for individuals who are wheel-chair bound.

Labs and Lab Results Policies

- If you are interested in getting blood work done by Dr. Michelle the payments and requisitions will be done during your appointment.
- All Lab requisition will incur the following charges:
    - Life Labs Documentation Fee $ 14.00 **OR** ICL documentation fee $22.00 (may vary)
    - Lab Interpretation fee $40.00
    - Plus the cost of the individual labs tested
- Fees are subjected to change without notice
- Some labs are covered by your benefit package, call your company to find out.
- Generally the lab results will be delivered to you at your next appointment, unless the results indicate an emergency situation, then you will be contacted by phone by Dr. Michelle. If you need your results sooner you can schedule a 15 minute consultation.

FORMS OF PAYMENT ACCEPTED

Trillium Health Clinic accepts the following forms of payment for all services:

Cash	Preferred method
Cheques	Cheques will be accepted and a credit card will be kept on file in the event of a bounced cheque. Any cheques that bounce are subject to a **$20.00 Bounced Cheque Fee** & the charges will be immediately charged to the credit card on file.
Visa & M/C	The last 5 minutes of the appointment will be dedicated to running credit cards and printing receipts.
E-mail Money Transfer	Email money transfers will be expected to be received during the visit. If forgotten, a credit card will be kept on file, and the payment can be paid prior to the end of the business day (5pm). If fees are not received by the end of the day, the credit card on file will be charged the full amount. Send to michellemyszko@gmail.com Auto-deposit set up

ADOLESCENT INTAKE FORM

(AGE 10 -17)

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

Adolescent's Name: _____ Date: _____

Date of birth: _____ (M/D/Y) Sex: M / F

Who filled out this form: _____
(Name and relationship)

Who does the child live? _____
(Name and relationship)

Parent's Relationship: Married Common-law Divorced Widowed Single-parent

CONTACT INFORMATION:

CHILD'S PRIMARY CONTACT INFORMATION:

Guardians Name: _____ Relationship to child: _____

Address:

_____
Number Street Town/City Province Postal Code

Phone Numbers:

Home: _____ Work: _____ Cell: _____

May we leave messages relating to your child's visits? Y / N Which number: Home / Work / Cell

E-mail Address: _____

Would you like to sign up for our e-newsletter? Y / N

ALTERNATIVE CONTACT:

Name: _____ Relationship to child: _____

Address:

_____
Number Street Town/City Province Postal Code

Phone Numbers:

Home: _____ Work: _____ Cell: _____

EMERGENCY CONTACT:

Name: _____

Phone number: _____ Relation: _____

YOUR ADOLESCENCE'S TEAM OF HEALTH CARE PROVIDERS:

Name & Designation	Phone Number

1.	
2.	
3.	
4.	
5.	

How did you hear about Trillium Health Clinic? Please check one of the following:

- ☐ Times Journal Ad
- ☐ Elgin County Market Ad
- ☐ Trillium Health Website
- ☐ CAND
- ☐ OAND
- ☐ Facebook

Referred By: _____ Other: _____

ADOLESCENCE'S HEALTH INFORMATION

WHAT ARE YOUR ADOLESCENT'S HEALTH CONCERNS, IN ORDER OF MOST IMPORTANCE:

1.
2.
3.
4.
5.

MEDICAL HISTORY:

How would you describe your adolescent's general state of health? Excellent Good Fair Poor

Serious Conditions, Hospitalizations, Illnesses or Injuries:	Dates Occurred:
1.	
2.	
3.	
4.	
5.	

If you are female are you currently pregnant? Y / N

If you are female are you currently breastfeeding? Y / N

Are you sexually active? Y / N

Do your adolescence get regular screening tests done by another doctor? (pap, blood tests, etc.)? Y / N

Check all that apply:

- ☐ Anemia
- ☐ Depression
- ☐ Heart Problems
- ☐ Menopause

☐ Anxiety	☐ Diabetes	☐ Heart Murmurs	☐ Migraines
☐ Asthma	☐ Diarrhea	☐ Hepatitis	☐ Osteoporosis
☐ Arthritis	☐ Emphysema	☐ Hearing Loss	☐ PMS
☐ Blood disorders	☐ Endometriosis	☐ Infertility	☐ Peptic Ulcers
☐ Back Problems	☐ Glaucoma	☐ Liver Disease	☐ Seizures
☐ Cancer	☐ High Blood Pressure	☐ Kidney or Bladder disease	☐ Thyroid disease
☐ Cataracts			

If yes to any of the above, please explain: _____

_____

Were you born via Caesarean Section? Y / N

Have you had your tonsils or adenoids removed? Y / N

Have you had ear, nose or sinus surgery? Y / N If yes, please explain: _____

_____

MEDICATIONS & SUPPLEMENTS:

CURRENT MEDICATIONS

List all current Medications (Prescription & Over the counter) & Dosage	Dates Started
1.	
2.	
3.	
4.	
5.	

PAST MEDICATIONS

List all past prescription medications & Dosage	Start/End dates
1.	
2.	
3.	
4.	

ANTIBIOTIC USE:

How many times have your adolescent been treated with antibiotics: This year: _____
Lifetime: _____

Please indicate what immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster When:_____
- ☐ Haemophilus influenza B
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ MMR (measles, mumps, rubella)
- ☐ Polio
- ☐ Smallpox Flu
- ☐ Other: _____

Please indicate if any caused adverse reactions: _____

SUPPLEMENTS

List all current Supplements (vitamins, herbs, homeopathics etc.)	**Dates Started**
1.	
2.	
3.	
4.	
5.	

DO YOUR ADOLESCENT FREQUENTLY USE ANY OF THE FOLLOWING:
Aspirin / Laxatives / Antacids / Diet pills

Birth control: pills / implants / injections

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day_____

Recreational drugs—what and how often _____

FAMILY HISTORY:
Indicate if a close relative (Grandparent, parent, sibling, child) has had any of the following:

Allergies	
Asthma	
Heart Disease	
High Blood Pressure	
Cancer	
Diabetes	
Depression	
Other mental illness	
Drug Abuse or Alcoholism	
Kidney Disease	
Other	

LIFESTYLE:

SLEEP:

How would you rate your adolescence's sleep: / 10 (0- no sleep/insomnia → 10 – excellent sleep)

Quality: Poor / Fair / Good / Excellent

Sleep Times: Bed time: _____ Wake up Time: _____ Avg. Hrs/ night: _____

Do they need an alarm to wake up? Y / N

Do they feel refreshed in the morning? Y / N

Frequent waking: Y / N # of Times/night: _____

Do they frequently wake at a specific time every night (ex. 1am)? If yes, what times:_____

Do they wake to urinate? Y / N If so how many times per night? _____

Any other comments about sleep? _____

How would you describe your Adolescence's temperament?_____

_____

Is the adolescent in: school / homeschool / other: _____

How would you describe your adolescent's behaviour and performance at school?

_____

_____

_____

What is their favorite activities: _____

_____

Does the adolescent exercise regularly? Y / N

What do they do for exercise, how much and how often?

_____

_____

How much television does your adolescent watch? _____ hrs a day/week

How often does your adolescent read (not for school), or how often does someone read to your adolescent?

□ Daily □ Several times a week □ Weekly □ Less than weekly

EMPLOYMENT:

Occupation: _____ Hours/week: _____

Do you like your job? _____

Do you take holidays: Y / N How many weeks per year: _____

STRESS:

What would you rate your stress level: /10 (0- no stress → 10 – extreme stress)

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

_____

Hobbies: _____

_____

How would you describe the emotional climate of your home?

_____

_____

_____

EXERCISE:

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____

_____

DIET: Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (and amount): _____

Water: _____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

ALLERGIES & SENSITIVITIES:

Does your adolescent have any allergies (medicines, environmental, etc.)? Y / N

If Yes please explain:

_____

_____

_____

FOOD SENSITIVITIES & ALLERGIES:

When did your adolescent's digestive symptoms begin? _____ Are the symptoms getting worse? Y / N

Does your adolescent have any food allergies or intolerances? Please list.

_____

_____

_____

Check any symptoms that you have experienced:

- ☐ Abdominal Cramping
- ☐ Anaphylactic shock
- ☐ Arthritis type symptoms
- ☐ Bed wetting
- ☐ Canker sores
- ☐ Celiac Disease
- ☐ Constipation
- ☐ Depression
- ☐ Diarrhea or loose stools
- ☐ Difficulty concentrating
- ☐ Eczema
- ☐ Emotional upset
- ☐ Fatigue or sudden drops in energy after meals
- ☐ Food cravings
- ☐ Gas or Bloating
- ☐ Hay-fever
- ☐ Heartburn or indigestion
- ☐ Hives
- ☐ Irritability
- ☐ Irritable bowel syndrome (IBS)
- ☐ Itching- skin or rectal
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Migraines or headaches
- ☐ Nausea
- ☐ Red rash around mouth
- ☐ Redness or swelling of skin
- ☐ Runny nose
- ☐ Stomach aches
- ☐ Swelling of lips or face
- ☐ Wheezing
- ☐ Vomiting

ENVIRONMENTAL EXPOSURES:

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe:

_____

_____

Are there any tobacco smokers in your house or work? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Number of Pets?_____ Indoor or Outdoor? ☐ Cats ☐ Dogs ☐ Birds ☐ Other

Do you live in a:	☐ House	☐ Apt/Duplex	☐ Condo/Town House
Do you live:	☐ In the city	☐ In the suburbs	☐ Rural Areas
Type of Heating system?	☐ Hot air	☐ Radiator (steam)	☐ Electric
	☐ Wood or Coal Stove	☐ Hot water baseboard	
Do you use a:	☐ Humidifier	☐ Dehumidifier	☐ Air cleaner

How long have you lived in your house/apartment? _____

Approximately how old is your house/apartment? _____

Do you have a basement? Y / N Is your bedroom in the basement? Y / N

What type of pillow do you have? _____

What type of comforter do you have? _____

Type of flooring in your bedroom: □ Wall - wall carpet □ Area rug □ Animal Skin □ Bare floor

How old is your mattress? _____ What is your mattress? (I.e. cotton, horsehair) _____

Do you have air conditioning? Y / N If yes, Window Unit or Central Air

Do you have water leaks, mold contamination? Y / N

Is your home excessively humid? Y / N

ENVIRONMENTAL ALLERGIES:

When did your allergy symptoms begin? _____ Are your symptoms getting worse?: Y / N

Do you have any of the following symptoms? Please check all that apply.

□ Cough	□ Headaches	□ Shortness of breath	□ Poor sense of smell
□ Chest tightness	□ Hives/Swelling	□ Sinus infections	□ Postnasal drip
□ Blocked ears	□ Itchy nose	□ Sneezing	□ Runny nose
□ Ear infections	□ Itchy/watery eyes	□ Snoring	□ Wheezing
□ Eczema	□ Nasal congestion	□ Phelgm/sputum: Colour:_____	□ Other: _____
□ Fatigue	□ Nasal polyps		

When are your symptoms worse?

		□ Year Round	
□ January	□ February	□ March	□ April
□ May	□ June	□ July	□ August
□ September	□ October	□ November	□ December

Which of the following trigger (or cause) the symptoms? Please check all that apply.

□ Aerosol sprays	□ Dogs	□ Humidity	□ Other animals
□ Alcoholic beverages	□ Drafts	□ Insecticides	□ Perfumes
□ Basements	□ Exercise	□ Latex (Rubber)	□ Pollution
□ Cats	□ Grass	□ Leaves	□ Smoke
□ Cold air	□ Hay	□ Mold & Mildew	□ Weather changes
□ Cosmetics	□ House dust	□ Nervousness	□ Other: _____
		□ Odors	

Describe any reaction to insect stings: _____

_____

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

_____

_____

_____