daziran
Integrative Health

Hello and welcome to the Daziran Integrative Health. We are privileged to be a part of your healing team. For most people, the naturopathic experience will be quite different than the conventional medical system to which they are accustomed. Your initial visit will include a consultation, detailed history, relevant physical exam, screening diagnostics and naturopathic assessments. Other lab work may be requested depending upon your specific presentation and concerns.

Your second visit, usually two weeks later, will include a detailed report of findings and your individualized treatment plan will be discussed. Also, any remaining portion of the relevant physical exam will be completed on this visit. Treatment plans may include dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy, or hydrotherapy.

Subsequent visits are typically every 4 to 6 weeks, though may be more frequent if your child's case requires active treatments or close follow-up. As your child starts to experience greater health and wellness, an office visit every three months is recommended for general health maintenance and disease prevention. Please note that for infants, well child visits are recommended at 1, 2, 3, 6, 9, 12 and 18 months. If ever an acute, non-emergency condition occurs, please call the office as naturopathic treatments may be indicated.

At Daziran, we attempt to treat the whole person with an emphasis on the cause of their concerns, not just the symptoms. Our treatment plans are gentle and non-invasive, working with the body's inherent ability to heal itself. Client education is strongly emphasized as it encourages our patients to become invested in their health and therefore increases the likelihood of a successful outcome.

Contrary to what you might think, naturopathic care does not need to be practiced in isolation. Many of our clients with pre-existing medical concerns and subsequent treatment seek out our services to best ensure that all their health needs are met. We look forward to continued professional relations with the medical community so that our patients get the best of what both approaches have to offer. An integrative approach to health is an essential part of building happy and healthy communities.

With all this in mind, please take a few minutes to answer the following health questionnaire openly and honestly. Our ability to treat you with the best that naturopathic care has to offer depends on it. Additionally, please include a copy of your child's most recent lab work or imaging studies as these will help direct the course of your individualized treatment.

Looking forward to meeting you and your family,

_____

Dr. Marika Geis, BSc, ND
Daziran Integrative Health

daziran
Integrative Health

Patient Information:

Name: _____ Birthday:_____ Age:_____ M/F
(First) (Middle) (Last) (dd/mm/yy)

Height:_____ Weight:_____

Address:_____
(Box Number) (Number) (Street) (suite/apt #)

_____
(City) (Province) (Postal Code)

Would you like to receive Dr Geis' quarterly newsletter ☐

Legal Guardian: _____

Relationship to Patient: _____

Guardian's Home Phone Number: _____ Guardian's Cell Phone Number: _____

Guardian's Work Phone Number: _____ Guardian's email address:_____

Where is the most convenient place to reach you (Guardian)? _____

Guardian's Marital Status: _____ Number of Siblings: _____

Guardian's occupation: _____ Referred by: _____

In Case of Emergency, Contact:

Name: _____

Relationship to Patient: _____

Home Phone Number: _____

Cell Phone Number: _____

Office use only: Credit Card Number: _____ Expiry Date:_____

2A-2146 Robinson Street, Regina, Saskatchewan, S4T 2P7 Phone: 306.757.4325 Fax:306.522.0745

daziran
Integrative Health

Primary Health Concerns:
(Please list in order or importance)

a) _____

b) _____

c) _____

d) _____

Medical History:

Is your child currently seeing a family physician? Y/N

Name of family doctor: _____

Address: _____

Phone Number: _____

Have there been any recent lab tests or imaging studies? Y/N

If so what were the results?

_____

Current/Past Illnesses, Conditions Hospitalizations:

_____
_____
_____
_____

List medications or supplements used currently:

_____
_____
_____
_____

Allergies/sensitivities (food, drug, seasonal, pets, etc.)

_____
_____
_____

List any medications/supplements used in the past:

_____
_____
_____

Date of last physical exam:_____
Date of last antibiotic use:_____

Vaccinations received to date, check all that apply:

DPT ___	HiB _____	Hep A ____	Meningococcal ___
Tetanus Booster __	Flu _____	Hep B ____	Chicken Pox ____
MMR ___	Polio _____	Pneumoccocal ____	HPV ____

daziran
Integrative Health

Did your child experience any adverse reactions to the immunizations (eg: fever, rash, ear ache, behavioral disturbances etc), either immediately or up to a month following vaccinations? If yes, please explain.

_____

_____

How frequently has your child been prescribed antibiotics? When was the last date of use? For what purpose?

_____

_____

What was the date of your child's last physical exam? _____

What was the date of your child's last eye exam? _____

What was the date of your child's last hearing assessment? _____

ILLNESSES/ Review of Systems (*Please check all that apply)*

Condition/Symptom	Present	Past	Never	Condition/Symptom	Present	Past	Never
Childhood Diseases				**Head, Ears, Eyes, Nose**			
Chicken Pox				Headaches			
Diphtheria				Dizziness			
Rubella (german/3day)				Severe head injury			
Measles (2 wk)				Vision Problems			
Mumps				Itchy, watery eyes			
Polio				Recurring Ear Infections			
Whooping Cough				Earaches			
Mononucleosis				Frequent Runny Nose			
Roseola				Congestion			
Rheumatic Fever				**Digestive Health**			
Scarlet Fever				Constipation			
Throat and Lungs				Diarrhea			
Strep Throat				Indigestion/ Gas			
Tonsillitis				Colitis			
Asthma				Vomiting			
Bronchitis				Jaundice			
Coughing/ Wheezing				Mucus/blood in stool			
Croup				**Urinary Health**			
Pneumonia				Bed wetting			
Pleurisy				Bladder infections			

daziran
Integrative Health

Cardiovascular Health				**Neurological Health**			
Heart murmur				Meningitis			
High Blood Pressure				Encephalitis			
Immunology				Cerebral Palsy			
Frequent infections				Paralysis			
Influenza				MS			
Fevers				Seizures			
Skin				**Blood Disorders**			
Acne				Anemia			
Ulcers				Leukemia			
Hives/ Rashes				**Hormonal Health**			
Herpes (oral)				Diabetes			
Eczema				Hyperthyroid			
Cradle Cap				**Mental/Emotional Health**			
Poor wound healing				Anxiety			
				Fears			

Perinatal/Neonatal history

Length of pregnancy (weeks): _____

Mother's age at birth: _____

Were there any complications during pregnancy (eg: nausea, vomiting, bleeding, high blood pressure, pre-ecclampsia, gestational diabetes, positive GBS, physical/emotional trauma)? Y/N

If yes, please describe:

Were there any complications during delivery (eg: induction, cesarean, vacuum/forcep extraction, pre-term labor etc..)?

If yes, please describe:

Describe any complications for the mother or baby after the birth?

If available, please indicate

Baby's birth weight: _____ APGAR Scores _____

Baby's birth length: _____ Head circumference_____

daziran
Integrative Health

Prenatal History, Mom's health:

Has the mother ever miscarried? Y/N

If so, please indicate the date and at what point during the pregnancy the miscarriage occurred.

_____

Did the couple experience any difficulty conceiving (eg: ectoptic pregnancies or infertility)? Y/N

If so, what interventions were used to conceive (if any)?

_____

What was the total weight gain during pregnancy? _____

Was the mother previously over/underweight? Y/N

Briefly describe mom's diet during pregnancy, any food cravings?

_____

_____

What medications/supplements did the mother take during pregnancy?

_____

Was mom physically active during pregnancy?

_____

Did the mom smoke while pregnant? Y/N

If so, indicate quantity and frequency: _____

Did the mother smoke before conception? Y/N

If so, indicate quantity and frequency:_ _____

Did the mom use drugs or alcohol? Y/N

If so, indicate type, amount and frequency: _____

daziran
Integrative Health

Prenatal History, Dad's Health:

Dad's age at birth: _____

Did the father smoke prior to conception? Y/N

If so, indicate quantity and frequency:

_____

Was mom exposed to second hand smoke during pregnancy? Y/N

Did the father use drugs or alcohol prior to conception? Y/N

If so, indicate type, amount and frequency:

_____

Feeding and Diet History:

Was your child breastfed? Y/N Until what age? _____

Approximate feeding schedule:

_____

Were there any difficulties with breastfeeding? If so, please describe:

_____

If formula fed, for how long? _____

Type of formula (eg: dairy or soy based, other?): _____

Combined with breast milk? Y/N

Any adverse reactions (eg: diarrhea, constipation, rash, behavioral changes)? If so, please describe:

_____

When were solids first introduced?_____

Can you briefly describe the order in which foods were introduced?

_____

_____

Please indicate if there were any adverse reactions to any newly introduced foods:

Food Introduced	Colic	Bloating	Gas	Change in bowel mvnts (diarrhea/constipation)	Nausea/vomiting	Rashes
1.						
2.						
3.						

Please indicate what your child has consumed in the last 24 hours:

Breakfast: _____ How many glasses of water per day?

Lunch: _____ How many carbonated drinks per day?

Dinner: _____ How many glasses of milk per day?

Snacks: _____ How many glasses of juice per day?

Is this typical? If not, please describe:

_____

Has your child lost or gained significant amounts of weight at any time? Y/N

If so, please describe:_____

In general, how is your child's appetite? _____

Is your child a picky eater? Y/N

Developmental History:

Please indicate at which ages the following behaviors took place:

First held head erect _____ Said their first words with meaning _____

Rolled over _____ Spoke in sentences _____

Sat without support _____ Crawled _____

Was toilet trained _____Tied their first shoes _____

Took first steps _____ Dressed without help _____

Cut their first tooth _____

Sleep History:

How many hours does your child sleep per night? _____

How many hours does your child sleep during the day? _____

Does your child wake up refreshed? Y/N

Is your child a restless sleeper or does he/she sleep throughout the night?

Environment:

Please indicate if your child is in:

Home care _____ Daycare _____ School _____ Other _____

What are your child's favorite activities? _____

How much time does your child spend inside? _____ Hours in front of TV or computer? _____

How much time does your child spend outside? _____ What type of activities? _____

Does anyone smoke at home?

Are there animals at home?

To your knowledge has your child ever been exposed to hazardous chemicals?

Are there any sources of stress in your child's life?

Family Health History:

Please indicate whether a close family relative (Mother (M), Father, (F) siblings (S), Grandparents (G)) has had any of the following:

Allergies_____ Cancer _____

Asthma _____ Diabetes _____

Heart disease _____ Depression _____

Stroke _____ Substance abuse _____

Epilepsy _____ Other mental illness _____

Kidney disease _____ Genetic defect _____

Thyroid problems _____ Multiple sclerosis _____

Other: _____ Blood disorders _____

Please use this space to add any information you feel is relevant to your child's history that has not been covered:

_____

_____

_____

daziran
Integrative Health

Fee Schedule

As of June 1, 2016

Naturopathic Consultations

Pediatric Initial Appointment (under 12)	60 minutes	$132
Follow-up Appointment	45 minutes	$99
Follow-up Appointment	30 minutes	$77
Follow-up Appointment	15 minutes	$55
House calls		Add $20
Email and Phone consultations	Subject to the length of visit/email	$18.50/5 minutes

Naturopathic Services are exempt from GST

- Email and phone consultations are only available after the first 2 visits
- Should a full length follow up appointment be held over the phone, the associated fees will apply.
- Laboratory tests are priced on an individual basis.
- Cancellations within 24 hrs of your appointment time will be charged 50% of the appointment fee.
- Cancellations without ANY notice will be charged the FULL appointment fee.

Our Cancellation Policy is strictly enforced.

2A-2146 Robinson Street, Regina, Saskatchewan, S4T 2P7 Phone: 306.757.4325 Fax:306.522.0745

daziran
Integrative Health

INFORMED CONSENT
FOR NATUROPATHIC DIAGNOSTIC & TREATMENT PROCEDURES

Your signature is required before any treatment is rendered. Your signature acknowledges the following:

1. You are ultimately responsible for your own health.

2. It is your responsibility to inform your Naturopathic Doctor of: any medical conditions or allergies that you are suffering from; any medications/supplements that you are currently taking; and if you are pregnant, may be pregnant, or if you are breast-feeding.

3. While changes in habits are not a prerequisite for treatment, failure to follow the recommended nutritional and lifestyle programs could undermine the expected results.

4. You understand that that it takes time to feel better when using naturopathic medicine. You accept that positive changes will occur more rapidly with increased compliance.

5. You are accepting or rejecting this naturopathic medical care of your own free will and choice. You are free to withdraw your consent and to discontinue treatment at any time.

6. You accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered. You acknowledge that canceling or rescheduling appointments must be done 24 hours in advance. Please see attached cancellation policy for clarification of fees.

7. If you have any questions regarding your treatment program, it is your responsibility to clarify these issues with your Naturopathic Doctor.

8. Naturopathic Doctors (ND) are not Medical Doctors (MD). Therefore, if standard medical treatment (drugs, surgery, etc.) is necessary, it must be obtained from a Medical Doctor.

9. You are not an agent of any private, local, county, provincial or federal agency attempting to gather information without stating your intention to do so.

10. There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to: pain, bruising, or injury from acupuncture or injections; allergic reactions to certain supplements and herbs; and aggravation of pre-existing symptoms.

I, _____ (please print),

have read, understood, and acknowledge the above statements.

Patient or Lawful Representative Signature _____

Date Signed _____ Witness _____

2A-2146 Robinson Street, Regina, Saskatchewan, S4T 2P7 Phone: 306.757.4325 Fax:306.522.0745

daziran
Integrative Health

Consent to Treat a Minor

I authorize Marika Geis, Doctor of Naturopathic Medicine, who has been engaged by me, that she may select or approve, to examine and administer Naturopathic care and treatment to _____ whose relationship to me is as a _____.

I have been given an explanation of and understand the nature of naturopathic medical care and treatment.

I authorize Marika Geis to take whatever measures she considers necessary or desirable in connection with such naturopathic care and treatment.

Dated in the province of Saskatchewan, this ____day of _____(month), _____(year).

_____ _____

Parent or legal guardian of minor (Please print) (Signature)

daziran
Integrative Health

Release of Medical Records

Instructions:

1. Please read and sign the following document.
2. When completed, we will fax your general practitioner. (Note: Any reports done by specialists will have been sent to your GP).
3. Please give your GP a courtesy call to confirm document was received and will be sent to our office. (Note: There may be a fee for the release of records, the records will not be sent until this fee is paid).

Please send or fax copies of:

_____ D.O.B._____/_____/_____
Month Day Year

LAB REPORTS ONLY to our office:

_____ All Previous Lab Reports.

_____ Lab Reports only in the past _____ years/months.

Doctor's Name: _____

Doctor's Address: _____

City:_____ Province: _____ Postal Code:_____

Telephone:_____ Fax:_____

Patient's Signature: Date:

_____ _____

Requested By:

☐ Dr. Marika Geis, ND (#438) ☐ Faxed: By: _____

☐ Received: By: _____

2A-2146 Robinson Street, Regina, Saskatchewan, S4T 2P7 Phone: 306.757.4325 Fax:306.522.0745