Full Circle Healing Arts

Contact Information

Full Name: _____

Date of Birth: _____ Sex: Male Female
Day/Month/Year

Occupation: _____ Marital Status: _____

Address: _____

City: _____Postal Code:_____

Telephone: (home) _____ (work) _____
(cell) _____
E-mail _____

Care Card Number _____

Any known drug allergies _____

Any life threatening food allergies _____

Name of Medical Doctor: _____ Tel: (_____)_____

Are you currently under his/her care? _____ If 'yes' for what? _____

Date of last visit to Medical Doctor: _____ Date last physical: _____

How or by whom were you referred to this clinic? _____

Have you been treated by a Naturopathic Doctor before? Yes No

If 'yes', by whom? _____ When? _____

In Case of Emergency:

Contact: _____ _____ (_____)_____
Full name Relation Telephone

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Informed Consent for Treatment

I hereby authorize Dr Jennifer Matthews to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures (including but not limited to venipuncture, pap smears, and blood and urine lab work, general physical exams, neurological and musculoskeletal assessments)
Psychological Counseling; Lifestyle Counseling; Exercise Prescriptions
Herbs/Natural Medicines (prescribing of various therapeutic substance including plants, minerals and animal materials. Substances may be given in the form of teas, pills, powders, tinctures—may contain alcohol; topical cremes, pastes, plasters washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.)
Dietary Advice and Therapeutic Nutrition (use of foods, diet plans or nutritional supplements for treatment—may include intramuscular vitamin injections.)
Soft Tissue Manipulation (use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, and craniosacral therapy)
Hydrotherapies (includes the use constitutional and contrast hydrotherapy, sitz baths, wet sheet wraps, wet sock treatments)

Potential Risks: Pain, discomfort, loss of consciousness or deep tissue injury from needle insertions; allergic reactions to prescribed herbs or supplements; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Dr Jennifer Matthews. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

Patient's Name (PRINT)	Guardian/Personal Representative's Name (PRINT)
Patient's Signature	Guardian/Personal Representative's Signature
Date	Relationship/Representative'sAuthority
	Date