NEW PATIENT REGISTRATION-ADULT

Dr. Sean Ceaser, N.D. Dr. Joel Guillemin, N.D.

Name:_____ Date:_____

Address: _____ (City)_____ (Prov./State)_____

(Postal/Zip code)_____ Tel#: Home_____ Work:_____ Cell:_____

Age:_____ Date of Birth:_____ Email:_____

Sex: Male/Female/Non-Binary Other: _____ Pronouns: _____ Occupation:_____

Place of work:_____ # of years :_____ Single/ Married/ Other - Partner's name:_____

Your medical doctor:_____ Other health practitioners involved in care: _____

Emergency phone contact: _____ Phone #_____

How did you hear about the clinic?_____

What Google search terms did you use: _____

INFORMED CONSENT FOR TREATMENT for Dr. Sean Ceaser, N.D. and/or Dr. Joel Guillemin, N.D.

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended treatments and procedures to be used so that you make an informed decision whether or not to undergo the recommended procedure(s) after knowing the benefits and risks involved. This notice is not meant to alarm you; it is simply to inform you that you may give or withhold your consent to treatment. *If you refuse any specific procedure this will not affect your receiving other care or future treatments.*

I voluntarily request Dr. Ceaser and/or Dr. Joel Guillemin as my Naturopathic Doctor to examine and treat me and my health conditions. I understand that the course of care therapy may include the use of multiple modalities of Naturopathic medicine including nutritional supplements, injection therapies, OncoTherm hyperthermia, prolotherapy, Platelet Rich Plasma, intravenous nutrients, chelation, ozone, acupuncture and other therapies offered by Dr. Ceaser and/or Dr. Joel Guillemin. I understand that my verbal consent to a specific treatment and my willing participation in receiving these therapies after explanation of benefits and risks is sufficient to indicate my consent to receive treatment. I waive the option of signing a consent to treat for each and every specific procedure at each treatment date.

I understand that I am free to pursue other medical opinions and treatments including conventional medical care at any time. I understand that I have the right and the opportunity to ask questions about my condition, discuss naturopathic and conventional options at any time. I understand there may be complications and risks related to the recommended procedure(s) and that I may request additional information regarding complications and risks (side effects) and refuse any specific treatment at any time. I understand that payment is due in full at the time of service.

I understand that no warranty or guarantee regarding a promise of cure as a result of care is provided for any condition. All information given now or at any point in the future is confidential. It is Naturopathic Physicians Group's policy to require a medical release form before releasing medical records to anyone other than the patient. I certify that I have read this form or have had it read to me and that I understand its content and meaning. I have sufficient information to give this informed consent.

Patient Name:_____

Patient Signature:_____

Date:_____

Photo and Video Consent Form

I, _____ (Patient's Full Name), grant Dr. Ceaser's Naturopathic Clinic permission to use photographs, videos, and comments of me for communication, promotional, and educational purposes. This includes newsletters, social media, the clinic's website, and educational materials.

I understand my participation is voluntary, and I will not receive financial compensation. I waive the right to inspect or approve the final products and release the clinic from any claims.

☐ **Yes, go ahead.** ☐ **No, Thank you.**

Patient's Signature:_____ Date:_____

MEDICAL HISTORY QUESTIONNAIRE

Please list the reasons for your visit in order of importance & how long you've had the problem:

1._____

2._____

3._____

Please indicate your expectations and what you hope to accomplish with your Naturopathic visit:

4._____

_____

Please circle all that apply. Note beside the symptom if you need. If it is a past issue please indicate "P" beside the symptoms.

Fatigue AM/after lunch/PM	Skin problems:	Diarrhea/Constipation
Weight gain/loss	Hair loss:	Nausea/vomiting
Cancer: Type & stage:	Headaches:	Liver problems:
Pain:	Eye problems:	Gallbladder problems:
Swelling:	Ear problems:	Urinary difficulties:
Stiffness	Sinus problems:	Kidney stones
Depression	Metal taste	Period begins every _____
Anxiety	Frequent sore throats	days Irregular cycles
Memory loss/foggy thinking	Thyroid problems:	Infertility
Behavioral problems	Heat/cold intolerance	Period cramping
Dizziness	Difficulty breathing:	Clotting
Insomnia. I sleep _____ hours/night	Wheezing	Breast tenderness
Numbness/tingling	Cough	Menopausal
Bone loss	Toxic exposure:	Hot flashes/night sweats
Weakness	Heart disease:	Testicular pain
Restless legs	Hypertension	Prostate problems
Cold hands/feet	Palpitations	Sexual difficulties:
Varicose veins	Digestive problems:	Other:

CURRENT HERBS, SUPPLEMENTS & MEDICATIONS Include medications, chemo & cancer drugs, vitamins, supplements, herbs, OTC rx

Medicine:	Dose:	Began on:	Stopped on:
1.			
2.			
3.			
4.			
5.			
6.			
7.			

List more on back if needed. **Allergies:** _____

Hospitalizations (&year): _____

Diseases in family history:_____

For Clinic Use Only

Clinic Representative:_____

Date:_____