Institute for Parent and Infant Care (IPIC)

Parenthood Matters!

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Adult Consultation Form

PERSONAL INFORMATION: PLEASE PRINT CLEARLY

Client's Name _____ Date of Birth (D/M/Yr) ___/___/___ Occupation _____

Address: _____

_____

Postal Code

Telephone _____ Home _____ Business _____ E-mail

Family Doctor _____ Specialist: _____

Family Cultural Background: _____ Number of Family Members Residing in Same Household? _____

Medical History

Please check if you have had any of the following conditions:

☐ Anemia ☐ Breast Lump / Biopsy ☐ Bleeding Problems ☐ Blood Clots ☐ Migraine Headaches ☐ High Blood Pressure

☐ Diabetes ☐ Stomach Problems / Ulcers ☐ Liver Disease / Hepatitis ☐ Kidney Disease ☐ Heart Murmur / Heart Surgery

☐ Stroke ☐ Heart Attack ☐ Gall Bladder Disease ☐ Cancer ☐ Asthma ☐ Depression ☐ Seizures ☐ Osteoporosis

☐ Psychiatric Illness ☐ Thyroid Problems ☐ Glaucoma / Eye Problem ☐ None ☐ Other _____

Obstetric and Gynecologic History

Gravida (# of pregnancies): _____ # of Vaginal Births: _____ # of Miscarriages: _____

Para (# of live births): _____ # of Caesarean Births: _____ # of Abortions: _____

# of Children: _____

Are you in menopause? ☐ YES ☐ NO Are you currently sexually active: ☐ YES ☐ NO

Have you ever had a sexually transmitted infection or pelvic inflammatory disease? ☐ YES ☐ NO

List any gynecologic procedures / surgeries you have had:_____

Social History

Are you? ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other

Highest level of education: ☐ College/University ☐ High School ☐ Other_ _____

Do you smoke? ☐ YES ☐ NO If yes ☐ Less than I Pack /Day ☐ More than 1 Pack /Day ☐ Other_____

How long have you smoked?_____ Do you drink? ☐ YES ☐ NO If yes # of drinks per day_____

Have you ever used marijuana, cocaine, heroin, methamphetamines, or any other street drug? ☐ YES ☐ NO

If yes, which one(s)_____

Do you get regular exercise? ☐ YES ☐ NO If yes, how often?_____

Do you have any dietary restrictions? ☐ YES ☐ NO _____

Do you feel safe at home? ☐ YES ☐ NO Do you want to discuss abuse? ☐ YES ☐ NO

Are any of your immediate family members suffering a significant medical condition?

_____

_____

Current Medications? _____

_____

Reason For Visit Today? _____

Who Else Have You Sought Help From About This Issue? _____

Referred By: ☐ Physician ☐ Midwife ☐ Family Member ☐ Pamphlet ☐ Ad in Newspaper ☐ Community Health Nurse ☐ Hospital

☐ Phone Book ☐ Internet Search ☐ Friend ☐ Retail Outlet ☐ Current Client Who? _____

□ Naturopathic Doctor □ Chiropractor □ Community Organization ☐ Other: Specify _____

Privacy of your personal information is an important part of our clinic. We are committed to collecting, using and disclosing your personal information responsibly. All staff members are aware of the sensitive nature of the information that you have disclosed to us and are trained in the appropriate use and protection of your information. We promise that only necessary information is collected about you and we only share your information with your consent. The Institute for Parent and Infant Care operated by IPIC Education and Counselling Services will be the health information custodian of your patient file. Our storage retention and destruction of your personal information complies with existing legislation with the College of Nurses of Ontario (CNO)

This clinic will collect, use and disclose your information for the following purposes:

- ❑ To assess your health concerns and provide health care
- ❑ To establish and maintain contact with you, or send newsletters
- ❑ To communicate with other health-care providers only with your written consent
- ❑ To allow us to efficiently follow-up for treatment, care and billing
- ❑ To invoice for goods and services and to process credit card payments

INFORMED CONSENT TO TREATMENT

This is to acknowledge and declare that I understand that:

- ❑ My care at the ***Institute for Parent and Infant Care*** will include the assessment of the whole person, taking into consideration physical, mental, emotional, spiritual and environmental factors, all of which play a role in an individuals' health. Gentle, non-invasive modalities of treatment are employed to promote wholeness and healing capacity. These may include assessment and interventions (including supportive counselling) for prenatal, postnatal, bereavement, post partum depression, birth trauma and or any other challenge associated with pregnancy and birth and infant growth and development as well as lifestyle counselling.

- ❑ As a client of the ***Institute for Parent and Infant Care***, I hereby acknowledge that I am willing to provide the nurse consultant with the information necessary for her to fully understand my medical history, presenting symptoms, and health goals I wish to achieve in our work together. I thereby consent to a thorough case history and relevant physical examination of myself. In addition, if I so wish, I may consent to the presence of another support person in the case history and exam of myself and/ or education and intervention sessions.
- ❑ Any treatment or advice provided to me as a client of Carol L. Hamilton RN, CPIC, BScN, MDiv is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another licensed health care practitioner.
- ❑ I have the option to seek or continue conventional medical care from a conventional medical doctor. Carol L. Hamilton, Nurse Consultant will not suggest to me to refrain from seeking or following conventional medical treatment.
- ❑ I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with nursing interventions suggested include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements, creams or herbs or interactions with prescription medications.
- ❑ As with all forms of therapy, I understand that nursing intervention sought also has its limitations and thus I understand that the results are not guaranteed.
- ❑ With this knowledge, I voluntarily consent to assessment, intervention, education and care and I intend for this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent at any time.
- ❑ In the event of a medical emergency, I am advised to seek conventional medical care at a hospital.
- ❑ I agree to pay my account in full at every visit and whenever remedies / equipment are purchased or rented.

By signing this form you have agreed that you have given your informed consent to treatment and to the collection, use and/or disclosure of your personal information.

Dated and signed this _____day of _____, 20_____.

Client's Name _____ Signature: _____

Support Person's Name: _____ Signature: _____

Nurse Consultant's Signature: _____