



# Dr. Gayamali Karunaratna, N.D.

350 Highway 7 East, Suite 211, Richmond Hill ON, 905-889-3640

Dear Patient,

I look forward to meeting with you in the very near future. Please fill out the forms enclosed in this package, print them off, and bring them with you to the first visit. Included in the package are the initial intake forms, and possibly a diet diary sheet on which to record what you eat and drink for the next 7 days.

You can expect your first visit to last approximately 2 hours, or approximately 1 to 1-1/2 hours for children 12 and under. During this time, we will discuss your health history in depth, and a physical exam will be performed. We will then discuss how you can best be treated. You may choose to either purchase your laboratory tests, supplements, botanicals, or homeopathic medicines from me, or you may go to the supplier of your choice. Your subsequent visits will be approximately ½ hour to 45 minutes long, during which I will review your progress and modify your treatments accordingly.

Please note that if you need to cancel your appointment, you must give me at least 24 hours notice, otherwise a fee will be charged.

My fee schedule for the visits is as follows:

	Adults (20-64 years)	Students (13-19 yrs) & Seniors (65+ years)	Children (0-12 years)
Initial visit	\$250.00 (2 hrs)	\$215.00 (2 hrs)	\$170.00 (1 to 1 1/2 hrs)
Subsequent visit (30-45 minutes)	\$90.00	\$85.00	\$85.00
Return visit (over 1 year)	\$170.00 (1 1/2 hour)	\$170.00 (1 1/2 hour)	\$135.00 (1 hour)
Microcurrent Non- Surgical Face-Lift (1 hour)	\$135.00	\$135.00	N/A
Missed Appointment (without 24 hours notice)	A missed appointment without at least 24 hours notice will result in the charge of the full fee of the visit. Please ensure that if you need to cancel that you provide enough notice so that a charge doesn't result.		
Telephone Consultations	10-15 minutes--\$45; 20-25 minutes--\$70.00; 1/2 hour-45 minutes--the fee for the subsequent visit		
Acupuncture session	10-15 minutes--\$45; 20-25 minutes--\$70.00; 1/2 hour-45 minutes--the fee for the subsequent visit		

Payment is due at the end of each visit in the form of cash, debit, Visa, or Mastercard. Please remember that many extended health insurance plans cover all or a portion of the visit costs. If you are covered, retain your receipt and send it to your insurance company for reimbursement.

I am very happy that you have decided to take an active roll in your health care, and I look forward to helping you strive toward your goals of well-being. Until we meet, keep well.

Yours in health, *Dr. Gayamali Karunaratna, Hon. B.Sc., M.Ed., ND, Birth Doula.*

Naturopathic Doctor.



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## Patient Consent Form For Collection, Use, And Disclosure Of Personal Information

### **\*Please Sign This Form If You Agree To Its Terms\***

Because of the sensitive nature of the information that you disclose during naturopathic visits, maintaining privacy and protecting your personal information is of utmost importance.

My Privacy Policy is such that:

Only necessary information is collected about you;

I only share your information with your consent;

Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;

My privacy protocols comply with privacy legislation and standards of the naturopathic profession's regulatory body.

### **How The Clinic Collects, Uses, And Discloses Patients' Personal Information:**

I will be collecting, using, and disclosing information about you for the following purposes:

To assess your health concerns, provide health care and advise you of treatment options

To establish and maintain contact with you

To remind you of upcoming appointments

To allow me to efficiently follow-up for treatment

To complete claims for insurance purposes

To invoice for goods and services

To process credit card payments

To collect unpaid accounts and follow up on billing as required

To comply with all regulatory and legal requirements including court orders, statutory

requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

### **Patient Consent**

I have reviewed the information above, regarding the collection and use of my personal information. I agree that

the clinic can collect, use, and disclose personal information about me as set out above in the information about the clinic's privacy policies.

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Patient Name

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Signature of Patient, or of Parent or Guardian if patient is a minor

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Date



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## Informed Consent Form

*\*Please note that this form must be printed off and signed prior to treatment\**

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. The Naturopathic Doctor will take a thorough case history, and perform a physical examination, If your case requires, the physical may include more specific examinations such as breast, rectal, prostate or genital exams.

*Potential Benefits of Naturopathic Medicine* includes the restoration of health and the body's maximal functional capacity, relief of pain and other symptoms of disease, assistance in disease and injury recovery, and prevention of disease or its progression.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications or over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

You will receive information about your diagnosis and/or treatment, alternative courses of action, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

Your treatment will include, but will not be limited to any of the following core modalities and procedures in order to assess, treat, or otherwise address your health concerns:

- Therapeutic Nutrition: Dietary modification and/or prescription of nutritional supplements, which may include intramuscular or subcutaneous injections of vitamins;
- Acupuncture and Oriental Medicine: The insertion of very fine needles at specific locations on the body; prescribing oriental herbs;
- Botanical Medicine: Prescribing herbal substances, such as teas, tinctures, capsules, creams, or other forms;
- Homeopathy: Prescribing the diluted forms of plants, animal substances, or mineral substances according to The Law Of Similars to stimulate a healing response;
- Lifestyle Counselling: Recommendations on the use of food, diet planning, exercise, sleep hygiene, and stress reduction for benefits to health;
- Physical Medicine: soft tissue massage, stretching, traction, microcurrent electrotherapy;
- Naturopathic Manipulation: Spinal and peripheral joint manipulation to correct problems in spinal alignment or peripheral joint alignment;
- Diagnostic Procedures: Including, but not limited to physical examinations, neurological examinations, musculoskeletal examinations, hair analyses, blood, saliva, or urine lab tests.

There are some slight health risks associated with treatment by Naturopathic Medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs, the duration is usually short.
- A small subset of patients experience allergic reactions to certain supplements or herbs. Please advise the Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from acupuncture or injection.



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- Fainting or puncturing of an organ with acupuncture needles.
- Rarely, muscle strains or ligament sprains from naturopathic manipulation. This may intensify soreness and pain temporarily, and increase the need for treatment; but in most every case, the issue resolves completely, and there are no long term effects to the patient. These problems happens so rarely that there are no statistics to quantify their probability.
- Although naturopathic manipulation is used to treat disc herniations successfully, there is a very small risk that an adjustment can aggravate a disc injury, or can cause a disc herniation if the disc is already damaged or weakened. These problems occur so rarely, that there are no statistics to quantify their probability.
- Rarely, naturopathic adjustment(s) may result in rib fracture. This risk is increased in elderly, or in patients with osteoporosis. The Naturopathic Doctor adjusts all patients very carefully, but especially the elderly patients with osteoporosis. Rib fracture occurs so rarely that there are no available statistics to quantify their probability.
- Stroke is VERY uncommon, but it is the most serious possible complication from a neck manipulation. In the May 1994 Chiropractic Report, it states: **“By any medical standard, cervical adjustments are extremely safe treatments. Vertebral artery injury causing stroke is the only serious potential complication. There is a risk rate (incidence) of about .0002%, or one case in two million.”** In another study, (Journal of CCA, Vol. 37, No. 2, June 1993) they estimate that **the risk of this type of stroke is .0003%, one in three million.** The Naturopathic Doctor does an in-depth screening prior to adjusting the neck.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

### Please Read And If You Agree Sign The Bottom

*I recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children, or in people on multiple medications. I acknowledge that the information I have provided is complete and inclusive of health concerns, including risks of pregnancy; and all medications, including supplements and over the counter drugs.*

*I understand that I may ask questions regarding my treatment before signing this form, and that I am free to withdraw consent and discontinue participation in these procedures at any time.*

*I realize that no guarantees have been given by the Naturopathic Doctor regarding cure or improvement of my condition.*

*I accept full responsibility for any fees incurred during the course of care and treatment.*

\_\_\_\_\_  
(Guardian Name—please print)

\_\_\_\_\_  
(Patient Name—please print)

\_\_\_\_\_  
(Guardian Signature)

\_\_\_\_\_  
(Patient Signature)

\_\_\_\_\_  
(Relationship to the Patient)

\_\_\_\_\_  
(Date)

## Intake Form

Name: \_\_\_\_\_ Sex: M F Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apt #: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: S M D W Sep Number of Children: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear of this office? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Tel. #: \_\_\_\_\_

### Major Health Concerns In Order Of Importance For You

Health Concern	Since When?	Causes

### What Medications Are You Currently Taking?

Medication	Quantity	Since When?	Adverse Effects

### What Supplements, Herbs, or Homeopathic Remedies Are You Taking?

Supplement	Quantity	Since	Results

How many times have you been on antibiotics? \_\_\_\_\_ This past year? \_\_\_\_\_

**Which of The Following Conditions Have You Had?**

Abscesses	Cold Sores	Gout	Malaria	Peritonitis	Skin Disease	Typhoid Fever
Alcoholism	Depression	Hay Fever	Measles	Pleurisy	Strep Throat	Venereal Warts
Allergies	Diabetes	Heart Disease	Miscarriage	Pneumonia	Sinusitis	Warts
Amnesia	Emphysema	Hepatitis	Mononucleosis	Prostatitis	Sunstroke	Whooping cough
Arthritis	Epilepsy	Herpes-Genital	Mumps	Rheumatic fever	Stroke	
Asthma	Gallstones	Influenza	Parasites	Rubella	Syphilis	Worms
Cancer	Goitre	Kidney Disease	Pelvic Inflammatory disease	Scarlet Fever	Tonsillitis	Yellow Fever
Chicken Pox	Gonorrhea	Leukemia		Sexual Abuse	Tuberculosis	

Any other major conditions? \_\_\_\_\_

Are there any of the preceding conditions after which you have not been totally well again, or which have been more severe than usual? Which ones? \_\_\_\_\_

**What Operations Have You Had?**

Operation	When	Complications

**What Major Injuries Have You Had?**

Injury	When	Long Term Effects

Age of First Period: \_\_\_\_\_ Number of Pregnancies: \_\_\_\_\_

What vaccinations have you had? \_\_\_\_\_

Any adverse effects from them? \_\_\_\_\_

Have you lost any weight lately? \_\_\_\_\_ How many pounds? \_\_\_\_\_ Was the weight loss intentional? \_\_\_\_\_

What exercise do you do, and how much? \_\_\_\_\_

**How Much of the Following Substances Are You Using?**

Tobacco:	Alcohol:
Coffee/Non-Herbal Tea:	Recreational Drugs:

**Indicate Below Which of the Following Ailments, Or Any Other Ailments, Have Affected Your Relatives**

Alcoholism	Asthma	Diabetes	Gout	Insanity	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease	Pneumonia	Tuberculosis

Relative	Age if Alive	Age at Death	Ailments
Mother:			
Father:			
Sisters:			
Brothers:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles:			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles:			

Are You Currently Under The Care of (An)other Physician(s)?

Physician	For What Conditions?	Treatments

Have You Been Treated With Naturopathic Medicine Before?

Physician	For What Conditions?	When?

Would you like to be included on my e-list to receive quarterly e-newsletters\_\_\_\_\_

## REVIEW OF SYSTEMS

Please circle those symptoms you have currently (meaning within the last 3 weeks). Please place a "P" beside the symptoms you have had in the past.

### General

General weakness \_\_\_\_\_

Chronic fever \_\_\_\_\_

Chills \_\_\_\_\_

Fatigue \_\_\_\_\_

Significant weight change (more than 5 lbs) within past year \_\_\_\_\_

### Skin

Change in hair \_\_\_\_\_

Change in skin colour \_\_\_\_\_

Change in nails \_\_\_\_\_

Yellow/thickened nails \_\_\_\_\_

Change in mole \_\_\_\_\_

Night sweats \_\_\_\_\_

Dryness \_\_\_\_\_

Itching \_\_\_\_\_

Lumps \_\_\_\_\_

Sores \_\_\_\_\_

Ulcers \_\_\_\_\_

Acne \_\_\_\_\_

Boils \_\_\_\_\_

### Head

Headache \_\_\_\_\_

Head injury \_\_\_\_\_

Dizziness \_\_\_\_\_

### Eye

Pain \_\_\_\_\_

Excessive tearing \_\_\_\_\_

Flashing lights \_\_\_\_\_

Redness \_\_\_\_\_

Double vision \_\_\_\_\_

Halos around objects \_\_\_\_\_

Itching \_\_\_\_\_

Blurred vision \_\_\_\_\_

Sensitivity to sunlight \_\_\_\_\_

Dryness \_\_\_\_\_

Loss of vision \_\_\_\_\_

Specks in vision \_\_\_\_\_

Discharge \_\_\_\_\_

### Ear

Frequent earaches \_\_\_\_\_

Ringing in ears \_\_\_\_\_

Bleeding from ears \_\_\_\_\_

Frequent ear infections \_\_\_\_\_

Hearing loss \_\_\_\_\_

Discharge from ears \_\_\_\_\_

### Nose & Sinuses

Frequent colds \_\_\_\_\_

Frequent discharge \_\_\_\_\_

Sinus trouble \_\_\_\_\_

Frequent nosebleeds \_\_\_\_\_

Stuffiness \_\_\_\_\_

### Mouth & Throat

Bleeding gums \_\_\_\_\_

Mouth/tongue ulcers \_\_\_\_\_

Dental cavities \_\_\_\_\_

Sore tongue/mouth \_\_\_\_\_

Frequent sore throats \_\_\_\_\_

Loss of taste \_\_\_\_\_

Dry mouth \_\_\_\_\_

Persistent hoarseness \_\_\_\_\_



Neck

Lumps \_\_\_\_\_ Swollen glands \_\_\_\_\_ Neck pain/stiffness \_\_\_\_\_ Goiter \_\_\_\_\_

Breast

Lumps \_\_\_\_\_ Breast pain \_\_\_\_\_ Discomfort \_\_\_\_\_  
Nipple discharge \_\_\_\_\_ Inverted nipple \_\_\_\_\_

Lungs

Persistent cough \_\_\_\_\_ Bloody sputum \_\_\_\_\_ Chronic sputum \_\_\_\_\_  
Wheezing \_\_\_\_\_ Shortness of breath \_\_\_\_\_ Pain on breathing \_\_\_\_\_  
Chronic bronchitis \_\_\_\_\_ Pneumonia \_\_\_\_\_ Tuberculosis \_\_\_\_\_  
Emphysema \_\_\_\_\_

Heart

Heart disease \_\_\_\_\_ Chest pain/discomfort \_\_\_\_\_ Heart palpitations \_\_\_\_\_  
High blood pressure \_\_\_\_\_ Ankle swelling \_\_\_\_\_ Blue-tinged lips \_\_\_\_\_  
Blue-tinged fingernails \_\_\_\_\_ Rheumatic fever \_\_\_\_\_ Heart murmur \_\_\_\_\_

Gastrointestinal

Difficulty swallowing \_\_\_\_\_ Heartburn \_\_\_\_\_ Poor appetite \_\_\_\_\_  
Nausea \_\_\_\_\_ Vomiting \_\_\_\_\_ Vomiting blood \_\_\_\_\_  
Constipation/diarrhea \_\_\_\_\_ Incontinence \_\_\_\_\_ Black/tarry stools \_\_\_\_\_  
Clay coloured stools \_\_\_\_\_ Abdominal pain \_\_\_\_\_ Excess belching/passing gas \_\_\_\_\_  
Yellow skin &/or eyes \_\_\_\_\_ Rectal bleeding \_\_\_\_\_ Hemorrhoids \_\_\_\_\_

Urination

Pain on urination \_\_\_\_\_ Bloody urine \_\_\_\_\_ Brown-coloured urine \_\_\_\_\_  
Urgency \_\_\_\_\_ Frequency \_\_\_\_\_ Hesitancy \_\_\_\_\_  
Pass a large/small amount each time \_\_\_\_\_ Must wake from sleep to urinate \_\_\_\_\_ Decreased force of stream \_\_\_\_\_  
Kidney stones \_\_\_\_\_ Incontinence \_\_\_\_\_ Dribbling \_\_\_\_\_

Genital (Male)

Discharge \_\_\_\_\_ Sores \_\_\_\_\_ Genital warts \_\_\_\_\_  
Testicular pain \_\_\_\_\_ Testicular lumps \_\_\_\_\_ Impotence \_\_\_\_\_  
Premature ejaculations \_\_\_\_\_ Hernia \_\_\_\_\_ Sexual difficulty \_\_\_\_\_

Genital (Female)

Irregular periods \_\_\_\_\_

Painful periods \_\_\_\_\_

Difficulty conceiving \_\_\_\_\_

Genital warts \_\_\_\_\_

Sores \_\_\_\_\_

Bleeding between periods/after intercourse \_\_\_\_\_

Pain during intercourse \_\_\_\_\_

Abortion \_\_\_\_\_

Chronic discharge \_\_\_\_\_

Lumps \_\_\_\_\_

No periods \_\_\_\_\_

Post-menopausal bleeding \_\_\_\_\_

Miscarriage \_\_\_\_\_

Itching \_\_\_\_\_

Sexual difficulty \_\_\_\_\_

Circulation

Easy bruising/bleeding \_\_\_\_\_

Clots in the veins \_\_\_\_\_

Varicose veins \_\_\_\_\_

Swelling in arms/legs \_\_\_\_\_

Transfusion \_\_\_\_\_

Swollen lymph nodes \_\_\_\_\_

Leg cramps \_\_\_\_\_

Ulcers on extremities \_\_\_\_\_

Deep leg pain \_\_\_\_\_

Cold hands/feet \_\_\_\_\_

Numb hands/feet \_\_\_\_\_

Skeletal System

Muscle pain/stiffness \_\_\_\_\_

Muscle weakness \_\_\_\_\_

Joint pain/stiffness \_\_\_\_\_

Backache \_\_\_\_\_

Muscle spasms/cramps \_\_\_\_\_

Joint swelling \_\_\_\_\_

Nervous System

Memory loss \_\_\_\_\_

Paralysis \_\_\_\_\_

Pins & needles sensation \_\_\_\_\_

Speech problems \_\_\_\_\_

Fainting \_\_\_\_\_

Numbness \_\_\_\_\_

Involuntary movements \_\_\_\_\_

Seizures \_\_\_\_\_

Loss of sensation \_\_\_\_\_

Loss of balance \_\_\_\_\_

Endocrine System

Heat intolerance \_\_\_\_\_

Excessive thirst/hunger \_\_\_\_\_

Cold intolerance \_\_\_\_\_

Excessive urination \_\_\_\_\_

Excessive sweating \_\_\_\_\_

Lack of thirst/hunger \_\_\_\_\_

Emotional State

Depression \_\_\_\_\_

Phobias \_\_\_\_\_

Mood swings \_\_\_\_\_

Insomnia \_\_\_\_\_

Anxiety/nervousness \_\_\_\_\_

Alcohol/drug abuse \_\_\_\_\_