SIÔN WILLIAMS
global naturopath

Name:

Sex: **D.O.B** **Age**:

Address:

City: **State:**

Post Code: **Country:**

Email: **Skype Name:**

Phone (AU only):

Occupation:

Vitals

(Please leave blank if unsure)

Blood Pressure (arm): **Right side**: **Left side:**

Pulse: **Basal Temps**:

Blood Sugar Levels (BSL):

How many bowel motions a day/week:

Main Presenting Complaint

Describe main complaint (symptoms) including any medical diagnosis:

When did it start (include any real-life events at the time)**?**

Do you know what caused it?

Minor complaints

Describe any minor complaints associated or not associated with main complaint:

Do you know what caused them?

Medical History

Childhood Diseases:

Hospitalisations or Surgeries:

Known Allergies:

Liver or Kidney Disease:

Medical Issues in Family (Parents, siblings):

Past Pharmaceutical medicines used:

Current Pharmaceutical medicines used:

Any side effect of medicines experienced:

Thank you for taking the time to complete this form.

Direction for Emailing form

The information contained within is vital to the success of the upcoming consultation. Once you have completed the last page and signed, save the file using a name like this SURNAME_FIRSTNAME_DOB and email to the below address. When you email the file, please complete the subject line with your Surname, First Name and the date of your appointment.

Email: naturopath@sionwilliams.com.au

Please read, sign and date the below consent form

INFORMED CONSENT TO TREAT

I hereby request and consent to the performance of a naturopathic medicine treatment and other procedures within the scope of the practice of naturopathic medicine on my (or on the patient named below, for I am legally responsible) by Siôn Williams and/or other natural therapy practitioners who or in the future treat me while employed by, working or associated with or serving as back-up for Siôn Williams including those working at the clinic or office or any other office or clinic, whether signatories to this form or not.

I understand that methods of treatment may include, but are not limited to herbal medicine, nutritional counselling, flower essences and iridology. I understand that the herbs, remedies and supplements should be consumed according to the instructions provided orally and in writing. I will immediately notify the clinic of any unanticipated or unpleasant effects associated with the herbs, remedies or supplements.

I have been informed that herbal medicine is a safe method of treatment, but that it may have some side effects, such as a healing crisis which could cause fatigue, nausea, muscle soreness, headache, etc. The herbs, remedies and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe, although some may be toxic in large doses. I understand that some herbs and supplements may be inappropriate during pregnancy or breastfeeding. I will notify the practitioner who is caring for me if I am or become pregnant or am currently breastfeeding.

I do not expect the practitioner to be able to anticipate and explain all possible risks and complications of treatment, and I wish to rely on the practitioner to exercise judgment during the course of treatment which the practitioner thinks at the time, based upon the facts then known is in my best interest. I understand that results are not guaranteed.

I understand the clinical staff may review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent.

By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of herbal medicine and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment. All parent(s) and legal guardian(s) must complete the authorization before the consultation may begin.

☐I understand that checking this box constitutes a legal signature confirming that I acknowledge and consent to be treated.

Date: