TORONTO IMMUNE & DIGESTIVE HEALTH
INSTITUTE

Dear Patients – PLEASE READ THIS IMPORTANT INFORMATION January 2021

In addition to a clinical practice and research program in digestive diseases at Mount Sinai Hospital and the University of Toronto I have opened the Toronto Immune and Digestive Health Institute (TIDHI) to further assist patients with digestive health and chronic immune diseases such as inflammatory bowel disease (IBD).

Numerous programs and services are available at TIDHI that have been set up to make your care more effective and efficient. These services include: care from a team of expert gastroenterologists, psychologists and mental health professionals, nutritionists and dietitians; access to nurses/physician assistants; on site blood tests, vaccine administration and TB tests; infusion/injection treatment centre and for patients for whom approved treatments are ineffective, rapid access to promising new treatments through clinical trials.

Some of these services require payments that are not covered by OHIP and many of these services generate revenue to pay our expenses and overhead at TIDHI. TIDHI is also paid to perform clinical trials although there is no cost to patients to participate in such trials. Dr. Mark Silverberg, Founder of TIDHI, is the sole owner of TIDHI and may benefit from these revenues.

Please be aware that any private pay services available at TIDHI are completely optional. Although you may be offered these services if TIDHI staff believe they may be of benefit to your care, you are not required to accept these services and if you choose not to it will in no way affect your medical care at TIDHI. You are also under no obligation to receive any services at TIDHI, including recommended services covered by OHIP such as endoscopic procedures, and you are welcome to pursue any of these services at a location of your choice or through outside providers. Please inquire with our staff if you have any questions or require clarification or would like a referral for services to be carried out in another location.

Mark S. Silverberg, MD PhD FRCPC, Director and Founder of TIDHI

I acknowledge that I have read and understand this document on (Date): _________________________

Name (PRINT): ______________________________

Signature: _________________________________

# Naturopathic Initial Intake Form:

**PLEASE LIST YOUR MAJOR COMPLAINTS IN ORDER OF IMPORTANCE**

| COMPLAINT | SINCE | POSSIBLE CAUSE(S) |
|---|---|---|

______________________________________________
______________________________________________
______________________________________________

**WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?**

| MEDICATION & WHY | SINCE | ADVERSE EFFECTS |
|---|---|---|

______________________________________________
______________________________________________
______________________________________________
______________________________________________

**PLEASE LIST YOUR SUPPLEMENTS/VITAMINS WITH DOSAGE**

______________________________________________
______________________________________________
______________________________________________

**PLEASE LIST ALL OF YOUR KNOWN ALLERGIES: (FOOD, ENVIRONMENTAL OR DRUG** ______________________________

______________________________________________
______________________________________________

**WHAT OPERATIONS/INJURIES HAVE YOU HAD?**

| OPERATIONS/ INJURIES | DATE | COMPLICATIONS |
|---|---|---|

______________________________________________
______________________________________________

**<u>WOMEN ONLY</u>**

Age of first menses ________________ Number of pregnancies __________________
Last Menstrual Period ______________ Describe cycle _________________________
Last Pap (date) __________________ Last Breast Exam (date) ____________
Bone Density Testing _______________ Was any test abnormal? YES / NO

**<u>MEN ONLY</u>**

Difficulty maintaining/ achieving an erection? YES / NO
Last prostate exam ________________ PSA (blood test done) YES / NO

**COGNITIVE:** ( Please circle)
Memory/ focus/ concentration/ headache

**DENTAL:** (Please Circle)
Amalgam (silver) fillings /Dental Implants/Root Canal / Orthodontics/Periodontal disease/ Extracted Teeth

**SLEEP:** (Please Circle)
How many hours do you sleep each night? ________________
Wakes feeling unrested/ difficulty falling asleep/ wakes multiple times

**DIGESTION:** (Please Circle)
Heartburn/reflux/Bloating/Passing Gas/ Cramping/Lack of appetite /Always hungry

**BOWEL MOVEMENTS:** (Please Circle)

| | | | |
|---|---|---|---|
| 1 Every other day | Less than 1 | 1-2/day | More than 3/day |
| Difficult to pass | Easy to pass | Well-formed | loose or watery |
| Grey Stools | Blood in Stool | Mucous in Stool | |
| Undigested Food in stools | | Rectal Itching | |

**URINATION:** (Please Circle)

| | | |
|---|---|---|
| Burning sensation | Urinary tract infections | incomplete emptying |
| Urgency to urinate | Low back pain | Blood in urine |

**FAMILY HISTORY:** (Details you may recall abut biologically related family)
Maternal ________________________________________________________________
Paternal ________________________________________________________________
Sibling ________________________________________________________________
Other ________________________________________________________________

**LIFESTYLE/ ENVORONMENT/ HYGIENE**
How old is your home? __________ How long have you lived there? ________________
Do you work in the presence of toxic fumes or chemicals? YES / NO
Are you a smoker? YES/ NO Any exposure to second hand smoke? YES / NO

**DIET & EXERCISE:**
Frequency of exercise? ________________ Do you have difficulty perspiring? YES/ NO
How does your body temperature compare to others around you? Low/ High/ Average
Glasses of fluids daily: Water_______ Juice/Soda______ Coffee_______ Alcohol_____
Any dietary restrictions? (religious or otherwise) ________________________________

**INSURANCE & FINANCIALS**:
Do you have a private health care plan? YES/ NO, if yes, limit? _____________
Have you seen a Naturopathic Doctor before? __________________________________

Anything else you would like to share?
________________________________________________________________________
________________________________________________________________________

# STATEMENT OF ACKNOWLEDGEMENT AND CONSENT TO EXAMINATION AND TREATMENT

Naturopathic medicine uses non-invasive methods of assessing the bodily functions and the use of natural therapeutics for treatment. The methods used at this clinic include the use of acupuncture, nutritional and lifestyle techniques as therapeutic methods. In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your cooperation in signing this statement of acknowledgement, in so doing you understand and agree that:

1. I am a Naturopathic Doctor, and not a medical doctor; that I use non-invasive, natural methods of assessment and treatment of body dysfunctions. That any treatment you receive is not mutually exclusive from any treatment or advise you may now be receiving or may receive in the future from another licensed health care provider.
2. I am required by my licensing board to perform a physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is deemed acceptable.
3. Treatment and/or referral to other health practitioners is based on the assessment of your health, through personal history, physical examination, laboratory testing and other methods of evaluation. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.
4. I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended. I reserve the right to discontinue my services where it is apparent that your expectations and what I can provide are not in agreement.
5. You are not an agent of any private or government agency attempting to gather information without so stating your intentions.
6. While changes in dietary habits are not an absolute prerequisite for treatment, that you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.
7. You are accepting or rejecting this care of your own free will and the ultimate responsibility for your health care is your own, and that I am here to support you in this.
8. That you understand that all fees, for services are payable at the time of the appointment by the patient or the guardian.

I, ____________________________ have read and understood and acknowledge the above statements.

X ________________________________________ ________________________________________

Signature of patient or guardian Date

## INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

Recommended Therapeutic Procedure: Nutritional, Botanical, Homeopathic, Supplements, Diet and lifestyle modification, Acupuncture

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic and therapeutic procedures and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the diagnostic and therapeutic procedures/plans with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.
As a result, I do hereby voluntarily consent my informed consent for the recommended diagnostic and therapeutic procedure(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

X ________________________________________ ________________________________________

Signature of patient or guardian Date