**Homeopathic Family Practice** **Pure, Simple and Amazing Inc.**

Hannah Shalom DCHM (Hon) FCHM HOM RsHom(NA)
Homeopath

**BULLETIN:**
Due to COVID-19, the Ontario Ministry of Health mandated that Health Professionals, when possible, should limit the number of in-person visits for the safety of health care providers and their patients. Practitioners are encouraged to continue to offer remote/virtual services and gradually restart in-person visits while supporting physical distancing to minimize patient contact. While scheduling appointments, patients will be screened for symptoms of COVID-19. Before entering the clinic at the exact appointment time, patients will be assessed and asked to wear a face covering to enter. If the previous patient has not finished, you will be asked to wait outside until there is room in the waiting area. Thank you for your patience.

# BIO-ELECTRIC LYMPH DRAINAGE INTAKE QUESTIONNAIRE AND CONSENT FORM

Patient Name _____ File No. _____

Practitioner: Hannah Shalom DCHM (Hon) FCHM RSHom Homeopath Registration #: 15459
Maureen Reyes LPN, BELD Tech, Cupping Practitioner

**PERSONAL INFORMATION** Date: _____

Address: _____ City: _____ Province: ____ Postal Code: _____

Telephone (cell): _____ (home): _____ (work): _____

Email: _____

Emergency Contact: _____

Weight: _____ Height: _____ Age: _____ Date of Birth: _____ Sex: _____

Occupation: _____ Are you under a doctor's care? _____

If yes, please explain_____

Doctor's Name: _____ Phone:_____

Major Physical Complaints_____

List any surgeries you have had _____

List all medications and supplements you take regularly (including over the counter)_____

_____

Are there any other details you feel should be mentioned about your health? If **YES**, please state:_____

_____

_____

Referred by? _____ What is your reason for coming? _____

**WHAT ARE YOU EXPECTING TO RECEIVE FROM THIS APPOINTMENT**?
Is there anything specific you would like to work on during the session?_____

Long Range Goals _____

_____

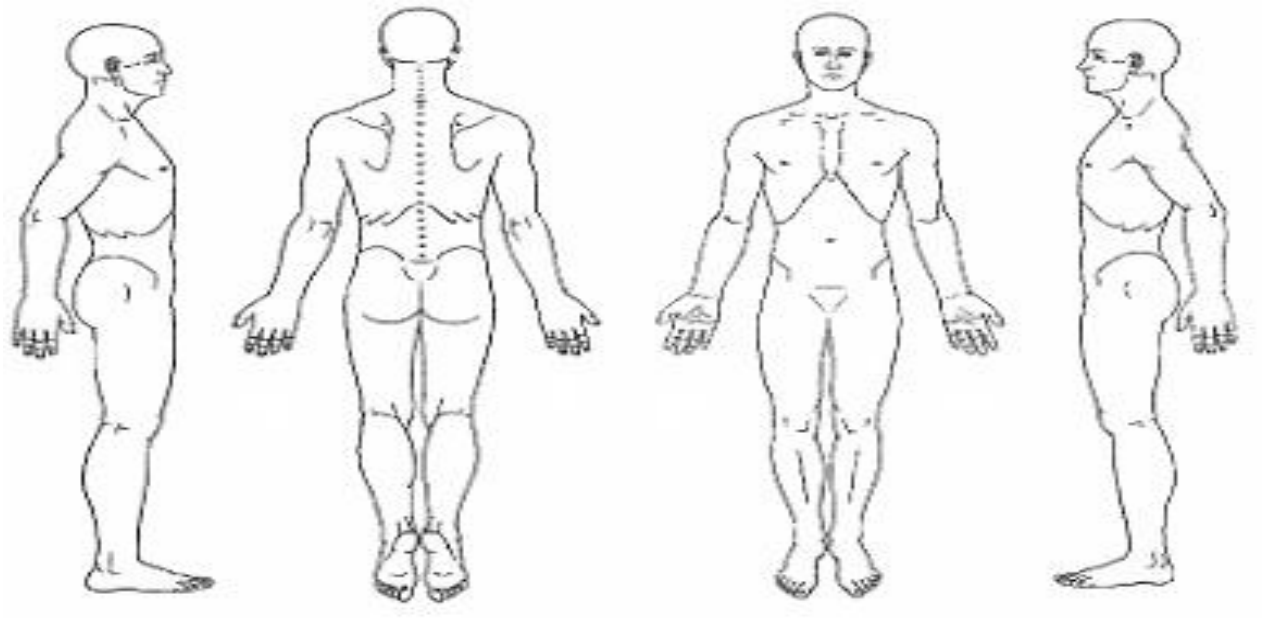
Hannah Shalom DCHM (Hon) FCHM HOM RsHom(NA)
Homeopath

**Please mark all present and former conditions that apply.**

| General | | Female Reproductive | |
|---|---|---|---|
| Fever | | Currently pregnant | |
| Undergoing cancer treatment | | Currently menstruating | |
| Last chemotherapy session | | Fibrocystic breast disease | |
| Arteriosclerosis | | IUD | |
| Carotid sinus issues | | Other: | |
| Hyperthyroidism | | Musculoskeletal | |
| Liver Cirrhosis | | Osteoporosis | |
| Other: | | Osteoarthritis | |
| Ears, Nose, Throat | | Hernia | |
| Ringing in ears | | Rheumatoid arthritis | |
| Sinus problems | | Other: | |
| Earaches | | Skin | |
| Other: | | Cellulitis | |
| Cardiovascular | | Rash | |
| Chest pain or pressure | | Major scars | |
| Swelling of legs | | Lumps | |
| Palpitations | | Other: | |
| Varicose veins | | Hematologic/ Lymphatic | |
| Dizziness | | Cuts that do not stop bleeding | |
| Acute deep vein thrombosis | | Enlarged lymph nodes (glands) | |
| Congestive heart failure | | Lymph nodes removed | |
| Heart attack | | Frequent bruising | |
| High/Low blood pressure | | HIV/AIDS: | |
| Aneurysm | | Other: | |
| Cardiac arrhythmia | | Neurological | |
| Other: | | Strokes | |
| Gastro-Intestinal | | Seizures | |
| Crohn's disease | | Other: | |
| Abdominal pain | | Allergies | |
| Surgical implant(mesh or other) | | Ear fullness | |
| GI inflammation | | Sinus congestion | |
| Diverticulitis/Diverticulosis: | | Recent sinus surgery | |
| Other | | Other: | |
| Urinary | | Emotional | |
| Kidney failure | | Stress | |
| Kidney stones | | Anxiety | |
| Urinary tract infection | | Difficulty sleeping | |
| Dialysis | | Depression | |
| Other: | | Other: | |

*Bio-Electric Lymphatic Drainage (BELD), is a very powerful modality, and certain medical conditions are contraindicated and determine if and when you can receive a session. After consultation and review of the information you have provided on this form, it will be determined if BELD should be administered to you today. For your safety and well-being, some conditions will require a note from your doctor, or consultation with your referring provider, before proceeding.*

## Circle affected areas



## I understand that I <u>may not</u> undergo BELD treatment if:

- **I have an implanted electronic device such as a pacemaker.**
- **I have had recent surgery (within the last 4 weeks) or an organ transplant.**
- **I am on life support.**
- **I have rods, pins, plates, head coils, staples or stents anywhere in my body.**
- **I have major cardiac problems.**
- **I take blood thinner.**
- **I have any hemorrhaging or bleeding.**
- **I am pregnant.**
- **I have had any recent significant trauma (auto accident, fall, etc.)**

I understand that the Electro Lymphatic Therapy I receive is provided for the basic purpose of improving the flow of my lymphatic system and also for relaxation. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I further understand that bio-electric lymphatic drainage (BELD) should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that BELD practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because Bio-Electric Lymphatic Drainage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

**Homeopathic Family Practice** **Pure, Simple and Amazing Inc.**

Hannah Shalom DCHM (Hon) FCHM HOM RsHom(NA)
Homeopath

**PLEASE READ CAREFULLY AND SIGN BELOW**

All statements made on this form are true to the best of my knowledge.
I understand that all personal information provided is confidential as governed by law except to facilitate treatment or diagnosis. All information given here is given only to assist the therapist in delivering appropriate, safe and beneficial lymphatic drainage treatments.

- I understand that the nature and purpose of the treatment will be explained to me and that I have the right to stop or modify the treatment at any time, as does the practitioner.
- I understand I have the right to ask questions at any time.
- I understand that the benefits of bio-electric lymphatic drainage include increased circulation to the tissues and increased relaxation, among other effects, and that I may feel temporary soreness post-treatment (24-48 hours) or a slight dizziness on rising from the table.
- I understand that verbal consent must be given before any treatment.
- I understand that I am responsible for payment in full of all treatment and related fees immediately following each of my appointments by cash, cheque, Visa or MasterCard.
- I understand that 24 hours' notice by telephone is required to re-schedule any future appointment, or full charges will apply.

I authorize Hannah Shalom/Maureen Reyes to perform the Electro Lymphatic Therapy Session, knowing that there are no guarantees as none have been expressed or implied. My signature on this page absolves any liability on behalf of Hannah Shalom of the Pure, Simple and Amazing Homeopathic Family Practice or any of their assigns at this present time or any time in the future.

_____ _____
Client signature Date

**Consent to treatment of a Minor (child) :**
By my signature below, I hereby authorize the certified lymphatic drainage therapist to administer Electro Lymphatic Therapy to my child or dependent as they deem necessary.

Signature of Parent/Guardian:_____ Date:_____

_____ _____
Client signature Date

_____ _____
Client signature Date

_____ _____
Client signature Date

_____ _____
Client signature Date

_____ _____
Client signature Date

_____ _____
Client signature Date

_____ _____
Client signature Date