Annette Stutzki, RN (EC) NP-PHC
Urban Integrative IV and Detox Clinic
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CONSENT AND DIRECTION

I hereby confirm that I am fully aware of the fact that Annette Stutzki, NP along with Allopathic medicine, utilizes complementary, alternative and naturopathic extended medicine. I understand that this means, at times when she considers it to be indicated, she may employ and recommend complementary, alternative, naturopathic and/or integrated remedies and /or treatments which may be considered unconventional by her medical colleagues.

I consent to Annette Stutzki, NP treating me and any members of my family for whom I am legally responsible, in the manner that Annette Stutzki, NP deems advisable in clinical situations.

I acknowledge my understanding that the medical services provided by Annette Stutzki, NP are not considered benefits of Ontario Health Insurance Plan (OHIP) and will be paid for by me personally.

I allow the sharing of my personal information as contained in my patient record to other health practitioners who practice and will or maybe involved in my health care at this Medical/Health Clinic.

Patient's name: _____

Date: _____ Signature: _____

Witness name: _____ Witness signature: _____

PATIENT MEDICAL HISTORY AND FUNCTIONAL INQUIRY

DATE _____ **PATIENT NAME** _____
ADDRESS _____
PHONE NUMBER _____ **WORK NUMBER** _____
HEALTH CARD NUMBER _____ **MANNER OF REFERRAL** _____
DATE OF BIRTH - YEAR _____ **MONTH** _____ **DAY** _____ **AGE** _____
OCCUPATION _____
E-MAIL ADDRESS _____

PAST HISTORY/RISK FACTORS

Have you had or do you have:

	YES	NO
HIGH BLOOD PRESSURE	☐	☐
DIABETES	☐	☐
ASTHMA	☐	☐
EPILEPSY	☐	☐
HEART MURMUR	☐	☐
HEART DISEASE	☐	☐
ULCER DISEASE	☐	☐
BLOOD TRANSFUSION	☐	☐
ABDOMINAL DISEASE	☐	☐
HEPATITIS	☐	☐
KIDNEY DISEASE	☐	☐
THYROID	☐	☐
MIGRAINE	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
RECENT COUGH/COLD	☐	☐
SKIN DISEASE	☐	☐
PSYCHIATRIC PROBLEMS	☐	☐

(See psychiatric history - plan attached)

Please list previous operations and ongoing medical problems _____

When _____

WHAT ARE YOU ALLERGIC TO?

PREGNANCY _____

ONGOING HEALTH CONDITION/SOCIAL HISTORY

SMOKING _____ YEARS _____
ALCOHOL INTAKE - YES ____ NO ____ QUANTITY _____
HEIGHT _____ WEIGHT _____

LONG TERM TREATMENT REGIMEN

HAVE YOU RECENTLY TAKEN THESE MEDICATIONS:

	YES	NO
ASPIRIN/TYLENOL	☐	☐
BLOOD THINNERS	☐	☐
BIRTH CONTROL PILLS	☐	☐
BLOOD PRESSURE PILLS	☐	☐
DIABETES MEDICATIONS	☐	☐
TRANQUILIZERS	☐	☐
STEROIDS/CORTISONE	☐	☐
HEART PILLS	☐	☐

Please list the major illnesses in close family members, e.g. Diabetes, Heart Disease, High Blood Pressure, Cancer

FATHER _____
MOTHER _____
BROTHER/SISTER _____
GRANDPARENTS _____
CHILDREN _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING?

What reaction did you have? _____

UPDATED INFORMATION _____

PATIENT HEALTH QUESTIONNAIRE

Are you affected by any of the following?

	YES	NO		YES	NO		YES	NO
Fatigue			Night sweats			Difficulty sleeping		
Loss of appetite			Intolerance to heat			Bleeding tendency		
Loss of weight			Intolerance to cold			Date of last Tetanus injection		
Fever			Any skin trouble			Date of last Polio injection		
Chill			Fainting					
HEAD and NECK								
Headaches			Nasal congestion			Frequent colds		
Eye trouble			Nose bleeds			Sore throat		
Hearing difficulty			Hay fever			Lumps in neck		
Earaches			Dental trouble			Neck pain		
Sinus trouble			Sore tongue					
RESPIRATORY								
Cough			Wheezing			Cigarette smoking		
Sputum			Shortness of breath			Number daily		
Bloody sputum			Date of last Tuberculin test			Date of last chest X-ray		
CARDIOVASCULAR								
Shortness of breath			Swelling of ankles			Have you ever had an Electrocardiogram?		
Chest pain			Pain in legs					
Palpitation			Varicose veins					
DIGESTIVE								
Difficulty swallowing			Abdominal pain			Bloody stools		
Heartburn			Gas			Black stools		
Nausea			Constipation			Do you take laxatives?		
Vomiting			Diarrhoea			Do any foods cause indigestion?		
URINARY								
Frequency of urination			Change in appearance of urine incontinence			Getting up at night to urinate		
Painful urination						How many times?		
LOCOMOTOR								
Painful, stiffness or joint swelling			Have you had any broken bones?			Back pain		
Limitation of joint movement			Foot trouble			Deformities		
NERVOUS SYSTEM								
Forgetfulness			Abnormal sensations			Difficulty walking		
Nervousness			Loss of balance			Tremors		
Depression			Clumsiness			Dizziness		
Spell of any kind			Muscle weakness					
WOMEN ONLY								
Irregular menstruation			Have you passed the menopause?			Number of pregnancies		
Painful menstruation			Abnormal discharge			Number of miscarriages		
Very heavy periods			Do you take birth control pills?			Date of last menstrual period		
Bleeding between periods			Any trouble with breast?			Date of last Pap smear		

ALLERGY SCREENING

Because allergies can have a negative impact on your health, Urban Integrative IV and Detox Clinic offers allergy testing. This initial testing is covered by OHIP.

In order to determine whether allergy testing is appropriate for you, please answer the following questions.

Name: **Date:**

1. Have you ever been diagnosed by a doctor as having allergies?	**YES ____**	**NO ____**
2. Have you ever received allergy injections?	**YES ____**	**NO ____**
3. If yes, have you discontinued the treatment?	**YES ____**	**NO ____**
4. If yes, why did you discontinue the injections?		
5. If you haven't been diagnosed with allergies, do you suspect that you have allergies?	**YES ____**	**NO ____**
6. Why do you think that you have allergies?		

7. Do you experience any of the following? (answer yes or no)

Runny nose ____	**Sinus pain ____**	**Sneezing ____**
Headaches ____	**Red face ____**	**Face swelling ____**
Shortness of breath ____	**Cough ____**	**Asthma ____**
Itching ____	**Hives ____**	**Eczema ____**
Skin rash ____	**Red/itchy eyes ____**	**Ear aches ____**
Night cough ____	**Fainting ____**	**Throat clearing ____**
Rapid swelling around the eyes ____		

8. Please add any more information about your allergies.

Please answer if you have responded YES to any of the above.

1. Have you had any anaphylaxis (severe allergic reaction) ever before?

2. Do you have Angina (chest pain from heart) or are you on any medication for Angina?

3. Do you have any heart Arrhythmia (heart beat irregularities) or are you on any medication for Arrhythmia?

4. Do you have allergy to peanut?

NIJMEGEN QUESTIONNAIRE

A score of over 23 out of 64 suggest a positive diagnosis of hyperventilation syndrom.

	Never 0	Rarely 1	Sometimes 2	Often 3	Very often 4
Chest pain					
Feeling tense					
Blurred vision					
Dizzy spells					
Felling confused					
Faster or deeper breathing					
Short of breath					
Tight feeling in chest					
Bloated feeling in stomach					
Tingling fingers					
Unable to breathe deeply					
Stiff fingers or arms					
Tight feelings round mouth					
Cold hands or feet					
Palpitations					
Feeling of anxiety					

Identi-T™ Stress Assessment

Name _____ Age _____ Sex _____ Date _____

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, your healthcare provider can create a natural stress relief program for your individual needs.

Directions:

Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1= Seldom true 2= Sometimes true 3= Often true

When under stress for two weeks or longer, I…

Section A:

1. Get wound up when I get tired and have trouble calming down	0	1	2	3
2. Feel driven, appear energetic but feel "burned out" and exhausted	0	1	2	3
3. Feel restless, agitated, anxious, and uneasy	0	1	2	3
4. Feel easily overwhelmed by emotion	0	1	2	3
5. Feel emotional — cry easily or laugh inappropriately	0	1	2	3
6. Experience heart palpitations or a pounding in my chest	0	1	2	3
7. Am short of breath	0	1	2	3
8. Am constipated	0	1	2	3
9. Feel warm, over-heated, and dry all over	0	1	2	3
10. Get mouth sores or sore tongue	0	1	2	3
11. Get hot flashes	0	1	2	3
12. Sleep less than seven hours a night	0	1	2	3
13. Have trouble falling asleep and staying asleep	0	1	2	3
14. Worry about high blood pressure, cholesterol, and triglycerides	0	1	2	3
15. Forget to eat and feel little hunger	0	1	2	3

Total points: _____

Section B:

1. Find myself worrying about things big and small	0	1	2	3
2. Feel like I can't stop worrying, even though I want to	0	1	2	3
3. Feel impulsive, pent up, and ready to explode	0	1	2	3
4. Get muscle spasms	0	1	2	3
5. Feel aggressive, unyielding, or inflexible when pressed for time	0	1	2	3
6. See, hear, and smell things that others do not	0	1	2	3
7. Stay awake replaying the events of the day or planning for tomorrow	0	1	2	3
8. Have upsetting thoughts or images enter my mind again and again	0	1	2	3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over	0	1	2	3
10. Worry a lot about terrible things that could happen if I'm not careful	0	1	2	3

Total points: _____

Section C:

1. Have muscle and joint pains	0	1	2	3
2. Have muscle weakness	0	1	2	3
3. Crave salt or salty things	0	1	2	3
4. Have multiple points on my body that when touched are tender or painful	0	1	2	3
5. Have dark circles under my eyes	0	1	2	3
6. Feel a sudden sense of anxiety when I get hungry	0	1	2	3
7. Use medications to manage pain	0	1	2	3
8. Get dizzy when rising or standing up from a kneeling or sitting position	0	1	2	3
9. Have diarrhea or bouts of nausea with or without vomiting for no apparent reason	0	1	2	3
10. Have headaches	0	1	2	3

Total points: _____

Section D:

1. Have trouble organizing my thoughts	0	1	2	3
2. Get easily distracted and lose focus	0	1	2	3
3. Have difficulty making decisions and mistrust my judgment	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6. Am forgetful	0	1	2	3
7. Feel unsettled, restless, and anxious	0	1	2	3
8. Wake up tired and unrefreshed	0	1	2	3
9. Experience heartburn and indigestion	0	1	2	3
10. Catch colds or infections easily	0	1	2	3

Total points: _____

Section E:

1. Feel tired for no apparent reason	0	1	2	3
2. Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3. Find it difficult to concentrate and complete tasks	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Feel cold or chilled – hands, feet, or all over – for no apparent reason	0	1	2	3
6. Have little or no interest in sex	0	1	2	3
7. Sweat spontaneously during the day	0	1	2	3
8. Feel puffy and retain fluids	0	1	2	3
9. Sleep more than nine hours a night	0	1	2	3
10. Have poor muscle tone	0	1	2	3
11. Have trouble losing weight	0	1	2	3
12. Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13. Have no energy and feel physically weak	0	1	2	3
14. Am susceptible to colds and the flu	0	1	2	3
15. Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Total points: _____

Add points from sections A, B & C	**Total for A, B & C:** _____
Add points from sections C, D & E	**Total for C, D & E:** _____

Lifestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:

1 2 3 4 5 6 7 8 9 10

2. What do you consider to be the major causes of your stress (for example — spouse, family, friends, work, finances, wedding, pregnancy, legal, commute):

_____

3. I eat breakfast _____ times a week. My typical breakfast is: _____

4. I take a multiple vitamin/mineral _____ days per week. I take a fish oil supplement _____ days per week.

5. I participate in 30 minutes of physical activity such as walking, aerobics (e.g., running), resistance training (e.g., weights, pilates), sports (e.g. biking), or yoga:

❑- Daily ❑- 5-6 times per week ❑- 3-4 times per week ❑- 1-2 times per week ❑- Less than once a week

6. I smoke _____ cigarettes daily.

7. I drink two or more 8 ounce cups of caffeinated coffee or other caffeinated beverages like energy/diet drinks, colas, or black or green teas:

❑- Daily ❑- 5-6 times per week ❑- 3-4 times per week ❑- 1-2 times per week ❑- Less than once a week

8. I drink two or more ounces of alcoholic beverages:

❑- Daily ❑- 5-6 times per week ❑- 3-4 times per week ❑- 1-2 times per week ❑- Less than once a week

9. List your current health problems and any over-the-counter or prescription medications that you are now taking:

Current health problem(s)	Date of onset	List all current medication(s)

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Consent

Please indicate whom we may contact in case of emergency.

In case of an emergency, I hereby give permission to the
Urban Integrative IV and Detox Clinic to contact

Name: _____

Phone number: _____

Relationship: _____

Patient's name: _____

Date: _____ Signature: _____

Witness name: _____ Witness signature: _____

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Patient name: _____ Date: _____

1. I have read and understand **the Policy** of the **Urban Integrative IV and Detox Clinic**. The Policy is posted on our website. Printed copy is available at reception, if you wish to refer to it at the office.

Initial _____

2. I have read and understand that two business days before your visit, the receptionist will phone with a reminder for booked appointment. Please reply to her message. However **any cancellations require two business days notice** otherwise a charge of **$150** for a new patient/client visit or **$75** for a follow-up visit is applied as for a missed appointment (no show).

Initial _____

3. I allow the sharing of my personal and health information as contained in my patient record to other health practitioners who practice and will or maybe involved in my health care at this Medical/Health Centre.

Initial _____

Consent for using electronic communications

Although convenient, it should be noted that the use of emails, faxes, text messaging, mobile devises, smart phones and social media are not secure ways of communicating with the office. As well, the use of these communication methods may allow for misinterpretation of results and other information. It is for these reasons booking an in-office appointment is preferable.

Should I wish to use these various electronic means of communicating with the office, I acknowledge the associated risk as described above.

Patient signature: _____

Signature of parent or guardian (if minor) _____