

Maria Gyuro, B.Sc., D.N.M., R.h.A.  
Doctorate of Natural Medicine, Registered Holistic Allergist  
Complete Wellness Clinic, 235 Starwood Drive, Unit 3, Guelph, ON N1E 7E8  
519-763-8855

**INFORMATION LETTER AND CONSENT FORM**  
**Maria Gyuro, DNM     **Doctorate of Natural Medicine****

With the intention of clarifying my role 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 doing so you understand that:

- Natural medicine is the treatment and prevention of diseases by natural means. Practitioners assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle non-invasive techniques are generally used to stimulate the body's inherent healing capacity. Principle natural medical treatments include: nutrition (via diet and nutritional supplementation), botanical medicine, homeopathic medicine, Traditional Chinese Medicine (includes acupuncture, botanical formulas and diet), hydrotherapy, physical medicine (includes hands-on techniques such as soft tissue and spinal manipulation), and lifestyle counselling.
- Practitioners assess your individual health by taking a thorough case history and can utilize diagnostic procedures such as a screening physical examination, urine analysis, hair analysis as well as referring you for further laboratory diagnostic tests when indicated.
- Natural medical treatment and conventional medical treatment are not mutually exclusive and
  - therefore you are encouraged to seek or continue medical care from a qualified physician or medical specialists.
- The ultimate responsibility for your health care is your own, and through an interactive process I am here to support you in this.
- While changes in dietary habits are not an absolute pre-requisite for treatment, failure to follow sound nutritional, exercise and lifestyle programs could undermine the expected results.
- **Payment is made by cash (exact change if possible), cheque, Visa, Mastercard, or Debit at the time of the visit.**
  - Please be aware that many private health insurance plans cover a portion of natural medicine treatments. Patients are encouraged to research their policy and to keep their receipts for this purpose.
    - Initial consult is 90 minutes and is \$130.00 + GST
    - Second visit is 60 minutes and is \$90.00 + GST
    - Follow-up visits vary in duration from 30, 45 or 60 mins, ranging from \$60, \$75 to \$90 + GST
- Missed appointments without 24 hours notice will be charged to your account.

I \_\_\_\_\_, have read, understood and acknowledged the above statements. I understand that the practitioner will answer any questions I have to the best of her ability. I understand that results are not guaranteed. I do not expect the practitioner to be able to anticipate and explain all risks and complications. I will rely on the practitioner to exercise judgement during the course of the procedure, which they feel at the time is in my best interests, based upon the facts then known. With this knowledge I voluntarily consent to the diagnostic and treatment procedures mentioned above. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw and discontinue participation in these procedures at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Re: Your Appointment:** \_\_\_\_\_

Dear New Patient: \_\_\_\_\_,

Thank you for choosing to see me as your Doctor of Natural Medicine. I appreciate and respect the energy and effort you are making to enhance your health. Natural Medicine is the art, science and practice of preventing, diagnosing and treating conditions of the body and mind with the use of natural substances and therapies. These therapies may include clinical nutrition, botanical (herbal) medicine, Traditional Chinese Medicine and Acupuncture, homeopathy, counselling, hydrotherapy and hands-on bodywork.

In this package you will find:

- an information letter and consent form
- a new patient intake form/Questionnaire
- a diet diary

To make our time together worthwhile and efficient, **please fill out all forms provided and bring them with you to your first appointment.** The diet diary should reflect for example the five days before your first visit OR a typical five days of your diet. Be as detailed as you can in describing the types and amounts of foods AND beverages you have consumed throughout each day and also note the daily regularity of your bowel movements and any other outstanding physical symptoms. The more thorough you are when filling out these forms the more value they will add to our discussion and therefore my assessment and recommendations.

If you have any questions about the information in this package please call 519-763-8855

Kindly note that payment must be made at the time of the visit. Payment methods include cash (exact change please), cheque, Debit, Visa or Mastercard. A \$25.00 fee applies for an NSF cheque. Details on fees are found on the Information Letter, and all consultation fees are subject to GST.

There is free parking at the Starwood-Grange Plaza.

I look forward to meeting with you.

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**ADULT - NEW PATIENT QUESTIONNAIRE**

*Please take the time to complete this questionnaire as thoroughly as possible. Print all information and mark anything that you don't understand with a question mark. Natural medicine care is most effective when the practitioner has a complete picture of your physical, mental and emotional health. This information is confidential.*

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Birthdate (Day-Month-Year): \_\_\_\_\_ Gender: M F  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email (optional): \_\_\_\_\_  
Occupation: \_\_\_\_\_ Full / Part time: \_\_\_\_\_

Emergency contact and relationship to patient: \_\_\_\_\_  
Contact's phone: \_\_\_\_\_

How did you find out about the natural medicine services at this clinic? \_\_\_\_\_  
Are you (circle one): single married separated divorced widowed  
Common-law significant relationship \_\_\_\_\_  
Do you live with (circle one): spouse partner relatives friends alone  
Do you have children? \_\_\_\_\_ Their ages: \_\_\_\_\_

Do you know your blood type? ( A, B, O, AB ) \_\_\_\_\_

Your General state of Health (circle one): Poor Fair Good Very good Excellent

What are your main health concerns? ( In order of importance to you )

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Please indicate if you have in the past or are currently working with other practitioners such as chiropractor, physiotherapist, counselor, psychologist, social worker, etc. If in the past, please state when and duration of treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Childhood illnesses: Scarlet fever Y N Diptheria Y N Rheumatic Fever Y N  
Mumps Y N Measles Y N German Measles Y N

Other: \_\_\_\_\_

Immunizations: Polio Y N Pertussis Y N  
Tetanus shot Y N Diptheria Y N  
Measles / Mumps / Rubella Y N

Other: \_\_\_\_\_

Any adverse reactions: \_\_\_\_\_

What hospitalizations or surgeries have you had and when:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Please list all known allergies ( foods, animals, environmental, medications, etc.. ):

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Current medications that you take or use: (please circle)

Pain relievers	<input type="checkbox"/> Y <input type="checkbox"/> N	Hormones	<input type="checkbox"/> Y <input type="checkbox"/> N	Thyroid med.	<input type="checkbox"/> Y <input type="checkbox"/> N
Antacids	<input type="checkbox"/> Y <input type="checkbox"/> N	Cortisone	<input type="checkbox"/> Y <input type="checkbox"/> N	Sleeping pills	<input type="checkbox"/> Y <input type="checkbox"/> N
Laxatives	<input type="checkbox"/> Y <input type="checkbox"/> N	Tranquilizers	<input type="checkbox"/> Y <input type="checkbox"/> N	Antidepressants	<input type="checkbox"/> Y <input type="checkbox"/> N

Any other meds, including Over The Counter medications, for what condition(s), and dosage and frequency (eg. 50mg tablet 3x day):

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Current supplements / herbals / vitamins and amounts that you are taking:

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Sleep pattern ( average amount of hours, awake rested?, naps, any difficulties? ):

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Do you exercise?  Y  N

Type,frequency,duration: \_\_\_\_\_

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Indicate whether you have been or are exposed to / use the following ( and if so, how much ):

Tobacco smoke \_\_\_\_\_

Coffee / tea \_\_\_\_\_

Pop drinks \_\_\_\_\_

Alcohol \_\_\_\_\_

Recreational drugs \_\_\_\_\_

Chemicals \_\_\_\_\_

Excess stress \_\_\_\_\_

Please check which of the following you have or may have had:

abscess	emphysema	headaches	influenza	pleurisy	strep throat
abortion	epilepsy	heart disease	diabetes	pneumonia	stroke
alcoholism	fibrocystic breasts	hepatitis	miscarriage	PMS	substance abuse
anemia	HIV / AIDS	mono	prostatitis	syphilis	arthritis
frequent colds	kidney disease	MS	psoriasis	tonsillitis	asthma
gallstones	leukemia	mumps	ulcers	tuberculosis	cancer
genital herpes	gout	parasites	warts	sexual abuse	scarlet fever
chicken pox	rheumatic fever	glaucoma	goiter	malaria	osteoporosis
peritonitis	rubella	cold sores	measles		sinusitis
depression	gonorrhea	worms	eczema	hay fever	
menstrual cramps	low or high blood pressure	pelvic inflammatory disease	whooping cough		

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others: \_\_\_\_\_  
\_\_\_\_\_

Any that are involved in your Family History? Afflicting past Family members, please list: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your family, work relationships:  
\_\_\_\_\_  
\_\_\_\_\_

***Thank you for answering all of these questions. Your accurate responses are vital for effective natural medicine treatment.***