

Better health begins with nature



CHILD INTAKE FORM (6 to 12 years old)

Child's Name _____ Today's Date _____
Date of Birth (Month/Day/Year) _____ Age _____ Gender: Female / Male
Child's Height _____ Weight _____ Grade Level _____
Mother's/Guardian's Name _____ Father's/Guardian's Name _____
Child's Address _____
City _____ Province _____ Postal Code _____
Phone (home) _____ (parents work &/or cell) _____
Whom does the child live with (name and relation)? _____
Who is filling out this form (name and relation)? _____

Emergency Contacts (in order of preference)

Name & Relation _____ Phone _____
Address _____
Name & Relation _____ Phone _____
Address _____

Other Health Care Providers

Type of Provider: Family Doctor Type of Provider: _____ Type of Provider: _____
Name: _____ Name: _____ Name: _____
Phone: _____ Phone: _____ Phone: _____

List your child's health concerns, in order of importance:

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

How did you hear about our clinic? _____
Has any other family member been a client at this clinic? _____
Has your child received naturopathic treatment in the past? _____

MEDICATIONS

	Now	Past		Now	Past
Aspirin			Antibiotics		
Tylenol			Anti-histamine		
Decongestant			Ibuprofen		

List any prescription or over-the-counter medications, vitamins, minerals, herbs, or other supplements that your child is presently taking.

ALLERGIES

Is your child allergic or sensitive to...

Any drugs/medications? _____

Any foods? _____

Any environmental? _____

Any chemicals? _____

Any supplements? _____

IMMUNIZATIONS

DPT (diphtheria, pertussis, tetanus)

HBV (Hepatitis B)

HIB (haemophilus influenza B)

Flu shot

MMR (measles, mumps, rubella)

Other: _____

Chicken pox

Other: _____

Please indicate any adverse reactions your child has experienced from an immunization.

MEDICAL HISTORY

Has your child experienced any of the following?

Scarlet fever

Measles

Diaper rash

Diarrhea

Pneumonia

Mumps

Rheumatic fever

Cradle cap

Impetigo

Tonsillitis

Chicken pox

Eczema

High fevers

Bedwetting

Ear infections

Shingles

Rashes

Jaundice

Sleep problems

Stomach aches

Rubella

Asthma

Constipation

Anemia

Frequent colds

Diphtheria

Other _____

Injuries/Surgeries/Hospitalizations (please list) _____

FAMILY HISTORY

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Allergies/Hayfever | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> I don't know the family medical history | | | |

SLEEP PATTERNS

What time does your child usually go to bed? _____

What time does your child usually wake in the morning? _____

Does your child have any sleep problems (trouble falling or staying asleep, nightmares, etc.)? _____

SOCIAL PATTERNS

How would you describe your child's behaviour at school? _____

How would you describe your child's behaviour at home? _____

What are your child's interests and favourite activities? _____

What, if any, recreational activities is your child involved in? _____

How would you describe your child's temperament and personality? _____

What situations does your child find stressful? _____

Has your child ever had any significant physical or emotional traumas? _____

Does your child exercise regularly? Yes No How much and how often? _____

How many hours of television does your child watch in a week? _____

How many hours does your child spend on video games and computers in a week? _____

How often does your child read? Daily Several times a week Weekly Less than weekly

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks (type and quantity): _____

What are your child's favourite foods? _____

Are there any foods that your child will not eat? _____

Does your child have any dietary restrictions (vegetarian, vegan, religious, etc.)? _____

Is there anything that you feel is important that has not been covered? _____



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INFORMED CONSENT

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors 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.

A number of different approaches may be used throughout the course of treatment. Treatments include diet and nutritional supplements, botanical medicine, homeopathy, Asian medicine, hydrotherapy, physical medicine, and lifestyle counselling.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved digestion, improved immunity, and general well being.

Botanical medicine is a plant-based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars – i.e., the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plants, animals, or minerals are used to stimulate the body's ability to heal itself.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Dietary advice is based on traditional Chinese medical theory.

Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, your Naturopathic Doctor will take a thorough case history, do a physical examination, and when indicated, take blood and urine samples. The physical examination may include more specific examinations such as gynecological (e.g., PAP), rectal, prostate, or genital exams.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g., pregnancy, lactation, very young children, or those taking multiple medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important, therefore, that you inform your doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

There are some slight health risks associated with Naturopathic Medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements/herbs
- Fainting with acupuncture needles
- Pain, bruising or injury from acupuncture
- Pain, bruising or injury from venipuncture

_____ I understand that a record will be kept of the health services provided to me. This
Initials record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medial record and can request a copy of it by paying the appropriate fee.

_____ I understand that the Naturopathic Doctor will answer any questions that I have to
Initials the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

_____ I understand that charges are to be paid at the time of the visit unless specific
Initials arrangements have been made **prior** to my scheduled appointment. Payment for all dispensary items is due at the time of the visit.

_____ I understand that a fee will be charged (Missed Appointment Fee) for any missed
Initials appointments or late cancellations (less than 24 hours notice).

As the patient, I am responsible for the total charges incurred at each visit. Ezentials accepts cash, debit, or visa. I am responsible for billing my own insurance company (if applicable) – Ezentials will provide all of the information necessary to send in a claim for reimbursement.

The Naturopathic Doctor may prescribe supplements that can be purchased at Nature's Apothecary or elsewhere. Most insurance companies do not cover the supplements that are prescribed and dispensed.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print) _____

Signature: _____ Date: _____

PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic, while providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

In this clinic, Tracy Gilbert (Naturopathic Doctor) acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body and the law.

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information.

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers

- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent

I have reviewed the above information that explains how your clinic will use my personal information and the steps your clinic is taking to protect my information.

I understand that this clinic has a Privacy Policy that I can ask to see at any time.

I agree that **Ezentials** can collect, use and disclose personal information about

Patient Name _____

_____ as set out above in the information about the clinic's privacy policies.

Signature: _____ Print Name: _____

Date: _____ Signature of Witness: _____

