

*Better health begins with nature*



## **PEDIATRIC INTAKE FORM (Birth – 5 years)**

Patient's Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Date of Birth (Month/Day/Year) \_\_\_\_\_ Age \_\_\_\_\_ Gender: Female / Male  
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. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 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)
- HIB (haemophilus influenza B)
- MMR (measles, mumps, rubella)
- Chicken pox

- HBV (Hepatitis B)
- Flu shot
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

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

---



---

## MEDICAL HISTORY

Has your child experienced any of the following?

- |  |  |                                       |   |   |
|--|--|---------------------------------------|---|---|
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Measles         | <input type="checkbox"/> Diaper rash  | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Pneumonia      |
| <input type="checkbox"/> Mumps         | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Cradle cap   | <input type="checkbox"/> Impetigo       | <input type="checkbox"/> Tonsillitis    |
| <input type="checkbox"/> Chicken pox   | <input type="checkbox"/> Eczema          | <input type="checkbox"/> High fevers  | <input type="checkbox"/> Bedwetting     | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Shingles      | <input type="checkbox"/> Rashes          | <input type="checkbox"/> Jaundice     | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Stomach aches  |
| <input type="checkbox"/> Rubella       | <input type="checkbox"/> Asthma          | <input type="checkbox"/> Constipation | <input type="checkbox"/> Anemia         | <input type="checkbox"/> Frequent colds |
| <input type="checkbox"/> Diphtheria    | <input type="checkbox"/> 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 |   |  |   |

## PRENATAL HISTORY

Mother's age at time of child's birth? \_\_\_\_\_ Number of pregnancies by birth mother? \_\_\_\_\_

Did the mother experience any of the following during pregnancy?

- |                                       |  |   |                                   |
|---------------------------------------|--|---|-----------------------------------|
| <input type="checkbox"/> Bleeding     | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Nausea                       | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Thyroid problems    | <input type="checkbox"/> Physical or emotional trauma |                                   |
| <input type="checkbox"/> Other: _____ |  |   |                                   |

Did the mother use any of the following during pregnancy?

- |  |                                  |  |
|--|----------------------------------|--|
| <input type="checkbox"/> Tobacco                             | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Recreational drugs: _____ |
| <input type="checkbox"/> Prescription medications: _____     |                                  |  |
| <input type="checkbox"/> Over-the-counter medications: _____ |                                  |  |
| <input type="checkbox"/> Vitamins and/or supplements: _____  |                                  |  |
| <input type="checkbox"/> Other: _____                        |                                  |  |

## BIRTH HISTORY

Term: Pre-term (37 wks or less) \_\_\_\_\_ Full-term (38-42 wks) \_\_\_\_\_ Post-term (more than 42 wks) \_\_\_\_\_

Location of birth:  Hospital  Home  Birthing Center  Other: \_\_\_\_\_

Length of labour: \_\_\_\_\_ Weight of infant at birth: \_\_\_\_\_ Type of birth:  Vaginal  C-section

Types of Interventions used:

- |   |   |  |                                     |                                       |
|---|---|--|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Induced labour | <input type="checkbox"/> Use of forceps | <input type="checkbox"/> Epidural/anesthesia | <input type="checkbox"/> Episiotomy | <input type="checkbox"/> Other: _____ |
|---|---|--|-------------------------------------|---------------------------------------|

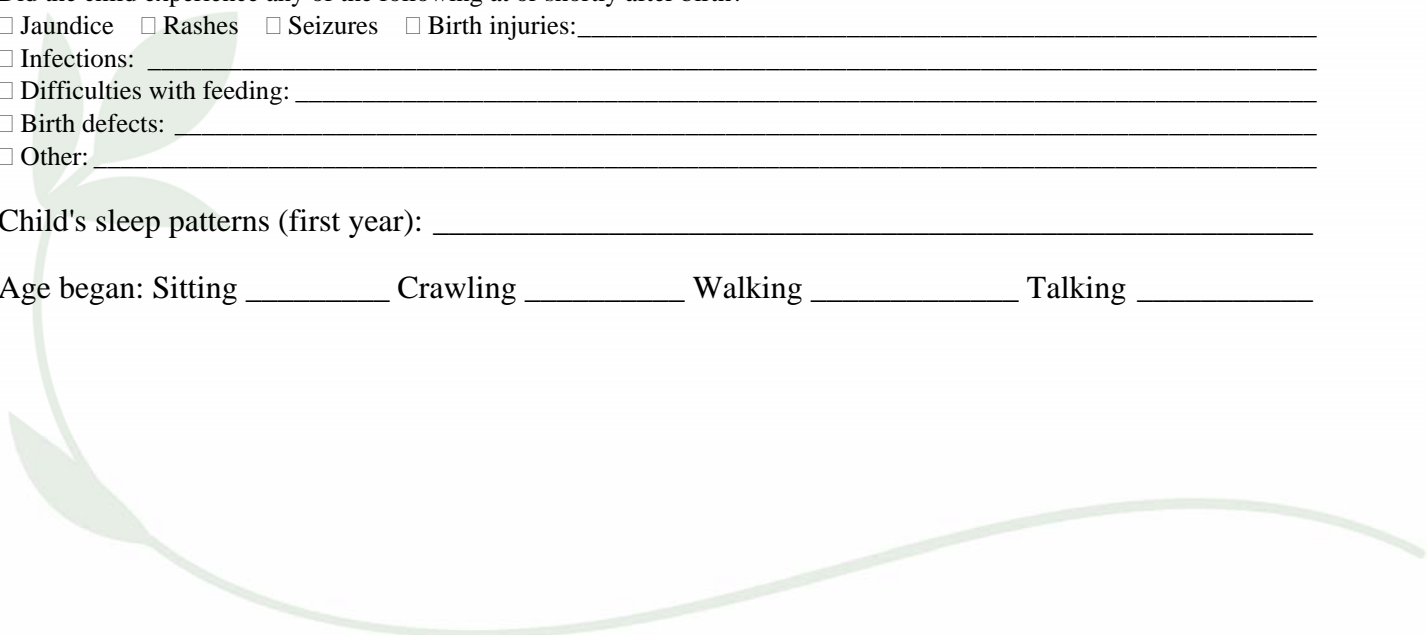
Were there any complications during delivery (e.g., breech delivery)? \_\_\_\_\_

Did the child experience any of the following at or shortly after birth?

- |   |                                 |                                   |  |
|---|---------------------------------|-----------------------------------|--|
| <input type="checkbox"/> Jaundice                         | <input type="checkbox"/> Rashes | <input type="checkbox"/> Seizures | <input type="checkbox"/> Birth injuries: _____ |
| <input type="checkbox"/> Infections: _____                |                                 |                                   |  |
| <input type="checkbox"/> Difficulties with feeding: _____ |                                 |                                   |  |
| <input type="checkbox"/> Birth defects: _____             |                                 |                                   |  |
| <input type="checkbox"/> Other: _____                     |                                 |                                   |  |

Child's sleep patterns (first year): \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_



## DIETARY HISTORY

How was your infant fed?

- Breast fed. How long? \_\_\_\_\_  Formula. Milk/Soy/Other: \_\_\_\_\_  
 Other: \_\_\_\_\_

Did your infant experience any reactions to the formula or breast milk? \_\_\_\_\_  
\_\_\_\_\_

What foods were introduced before 6 months? Please list the approximate month that each food was introduced, as well as any reactions that may have occurred. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What foods were introduced between 6 and 12 months? Were there any reactions to these foods?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did your child ever experience colic? Yes No If yes, how severe was the colic? Mild Moderate Severe

## DIET

Please describe your child's typical daily diet:

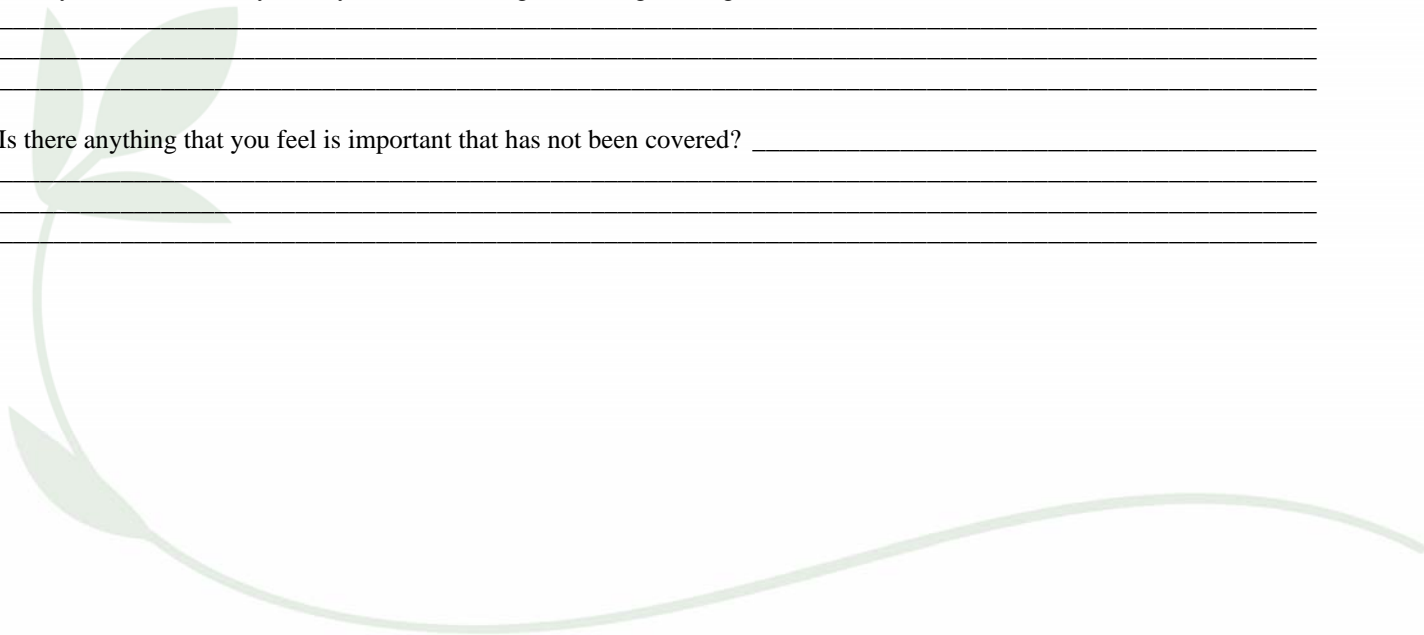
Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_  
Snacks: \_\_\_\_\_  
Drinks (type and quantity): \_\_\_\_\_

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? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## 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.

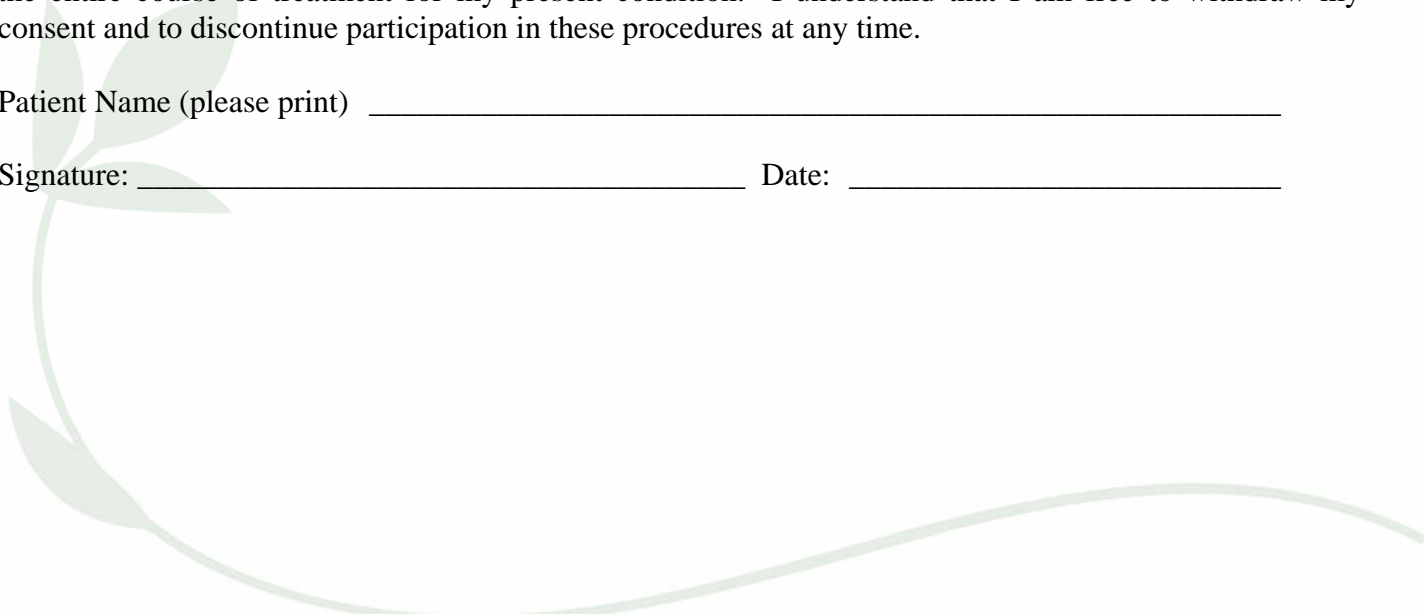
The Naturopathic Doctor may prescribe supplements that can be purchased at Nature's Apothecary or elsewhere. Most insurance companies do not cover the supplements that are prescribed and dispensed.

---

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: \_\_\_\_\_

