Better health begins with nature

Ezentials
NATURAL HEALTH CENTRE & SPA

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? _____

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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 environmentals? _____
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?

□ 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

□ Cancer □ Allergies/Hayfever □ Heart Disease □ Mental Illness
□ Diabetes □ Eczema □ High Blood Pressure □ Other:_____
□ Arthritis □ Birth Defects □ Asthma □ Other:_____
□ 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?
□ Bleeding □ High blood pressure □ Nausea □ Vomiting
□ Diabetes □ Thyroid problems □ Physical or emotional trauma
□ Other: _____

Did the mother use any of the following during pregnancy?
□ Tobacco □ Alcohol □ Recreational drugs: _____
□ Prescription medications: _____
□ Over-the-counter medications: _____
□ Vitamins and/or supplements: _____
□ 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:
□ Induced labour □ Use of forceps □ Epidural/anesthesia □ Episiotomy □ Other: _____

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

Did the child experience any of the following at or shortly after birth?
□ Jaundice □ Rashes □ Seizures □ Birth injuries:_____
□ Infections: _____
□ Difficulties with feeding: _____
□ Birth defects: _____
□ 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 advise 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
- Fainting with acupuncture needles
- Pain, bruising or injury from venipuncture
- Allergic reactions to supplements/herbs
- Pain, bruising or injury from acupuncture

_____ Initials I understand that a record will be kept of the health services provided to me. This 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.

_____ Initials I understand that the Naturopathic Doctor will answer any questions that I have to 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):

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

_____ Initials I understand that a fee will be charged (Missed Appointment Fee) for any missed 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: _____