Lakeside Natural Health
CENTRE

Occupational Therapy Intake

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

We would like to take this opportunity to welcome you to Lakeside Natural Health Centre. This clinic utilizes the principles and practices of Occupational Therapy (OT), a health profession which aims to increase ability and function in daily life. To achieve this goal, the Occupational Therapist assesses and treats physical, sensory, emotional, mental, developmental, social and situational factors in a given situation. The treatment and advice provided to you by the Occupational Therapist is not being provided in place of, or to the exclusion of, any other treatment or advice that you may now be receiving, or may in the future receive, from a physician, surgeon, or any other licensed health practitioner. The Occupational Therapist is accountable to the Code of Ethics and all Practice Standards as outlined by the College of Occupational Therapists of Ontario (COTO).

Privacy of your personal information is an important part of providing you with quality care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. Our privacy protocol complies with privacy legislation and standards of COTO. This includes Standards of Record keeping, which requires that all information is maintained in compliance with Personal Health Information and Protection Act (PHIPA). This means that all personal information obtained, used and disclosed is done so with your consent. Certain situations when your information will be shared are:

- when you have provided verbal or written permission to have information shared with another person(s). In this case, you will be required to sign an authorization form that allows this information sharing, and/or your verbal permission will be documented in your file.
- when the therapist is mandated by law to disclose information, such as to the Children's Aid Society/Family and Children's Services when there is suspected need of protection or at risk of harm, or when ordered to testify in court.
- when the therapist is chosen to participate in a quality assurance review by the College of Occupational Therapists of Ontario (COTO), which all therapists registered in the province must undergo at some point(s) in their professional career.

Your personal information is protected by specific safeguards including locked cabinets and computer passwords.

I understand that a confidential record will be kept of the health services provided to me. I understand that I may look at my medical records at any time and can request a copy of my file with a fee of $0.10 per page. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

I expect to receive information about the assessment findings, proposed treatment plan, alternative courses of action, possible risks or side effects of therapy, and likely consequences of not having treatment. I do not expect my Occupational Therapist to be able to anticipate and explain every possible risk and complication. I understand that treatment results are not guaranteed. With this knowledge, I voluntarily consent to Occupational Therapy services. Should the proposed treatment goals or plan change, I will be required to provide another consent. I understand that I am free to withdraw my consent at any time.

Patient Name (Please print name): ____
Signature of Patient or Guardian: ____________________________________ Date: ____________________
Occupational Therapist: ________________________________ Occupational Therapist Signature: ________________________

The vision of Lakeside Natural Health Centre is to provide true integrative health care. Given our commitment to this best-patient practice, we will communicate with your other practitioners at our clinic to ensure that you are receiving true complementary care. This will be done with respect for all privacy laws and any restrictive stipulation you may have placed on this communication. Please speak to your practitioner if you would like more clarification on this process.
I welcome professional dialogue regarding my case between members of my health care team at Lakeside Natural Health Centre (please circle): Yes / No
Signature: ________________________________

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Billing Authorization Form

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Credit Card on File:

Client's Name: ____

Name as it appears on the credit card: ____________________________________

Type of credit card (please circle): MasterCard / Visa

Card Number: ____

Expiration Date (month/year): ________________ Security Code (3 digits on back of card): _____________

Cancellation Policy:

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours' notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with our clinic policy.

I, ____, authorize Lakeside Natural Health Centre to process the above credit card as "Signature on File" for any balance due on my account past 30 days and for any appointments not cancelled in accordance with Lakeside Natural Health Centre's cancellation policy. I understand that a receipt will be promptly sent to me upon any charges.

Cardholder's Signature: ____ Date: ______________________

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Please complete the following form to provide us with the background information we require to ensure you receive comprehensive care. It should take 15 – 20 minutes.

Contact Information:

Parent Name(s)* ______________________

Child's Name ______________________

Date of Birth M__________D__________Y__________

Gender (circle) Male / Female Age__________

Home # ______________________

Address ______________________

Occupation(s) ______________________

Work # ______________________

Cell # ______________________

Email ______________________

Emergency Contact ______________________

Emergency Contact # ______________________

*Please note: If you are separated or divorced, I will require consent from both parents to provide services for the child, unless you have sole legal custody. Please provide supporting documentation of your legal custody arrangements prior to your first visit.

YES / NO Can we send you our monthly newsletter and new event listings via email? Your email address will not be shared.

How did you hear about Lakeside Natural Health Centre? ______________________

Health Concerns (List in order of importance):

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Health Care Providers:

Medical Doctor ______________________

Phone # ______________________

Fax # ______________________

Dentist ______________________

Phone # ______________________

Fax # ______________________

Specialist ______________________

Phone # ______________________

Fax # ______________________

Specialist ______________________

Phone # ______________________

Fax # ______________________

Other Health Care Providers:

Type of Provider ______________________

Name ______________________

Phone # ______________________

Type of Provider ______________________

Name ______________________

Phone # ______________________

Type of Provider ______________________

Name ______________________

Phone # ______________________

Type of Provider ______________________

Name ______________________

Phone # ______________________

Birth History

Please describe the prenatal period:

- difficulty with conception (please circle): Yes No
- my pregnancy was (please circle): unexpected expected

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- overall prenatal health:____
- emotional climate (work, home, support network, etc.): ____

  ____

  ____

My child was born at (please circle): _____(weeks)

Birth weight: _____________

My child was delivered (please circle): vaginally via C-section (please circle: planned or emergency)

My labour was ________hours.

My child's delivery required the use of (please circle): induction forceps vacuum other:______________

Were there any complications? Please describe:

____

____

____

Medical and Developmental History

My child's general state of health is (please circle): excellent good fair poor

Does your child have a history of any health conditions (please circle):

seizures poor dental health enlarged tonsils/adenoids asthma regular constipation reflux
gags easily vomiting (not from illness) aspiration other:____

Please describe any serious illnesses or injuries, hospitalizations/surgeries to date:______________________________

____

____

Does your child have allergies or food intolerances? Please list and describe reactions:__________________________

____

____

Please list any current medications or supplements being taken:____

____

____

Are there any concerns about your child's hearing or vision?____

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When did your child:

Roll over: ________________________________ Babble: ________________________________

Sit independently: ________________________ Say first words: ________________________

Crawl: ___________________________________ Follow simple instructions: ______________

Walk independently: _______________________ Speak in sentences: _____________________

How does your child sleep (please circle)? Well fair poor

<u>Getting to Know Your Child</u>

Please provide your child's daily schedule during the week (including wake-up times, meal/snack times, naps, scheduled activities and bedtime):

Please describe the strengths, personality, and unique characteristics of your child: ____________________________________

____

____

Please describe what activities your child enjoys/special interests: ____

____

____

Please describe what is upsetting for your child, fears, etc.: ____

____

Please describe your child's typical mood and the emotional climate at home (e.g., calm, busy, stressful, etc.):

____

____

How does your child get along with others (parents, siblings, peers, teachers, etc.)?: ________________________________

____

____

How would you describe your child's ability to concentrate and pay attention in focused activities? __________________________

Looking forward to the next few months, please identify some areas of change you hope to see in your child (e.g., to eat more variety, to decrease tantrum behaviours, to sleep through the night, etc.):

1.
2.
3.

What have you already tried in order to encourage growth in the above areas?:____

____

____

Please describe your child's response to these attempts:____

____

____

Please add any additional information about your child that you feel is relevant to our working together:

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