Lakeside Natural Health
CENTRE

Pediatric Intake

Patient Information:

First Name: _____ Last Name: _____Age: _____ Date of Birth: _____

Gender: _____ Weight: _____ Height: _____ Email Address: _____

Address: _____ Postal Code: _____

Home phone number: _____Guardian's business phone number: _____

Medical Doctor/other health care providers: _____ Referred by: _____

Who is filling out this form (name & relation)? _____

I authorize _____, Doctor of Naturopathic Medicine who has been engaged by me as she may select or approve, to examine and administer Naturopathic care and treatment to _____ whose relationship to me is as a _____. I have been given an explanation of and understand the nature of naturopathic medical care and treatment. I authorize _____, Naturopathic Doctor, to take whatever measures she considers necessary or desirable in connection with such Naturopathic care and treatment.

Dated in the province of Ontario, this _____ day of _____(month), _____(year).

_____ _____
Parent or Guardian of Minor (print name) Signature

_____ _____
Witness (print name) Signature

Contact(s):

Name: _____ Relationship to child: _____

Address: _____ Postal Code: _____

Home phone number: _____ Business phone number: _____

Whom does the child live with? _____

What are the child's health concerns, in order of importance?

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

Medical History:

How would you describe your child's general state of health? (Please check)

Excellent ☐ Good ☐ Fair ☐ Poor ☐

How would you describe your child's usual energy level? _____/10 (0 = no energy, 10 = an abundance of energy)

Please indicate any serious condition, illnesses or injuries, and any hospitalizations/surgeries: along with approximate dates.

_____

_____

Which of the following has your child had?

- ☐ Rubella
- ☐ Measles
- ☐ Chicken pox
- ☐ Mumps
- ☐ Roseola
- ☐ Scarlet fever
- ☐ Whooping cough
- ☐ Strep throat
- ☐ Impetigo
- ☐ Mononucleosis
- ☐ Frequent ear infections
- ☐ Herpes Simplex

Has there been a significant gain or loss of weight? ☐ Yes ☐ No

Has there been a failure to gain weight appropriate for child's age? ☐ Yes ☐ No

If the answer is yes to either of the above questions, please explain:

_____

_____

Does your child have any allergies (medicines, environmental, etc.). If yes, please record reaction to allergen (rash, itching, runny nose, watery eyes, difficulty breathing, etc.)?

_____

_____

Does your child have any food allergies and/or intolerance? Please list food item and reaction to allergen.

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.). Please list dose, frequency, and brand name.

_____

_____

Please list past prescription medications.

_____

_____

How many times has your child been treated with antibiotics?

_____

Please indicate the immunizations your child has had; please indicate date(s) of immunizations:

- ☐ DPT (diphtheria, pertussis, tetanus): _____
- ☐ Tetanus booster: _____
- ☐ MMR (measeles, mumps, rubella): _____
- ☐ Haemophilus influenza B: _____
- ☐ Other? _____
- ☐ Flu: _____
- ☐ Polio: _____
- ☐ Hepatitis B: _____
- ☐ Hepatitis A: _____

Please indicate if any caused adverse reactions (for example, fever, rash, ear ache, behavioural disturbances, etc.), immediately or up to a month following vaccinations:

_____

_____

What is the date of your child's last physical examination _____, dental visit _____, vision examination _____, hearing examination _____, and blood test _____?

What is your child's sleep pattern? # of hours per night? _____ hrs, # of hours during the day? _____ hrs.

Is your child a sound sleeper? ☐ Yes ☐ No Is your child a wakeful sleeper? ☐ Yes ☐ No

What is your child's routine at bedtime? _____

Family History:

Indicate if a close relative (grandparent, parent, sibling) has or has had any of the following:

	Who?		Who?
Alcoholism		Hodgkin's	
Allergies		Hypertension	
Arthritis		Juvenile arthritis	
Asthma		Kidney disease	
Autoimmune disease		Learning disability	
Blood disorder		Mental illness	
Birth Defects		Seizure disorder	
Cancer		Sickle cell anemia	
Cardiovascular disease		Stroke	
Diabetes (I or II)		Tuberculosis	
Endocrine disease		Other?	

Do either of the parents/guardians and/or siblings have a chronic illness?

_____

Grandparents' History:

Relative	Alive/Deceased?	Age/Age at Death	Major Health Conditions
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Environment:

Is your child in: ☐ home-care (with whom?) _____ ☐ daycare ☐ school ☐ other? _____

What are your child's favourite activities? _____

How is your child's academic/social performance at school (if applicable)?

_____

Does your child exercise regularly? ☐ Yes ☐ No

If so, how often and what type of exercise? _____

How often does your child play outside? _____ hours/weekday _____ hours/weekend day

How much television does your child watch? _____ hours/weekday _____ hours/weekend day

Does anyone in the child's household smoke? ☐ Yes ☐ No

Are there any animals in the home? ☐ Yes ☐ No

How is the child's home heated? _____

How old is the child's home? _____ Has it been newly renovated? ☐ Yes ☐ No

Do you know of any toxins/hazards the child is regularly exposed to (home, school, hobbies, etc.)? For example, mould, asbestos, lead paint, pesticides (lawn), bug repellent, rodent toxins, etc. Please describe.

_____

How would you describe the emotional climate of the child's home?

_____

Please indicate the number of hours each parent is away from home during the day?

Father _____ hours Mother _____ hours

Home safety: Are there precautions for poisons, medications, household cleaning products? ☐ Yes ☐ No

Is there the presence of gates for stairways, if applicable? ☐ Yes ☐ No

Is there a family safety plan in case of an emergency that the child is aware of? ☐ Yes ☐ No

Please record any recent stressful experiences (death, divorce, move, loss of special friend, etc.): _____

_____

If so, has there been a change in behaviour or mood? Please describe. _____

_____

Parents' Pre-natal History

Has the mother ever miscarried? ☐ Yes ☐ No

If so, please indicate date of miscarriage and at what point of the pregnancy it occurred?

_____

Has the mother experienced any birth complications with any other siblings (e.g. pre-term labour, still-births, C-section, forceps, Rh compatibility complications, etc.)? Please describe.

_____

What was the parents' age at birth? Mother _____ Father _____

What was the health of the parents before conception?

Mother : ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Please describe the general health of the mother before conception, include the following: diet, lifestyle (stress, exercise), substance use (alcohol, cigarettes, over-the-counter drugs, and illegal drugs).

_____

_____

Father : ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Please describe the general health of the father before conception, include the following: diet, lifestyle (stress, exercise), substance use (alcohol, cigarettes, over-the-counter drugs and recreational drugs).

_____

_____

How was the mother's diet during pregnancy? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Did the mother experience any cravings during pregnancy? Please describe.

_____

Were there any difficulties with conception? ☐ Yes ☐ No

If so, what were the methods used to conceive (if any)? _____

Did the mother receive prenatal medical care? ☐ Yes ☐ No ☐ Unknown

How many ultrasounds did the mother receive, and in what week or month? _____

Did the mother have any x-rays during the pregnancy? ☐ Yes ☐ No

If yes, how many and in what month? _____

What was the weight of the mother before pregnancy?

☐ under-weight ☐ average ☐ over-weight ☐ obese

What was the weight gain during pregnancy? _____lbs

Did the mother experience any of the following during pregnancy?

☐ Bleeding ☐ High blood pressures ☐ Nausea ☐ Physical or emotional trauma

☐ Diabetes ☐ Thyroid problems ☐ Vomiting ☐ Swelling of hands and feet

☐ Infections ☐ Other _____

What interventions were used for any of the above conditions?

_____

Did the mother travel during pregnancy? ☐ Yes ☐ No

If so, describe location and timing in pregnancy? _____

What was the emotional environment during pregnancy (work, home, support network, etc.). Please describe.

_____

What was the attitude toward the pregnancy? (of mother, father, siblings, other family members?) Please describe:

_____

_____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs ☐ Prescription medications

☐ Supplements ☐ Homeopathics ☐ Botanicals ☐ Over-the-counter medications

Please list dose and frequency _____

Child's Birth History

Term length: ☐ Full ☐ Premature:_____(weeks) ☐ Late: _____(weeks)

Length of labour:_____ Weight at birth:_____ lbs/kg Head Circumference: _____ inches/cm

Blood type: _____ Rh ☐ +ve ☐ -ve Apgar Score: _____

Was the birth (please check all that apply): ☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps ☐ Anesthesia (epidural)

Any complications? Please describe. _____

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

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries ☐ Birth Defects ☐ Other _____

If so, please explain: _____

Diet

How was your infant fed?

☐ Breastfed. How long? _____ Please record nursing frequency and duration: _____

_____

Please describe age and method of weaning. _____

☐ Formula. Milk/Soy/Other?: _____ Please list any reactions (rash, colic, diarrhea/constipation, etc.)

_____

Please record feeding frequency and amount: _____

☐ Other. Please describe: _____

Were there any feeding problems (eg/ spitting up, colic, diarrhea, etc.)? Please describe.

_____

What foods were introduced before 6 months? (Please list which foods, amount given, approximate month and any reactions, if applicable). _____

_____

_____

What foods were introduced between 6-12 months? (Please list which foods, amount given, approximate month and any reactions, if applicable).

_____

_____

Were foods home or commercially made? _____

Did your child ever experience colic? ☐ Yes ☐ No If so, how severe? ☐ Mild ☐ Moderate ☐ Severe

How was it treated? _____

Please record the food and beverage intake of the child in the last 24 hours (with quantities, if possible):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks throughout day: _____

Water intake (number of glasses and source of water): _____

Other beverages (please specify type and amount): _____

Is this a typical day for the child? ☐ Yes ☐ No

If no, please explain: _____

Developmental History

Milestones: Please list the age at which the child reached these milestones:

First held head erect		Said his/her first words with meaning	
Rolled over		Spoke in sentences	
Sat alone		Was toilet trained	
Walked alone		Tied his/her own shoes	
Cut his/her first tooth		Dressed without help	

Does the parent believe this development has been normal? Yes ☐ No ☐

If no, please explain: _____

How does this child's development compare with siblings or peers? Please explain. _____

_____

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FEE SCHEDULE, CANCELLATION POLICY & PAYMENT OPTIONS

PATIENT COPY

Fee Schedule	Visit Type	Adult	Child (under 12)/ Senior (Over 65)
	Initial Consultation	190.00	160.00
	Follow up Consult - 15 min	45.00	40.00
	30 min	80.00	70.00
	45 min	110.00	100.00
	60 min	140.00	130.00

Telephone Consults	Charged according to above rates
Email Consults	Charged according to above rates for any new concerns (emails regarding treatment plans already prescribed are free of charge)

***** All fees Include HST
***** Any Prescribed supplements/botanicals/homeopathics and /or appliances are not included in the above fees

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 advance notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with this clinic policy.

Payment Options

At Lakeside we are pleased to be able to accept the following method of payments for your convenience:
Cash, Cheque, Debit, Visa and MasterCard

CANCELLATION POLICY & PAYMENT OPTIONS
CLINIC COPY

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 advance notice are subjected to a charge of 100% of the fee for the service scheduled. The clinic will retain a record of your credit card only to process missed appointment fees and a receipt will be promptly issued for any missed appointment fees. We appreciate your cooperation with this clinic policy.

Credit Card Information
Card # _____ Exp. _____ 3 Digit Code _____

Payment Options
At Lakeside we are pleased to be able to accept the following method of payments for your convenience:
Cash, Cheque, Debit, Visa and MasterCard

Patient Confirmation
By signing this form you have agreed to the conditions of our cancellation policy and acknowledge our fee schedule and payment options.

I _____ have reviewed the above information and understand that if I do not provide 48 hours notice to cancel my appointments I will be sent an invoice by mail that will be due 15 days from invoiced date.

Signature _____ Date _____

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PATIENT CONSENT FORM

INFORMED CONSENT

We would like to take this opportunity to welcome you to Lakeside Natural Health Clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means. Your practitioner will conduct a thorough case history. If you are working with a naturopathic doctor a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up.

Statement of Acknowledgement

As a patient of this clinic I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I understand that my treatment will be based in naturopathic medicine, which has a proven clinical foundation, yet may not be accepted practice by standard allopathic medicine. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture. I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

PRIVACY POLICY

Privacy of your personal information is an important part of providing you with quality naturopathic care. We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. The privacy policy outlines what the centre 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, the Board of Directors of Drugless Therapy – Naturopathy.

The centre will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care and 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 comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners Act
- To invoice for goods and services and to process credit card payments
- To collect unpaid accounts
- To comply generally with the law

PATIENT CONSENT

By signing the consent section of this Patient Consent Form, you have reviewed, understood and agree that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above, and give written informed consent to the statements above regarding Naturopathic Care.

Signature	Print Name
Date	Signature of Witness

Lakeside Natural Health
CENTRE

Jessica Liu, ND, Jen Newell, ND

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AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL TO LAKESIDE HEALTH CENTRE

(Please send a copy of this form back with records)

Section 1:

(Patient to complete Section 1 and 3 of this form)

To: Dr.(MD): _____ **From: Patient:** _____
(please print) **(please print)**

Fax No#: _____ **Date of Birth:** _____

Address: _____ **Address:** _____

_____ _____

_____ _____

Telephone: _____ **Telephone:** _____

Section 2:

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _____

Laboratory Results ***most recent blood and physical work-up**

Imaging Results _____

Other _____

Section 3:

I _____ give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.

Signature of patient: _____ **Date:** _____