Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

Naturopathic Medicine Informed Consent – Child Intake 0 – 8 years

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 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. Naturopathic doctors asses the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Your ND will conduct a thorough case history and may perform a physical exam, specific blood and/or urinary laboratory reports as part of the treatment work-up. It is very important that you inform your Naturopathic Doctor of any medical concerns or medication and supplements you may be taking. Please advise your ND if you are pregnant, suspect you are pregnant or if you are breastfeeding. As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine including acupuncture. By signing this form you acknowledge your understanding of the associated risks and accept full responsibility for any fees incurred during care and treatment and grant permission to proceed. Possible side effects include, but not limited to; aggravation or pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture.

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. Our privacy protocol complies with privacy legislation and standards of our regulatory body, the College of Naturopaths of Ontario.

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record 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 record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the naturopathic doctors to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

Patient Name (Please print name): _____
Signature of Patient or Guardian: _____ Date: _____
Naturopathic Doctor: _____ ND 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: _____

Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

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): _____

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.

Patient / Cardholder's Signature: _____ Date: _____

Lakeside Natural Health
CENTRE
HEAL · GROW · THRIVE

Naturopathic Medicine – Pediatric Intake Form (0 to 8 years)

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.

Patient Contact Information:

Name _____
Date of Birth M_____D_____Y_____
Gender (circle) ____Male / Female_____ Age_____
Home # _____
Address _____
_____

Cell # _____
Email _____
Emergency Contact _____
Emergency Contact # _____
Health Card # _____

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. _____

Primary Contact:

Name _____
Relationship _____
Address _____
_____

Home # _____
Work # _____
Cell # _____
Email _____

Secondary Contact:

Name _____
Relationship _____
Address _____
_____

Home # _____
Work # _____
Cell # _____
Email _____

Health Care Providers:

Medical Doctor _____
Phone # _____
Fax # _____

Dentist _____
Phone # _____
Fax # _____

Specialist _____
Phone # _____
Fax # _____

Other Provider _____
Name _____
Phone # _____

Medical and Lifestyle Information

Please check if your child has had the following:

- ☐ Asthma
- ☐ Cold or influenza
- ☐ Fever (above 105°F)
- ☐ Cough
- ☐ Jaundice
- ☐ Diabetes
- ☐ Ear infections
- ☐ Measles
- ☐ Mumps
- ☐ Rubella
- ☐ Warts
- ☐ Chicken pox
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Polio
- ☐ Strep throat
- ☐ Mononucleosis
- ☐ Impetigo
- ☐ Eczema
- ☐ Whooping cough

Lakeside Natural Health CENTRE
HEAL · GROW · THRIVE

General Information:

General state of health (circle one): excellent good fair poor Energy level: _____ / 10 (0 – no energy, 10 – abundance of energy)
How many times have they taken antibiotics in the last 5 years? _____ Is your child a sound sleeper? (circle one): YES / NO
How many hours of sleep does your child get per night? _____ How many hours of sleep does your child get per day? _____
What is your child's routine at bedtime? _____
Quality of sleep (circle): easily aroused hard to wake nightmares sleep on stomach sleep on back
Has there been a significant gain or loss of weight? (circle one): YES / NO
Please explain: _____
Has there been a failure to gain weight appropriate for your child's age? (circle one): YES / NO
Please explain: _____
Is your child in? (circle one) home-care (with whom?): _____ day care school other (please specify): _____
What are your child's favourite activities? _____
How is your child's social or academic performance? _____
Does your child exercise regularly? (circle one): YES / NO If yes how often and that type of exercise: _____
How often does your child play outside? _____ hours/weekday _____ hours/weekend
How often does your child watch television? _____ hours/weekday _____ hours/weekend
How often does your child use electronic devices? _____ hours/weekday _____ hours/weekend
Does anyone in the household smoke? (circle one): YES / NO Are there animals in the home? (circle one): YES / NO Type? _____
How is the child's home heated? _____ How old is the child's home? _____ Has it been newly renovated? circle one): YES / NO
Please describe the emotional climate of the child's home: _____
Do you know of any toxins/hazards the child is regularly exposed to (home, school, hobbies, etc.)? For example, mould, asbestos, lead paint, pesticides, bug repellent, rodent toxins, etc. Please list: _____
Please indicate the number of hours each parent is away from the child. Father _____ hours Mother_____ hours
Has your child experienced any other trauma or loss in their life? (circle one): YES / NO
Please explain: _____

Medical Conditions: Please indicate any serious illnesses, conditions or reasons for hospitalizations

Illness/ Hospitalization	Date of Diagnosis	Diagnosed by?	Is the condition still present?	Symptoms

Allergies or Food sensitivities: Please indicate any allergies and/or serious food sensitivities

Allergy / Sensitivity	Severity of reactions

Medications/Supplements: Please list all current medications/supplements/homeopathics and over-the-counter medications

Medication/Supplement	Dose/Length of use	Condition it is treating

Lakeside Natural Health CENTRE

HEAL · GROW · THRIVE

Screening Tests: Please check which of the following screening test your child has received

Test	✔	How often	Date of last test
Blood work			
Dental check up			
Hearing			
Physical exam			
Vision			
Other			
Other			

Vaccinations: Please check which vaccinations your child has received

Vaccinations	✔	Age	Side Effects / Hospitalization
Chicken Pox (Varicella Zoster)			
Diphtheria, Pertussis, Tetanus (DPT)			
Flu			
Haemophilus Influenza B (Hib)			
Hepatitis A			
Hepatitis B			
Measles, Mumps, Rubelia (MMR)			
Meningitis (MCV, Menactra)			
Polio			
Rabies			
Tetanus			
Rotavirus			
Other			

Family History: Please check and indicate which family member

Illness	✔	Family member/s and age	Complications/Severity
Allergies			
Asthma			
Cancer			
Depression			
Diabetes			
Family history unknown			
Heart Disease			
High blood pressure			
Infertility			
Kidney disease			
Other			
Other mental illness			
Post-partum depression			

Parents' Prenatal History

General health of the mother before conception (circle one): Excellent Good Fair Poor Unknown Mother's age at birth: _____
Please describe the general health of the mother before conception, include the following: diet, lifestyle, stress, exercise, substance use (alcohol, cigarettes, over-the-counter and illegal drugs): _____

_____

General health of the father before conception (circle one): Excellent Good Fair Poor Unknown Father's age at birth: _____
Please describe the general health of the mother before conception, include the following: diet, lifestyle, stress, exercise, substance use (alcohol, cigarettes, over-the-counter and illegal drugs): _____

_____

Lakeside Natural Health CENTRE

HEAL · GROW · THRIVE

Parents' Prenatal History continued

Has the mother ever miscarried? (circle one): YES / NO If yes please indicate date of miscarriage and at what point of the pregnancy it occurred: _____

Did the mother or has the mother ever experienced any birth complications (e.g. pre-term labour, still-births, C-section, forceps, Rh compatibility complications, etc.)? Please explain: _____

How was the mother's diet during pregnancy? (circle one): Excellent Good Fair Poor Unknown

Did the mother experience cravings during pregnancy? Please explain: _____

Were there any difficulties with conception? (circle one): YES / NO

If so, what were the methods used to conceive? (circle one): YES / NO Please explain: _____

Did the mother receive prenatal medical care? (circle one): 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? (circle one): YES / NO

If yes, how many and in what month? _____

What was the weight of the mother before pregnancy? (circle one): Under-weight Average Over-weight Obese

What was the weight gain during pregnancy? _____lbs

Did the mother travel during pregnancy? (circle one): YES / NO If yes, where to and what time in pregnancy? _____

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

_____

What was the attitude toward the pregnancy (of mother, father, siblings, other family members, friends?) _____

_____

Did the mother experience any of the following during pregnancy? Please check all that apply

☐ Bleeding ☐ Infections ☐ Vomiting ☐ Thyroid problems ☐ Nausea

☐ Swelling in hands and feet ☐ Physical or emotional ☐ High blood pressure ☐ Diabetes ☐ Other _____

What interventions were used for any of the above conditions? _____

Did the mother use any of the following during pregnancy? (please check) ☐ Prescription medications ☐ Tobacco ☐ Supplements

☐ Alcohol ☐ Homeopathics ☐ Recreational drugs ☐ Botanicals ☐ Over-the-counter medications

Please list dose and frequency: _____

Child's Birth History

Was the birth (please check): ☐ Vaginal ☐ C-Section ☐ Induced ☐ Forceps ☐ Anesthesia (epidural)

Were there any complications? Please explain: _____

Where did the birth occur? (circle one): Home Hospital Birthing centre Did the mom have a (please circle)? Doula Midwife

Term length (please check and indicate time): ☐ Full ☐ Premature: _____weeks ☐ Late: _____weeks

Length of labour:____ Weight at birth: ____lbs/kg Head circumference: ____in./cm Blood type: :____ Rh ☐ +ve ☐ -ve Apgar score:____

Did the child experience any of the following at or shortly after birth? (please check)

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries ☐ birth defects ☐ Other: _____

Developmental History

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

_____ First held head erect _____ Sat alone _____ Cut first tooth _____ Spoke in sentences _____ Tied own shoes

_____ Rolled over _____ Walked alone _____ Said first words _____ Was toilet trained _____ Dressed without help

Do you believe this development was normal? Please explain: _____

How does the child's development compare with siblings or peers? Please explain: _____

Diet History

Feeding (please circle): Breast fed – for how long _____ Formula fed – for how long _____ - What formula was used? _____

Please record nursing frequency and duration: _____

Please list any reactions (rash, colic, diarrhea, constipation, etc.): _____

List foods introduced before 6 months (please indicate amount give, approximate month and any reaction): _____

_____

List foods introduced after 6 months (please indicate amount give, approximate month and any reaction): _____

_____

Lakeside Natural Health CENTRE
HEAL · GROW · THRIVE

Diet History Continued

Most common eating style (circle one): Home made (from scratch) home made (packaged) Eating out at restaurants
Did your child experience colic? (circle one): YES / NO If so, how severe? (circle one): Mild Moderate Severe
How was it treated? _____

Please record the food and beverage intake of your child in the last 24 hours
Breakfast: _____ Dinner: _____
Lunch: _____ Snacks: _____
Water intake (# of glasses and source of water): _____
Other beverages (please specify type and amount): _____
Is this a typical day for the child? (circle one): YES / NO In no, please explain:_____

Check off any of the following if they are a CURRENT or RECURRING symptom:

General:

- ☐ Change in appetite
- ☐ Chills
- ☐ Sweat easily
- ☐ Weight Gain
- ☐ Peculiar tastes or smells
- ☐ Poor sleep
- ☐ Fevers
- ☐ Strong thirst
- ☐ Weight Loss
- ☐ Sudden decrease in energy
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cravings
- ☐ Bleed or bruise easily

Skin and Hair:

- ☐ Rashes
- ☐ Itching
- ☐ Loss of hair
- ☐ Recent moles
- ☐ Ulcerations
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Dryness
- ☐ Skin Cancer
- ☐ Change in hair or skin texture

Head, Eyes, Ears, Nose and Throat:

- ☐ Headaches
- ☐ Glasses
- ☐ Blurry vision
- ☐ Ringing in ears
- ☐ Jaw clicks
- ☐ Head or neck problems
- ☐ Night blindness
- ☐ Cataracts
- ☐ Sinus problems
- ☐ Gums bleed easily
- ☐ Concussions
- ☐ Eye pain
- ☐ Ear aches
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Eye Strain
- ☐ Colour blindness
- ☐ Poor hearing
- ☐ Teeth problems
- ☐ Recurrent sore throats
- ☐ Sores on lips, tongue or mouth

Respiratory:

- ☐ Difficulty breathing
- ☐ Bronchitis
- ☐ Coughing blood
- ☐ Pain with a deep breath
- ☐ Other
- ☐ Cough
- ☐ Asthma
- ☐ Pneumonia
- ☐ Production of mucus

Cardiovascular:

- ☐ High blood pressure
- ☐ Dizziness
- ☐ Chest pain
- ☐ Blood clots
- ☐ Swelling of hands
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Varicose veins
- ☐ Cold hands and feet
- ☐ Swelling of ankles/feet
- ☐ Irregular heartbeat

Gastrointestinal:

- ☐ Indigestion
- ☐ Constipation
- ☐ Vomiting
- ☐ Rectal pain
- ☐ Blood in stool
- ☐ Gas
- ☐ Nausea
- ☐ Laxative use
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Bad breath
- ☐ Abdominal pain or cramps

Genito-urinary:

- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals
- ☐ Wake at night to urinate
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Impotency
- ☐ Unable to hold urine
- ☐ Other
- ☐ Pain on urination
- ☐ Frequent urinary tract infections

Musculoskeletal:

- ☐ Neck pain
- ☐ Hand / wrist pain
- ☐ Knee pain
- ☐ Hip Pain
- ☐ Muscle weakness
- ☐ Back pain
- ☐ Shoulder pain
- ☐ Foot / ankle pain
- ☐ Muscle pain
- ☐ Other joint or bone problems

Neuropsychological:

- ☐ Loss of balance
- ☐ Poor memory
- ☐ Depression
- ☐ Concussion
- ☐ Susceptible to stress
- ☐ Quick temper
- ☐ Anxiety
- ☐ Dizziness
- ☐ Seizures
- ☐ Lack of coordination

Lakeside Natural Health Centre

7 Elmwood Avenue North
Mississauga, ON L5G 3J8
Tel: 905-274-4375
Fax: 905-274-6209
info@lakesidehealthcentre.com

AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL TO LAKESIDE NATURAL 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 _____

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: _____

Requesting Practitioner: _____

Date: _____