LiveWell
Family Health Centre
Chiropractic • Massage • Fitness Training • Nutrition
Natural Pharmacy • Orthotics • Naturopathy

Naturopathic Confidential Pediatric Patient Intake please print

Today's Date: _____
Child's Full Name: _____ Age: _____ Sex: M F
Date of Birth: ___/____/____ Blood Type _____ (+ or -) Height: _____ Weight: _____ lbs
DD/ MM/ YY
Parent(s)/ Guardian(s) Name(s): _____ Relation: _____
With whom does the child live? _____
Address: _____
Street & Apt. City Province Postal Code
Home Phone: _____ Business Phone: _____
Cell Phone: _____ E-mail: _____
Family Status (Please check (√): ☐ Single Parent ☐ Married ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed
Emergency Contact: _____ Phone: _____
Name and Relationship
Is the child currently receiving healthcare? Y N If yes, where and from whom?

Type of Provider	Name	Phone #	Address
_____	_____	_____	_____
_____	_____	_____	_____

How did you hear about the clinic?
_____

Current Health Concerns:
State your main reason for your visit today.
How long? Prior treatment(s)? Results?
_____
_____
_____

Current Medications: (Prescription and over-the-counter)

Name of Drug	Reason for Drug	Dose (mg/etc)	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Vitamins, Minerals and Supplements: What is your child taking and dosages?

Name of Supplement	Reason	Dose (mg/etc)	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: (Please circle)
Past experiences: Eczema Hives Wheezing Asthma Stuffy Nose (or constant cold)
Known allergies to: Medicines Animals Foods or Other Substances

Substance	Reaction
_____	_____
_____	_____

Family History:
Please indicate if any of your child's close relatives (sibling, parent, maternal or paternal grandparent, aunt, uncle) has had any health condition(s) including the following (please check (√)):

	Which family member and age?		Which family member and age?
☐	High blood pressure _____	☐	Allergies _____
☐	Heart attack _____	☐	Alcohol/Drug Abuse _____
☐	Diabetes _____	☐	Cancer _____
☐	Skin disorders _____	☐	Osteoporosis _____
☐	Depression _____	☐	Mental Illness _____
☐	Asthma _____	☐	Other serious illness _____

Vaccinations: (Please circle those received)

Haemophilus B	Pertussis	Tetanus	Diphtheria	Polio	Hepatitis B
Measles	Mumps	Rubella	Influenza	Chicken Pox	Meningococcal
HPV					

Adverse Reactions? If yes, please explain: _____
_____

Medical Conditions: Check (√) if your child has had any of the following:
Circle if it is a Current/Yes (Y) or Past Condition (P)

☐	Allergies	Y P	☐	Cradle Cap	Y P	☐	Jaundice	Y P
☐	Anemia	Y P	☐	Dental Caries	Y P	☐	Pneumonia	Y P
☐	Asthma	Y P	☐	Diarrhea	Y P	☐	Seizures	Y P
☐	Candida infection	Y P	☐	Ear Infections	Y P	☐	Sensitivities (foods /noise)	Y P
☐	Chronic infections	Y P	☐	Eczema	Y P	☐	Slow Weight Gain	Y P
☐	Colic	Y P	☐	Fracture	Y P	☐	Stomach Aches	Y P
☐	Constipation	Y P	☐	Frequent Colds	Y P	☐	Whooping Cough	Y P

Hospitalizations and Surgeries:
_____ Year: _____
_____ Year: _____
_____ Year: _____

X-Rays, CAT Scans, or Other Diagnostic Studies:
_____
_____
_____

Accidents/Injuries: (Type, Date and Important Details)
_____
_____
_____

Current Medical History:
The general state of your child's health is: ☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor
What time of day is your child's energy best?: _____ Worst?_____

Typical Food Intake:

Breakfast:_____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

Beverages: _____

How much water per day?:_____

Does the child follow any dietary modifications? _____

Bowel Movement Habits: Please Check (√)

Frequency (how often): □ Every day □ Every other □ Every week □ Other? _____

Color: □ Dark □ Brown □ Green □ Yellow □ White □ Grey

Consistency: □ Soft □ Hard □ Watery

Any, □ Mucus □ Blood →If Blood is present: □ Bright □ Dark

Prenatal Health and History

Did the mother experience any food cravings/aversions during pregnancy? Y N

If yes, please list Aversions: _____

Cravings: _____

Did the mother experience any of the following during pregnancy? Please Check (√)

□ Bleeding □ Nausea □ Thyroid Issue

□ High Blood Pressure □ Vomiting

Were any of the following interventions used during pregnancy? Please Check (√)

□ Ultrasound □ Chorionic Villi Sampling □ Triple Screen

□ Amniocentesis □ Maternal Serum Screening □ Other

Did the mother use any of the following during pregnancy? Please Check (√)

□ Tobacco □ Alcohol

□ Recreational Drugs Please specify: _____

□ Prescription Medications Please specify: _____

□ Over-the-Counter Meds Please specify: _____

Birth History

Term Length: _____ weeks

Type of Birth: □ Vaginal □ C-Section

Interventions: □ Induction □ Episiotomy □ Use of Forceps □ Epidural

Were antibiotics administered for Strep B positive? Y N

Were there any complications during delivery (eg. Breech / Posterior)? _____

Length of Labour: _____ hrs

Weight of Infant at Birth: _____ lbs

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

□ Jaundice □ Infections □ Birth Injuries

□ Rashes □ Seizures □ Difficulty with Feeding

Nutritional History

Was the child breastfed? Y N For how long? _____
Was the child formula fed? Y N From what age? _____
Did your infant experience any reactions to the breast milk or formula? Y N
What foods were introduced before 6 months? Please list the approximate month and any reactions.

_____

Has your child ever experienced colic? Y N
Does your child have any food allergies or intolerances? Y N If so, please list.

_____

_____

Does your child have any dietary restrictions (vegetarian/vegan, religious etc.)? _____
Please describe your child's eating habits/favourite foods: _____

_____

Does your child have strong aversions to any foods? _____

Sleep Patterns

What time does your child usually go to bed? _____ Wake in the morning? _____
Does your child nap during the day? Y N What times (s): _____
Does your child have nightmares? Y N How Often? _____
Does your child have any problems associated with sleeping (eg. trouble falling asleep, grinding teeth, sleep walking, etc.)? _____

Social Patterns

Is your child in: ☐ School ☐ Daycare ☐ Homecare ☐ Other: _____
What grade level? _____
How would you describe your child's behaviour at school? _____

_____

How would you describe your child's behaviour at home? _____

_____

Does your child make friends easily? Y N
What are your child's interests & favourite activities? _____
Is your child physically active regularly? Y N How much and how often? _____
Does your child have any habits (eg. Thumb sucking)? _____
Does your child have any fears? _____
How much television does your child watch? _____ hours/day
Does your child play on the computer or video games? Y N hours/day: _____ or hrs/week: _____
How often does your child read (not for school) or how often does someone else read to your child?
☐ Daily ☐ Several Times a Week ☐ Weekly ☐ Less than Weekly

Environment

Does your child have any environmental allergies or sensitivities? Please list.

_____

_____

Are there any pets in the home? Y N What type and how many? _____
Does anyone in the child's household smoke? Y N
Has your child ever had any significant physical or emotional traumas? _____

_____

Please write a little about our child's personality, both positive and negative. Is there anything that you would want to change? _____

_____

_____

Thank you for taking the time to fill out this form This is a confidential record of your child's medical history and will not be released without your authorization.

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INFORMED CONSENT TO NATUROPATHIC TREATMENT

Welcome to the naturopathic clinic of Live Well Family Health Centre. Naturopathic Doctors use 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.

You will find that Naturopathic Medicine has some similarities and many differences in comparison to regular medical treatments. Most of our treatments are less invasive and have few side-effects, yet many of our natural treatment methods are very powerful and some side-effects and complications may occur. The extensive training that a licensed and regulated Naturopathic Doctor (ND) receives helps ensure patient safety. The licensed and regulated practitioners of this clinic will inform you of any risks that are involved with certain therapies as they arise, but on rare occasions there may be unforeseen risks.

It is important that the information you include on the intake form is complete. This will help us prevent unwanted drug and/or supplement interactions and prevent us from prescribing products that may exacerbate any existing conditions. It is also important to notify us if you are pregnant, suspect that you may be pregnant, or are breastfeeding.

As a patient, you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, expected benefits, risks, side-effects, and in each case the consequences of not having the diagnosis and/or treatment acted upon. Some of the risks may include, but are not limited to: aggravation of pre-existing conditions and symptoms; allergic reactions to supplements and herbs (please advise us of any allergies); pain, fainting, bruising, or injury from venipuncture or acupuncture; muscle strains and sprains, and/or disc injuries from spinal manipulations; potential for stroke or emboli is a concern in cervical manipulation.

Cancellation Policy

Please ensure that you give us **at least 24hrs notice** in the event that you should need to cancel or reschedule and appointment. **For appointments cancelled within 24hrs, or for missed appointments, 50% of the cost of the missed appointment will be charged**. You are responsible for ensuring that you are keeping track of your appointments. Special consideration may be given in unforeseeable circumstances.

I understand the risks of Naturopathic treatment as stated above and know that I may ask the Naturopathic Doctor to explain any risks to specific treatments as they come up. I also understand that I may refuse any treatment that is offered to me at any time. I will rely on the Naturopathic Doctor to exercise his/her best judgment in my best interests based on his/her present knowledge of my condition and the proposed treatment method.

I confirm that I have read this agreement and consent to any treatments (other than the exemptions listed below) from my Naturopathic Doctor, and I understand that I can withdraw my consent to any treatment at any time. I also understand that I will be responsible for any fees incurred during care and treatment at this clinic.

Exemptions to treatment:_____

Patient's name:_____ Patient's Signature (Guardian if under 18): _____

Naturopathic Doctor: _____ Witness Signature: _____

Date: _____

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PATIENT CONSENT FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our Centre while providing you with quality naturopathic 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.

Our privacy policy outlines what our 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 or our regulatory body, the Board of Directors of Drugless Therapy — Naturopathy.

How our Centre collects, uses and discloses patients' personal information:

Our Centre understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our Centre is using and disclosing your information. This Centre 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 healthcare 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, the Board of Directors of Drugless Therapy — Naturopathy acting under the authority of the *Drugless Practitioners Act*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this Centre to comply with all regulatory requirements
- To comply generally with the law

At LiveWell Family Health Centre, we use e-mail and other firms of electronic communication to conduct regular business with our clients. We never share this information with any individual or third party outside our Centre.

Please initial the following statement:

☐ I give permission to LiveWell Family Health Centre to send me statements, receipts, appointment reminders/calendars, upcoming events notices, newsletters and/or other health information via e-mail.

I understand that my patient file will be kept confidential according to the principles outlined above. I also understand that the information in my file will not be shared with anyone outside this Centre unless it is required by law or written consent to share the information with another person (i.e. another healthcare practitioner) has been given by me.

Patient's name:_____ Patient's Signature (Guardian if under 18): _____
Naturopathic Doctor: _____ Witness Signature: _____
Date: _____