HEAD TO TOE HEALTH CENTRE

Children's Intake Form - Naturopathy

This confidential information of your child's medical record and health history will be kept in the Head to Toe Health Centre and will not be released to any individual except when you have authorized this release in writing or when required by law. Please complete this form as thoroughly as possible to optimize your child's health care outcomes.

Contact Information:

Child's Name: _____ Age: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Parent/Guardian Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ Email: _____

Parent/Guardian Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ Email: _____

Emergency contact: _____ Relationship: _____ Phone: _____

Other Health Care Provider #1: _____

Other Health Care Provider #2: _____

How did you become aware of the Head to Toe Health Centre: _____

Note to Parent or Guardian:

Periodically Head to Toe sends out an e-newsletter updating patients on clinic news and events providing helpful holistic health care information. Your email address will not be shared.

Would you like to receive our e-newsletter to the email address provided?

☐ Yes ☐ No

Health Goals/Concerns:

What main health goal/concern brought you to the clinic today? _____

_____

When did it start? _____ Is it episodic? ☐ Y ☐ N Duration: _____ Frequency: _____

Is your child's health currently getting better, worse or remaining the same? _____

What seems to make it better? _____ What seems to make it worse? _____

Have you consulted a naturopathic doctor before regarding your child? ☐ Y ☐ N If so, who? _____

What types of therapy have you tried for this problem? (*Please record details of pharmaceuticals on Medical History form*)

☐ Diet modification ☐ Vitamin/mineral supplements ☐ Herbs ☐ Homeopathy ☐ Chiropractor

☐ Acupuncture ☐ Conventional drugs ☐ Osteopathy ☐ Other _____

Main Concern (cont.)

Have you consulted a medical doctor before regarding your child? ☐ Y ☐ N If so, please explain his/her diagnosis, therapy and results where applicable: _____

_____

Please list any other health concerns or goals in order of importance: _____

_____

Please check any of the following conditions your child has experienced in the past:

☐ Allergies	☐ Ear Infections	☐ Joint Problems	☐ Rubella
☐ Asthma	☐ Eczema	☐ Many Cavities	☐ Seizures
☐ ADD/ADHD	☐ Frequent Bloody Nose	☐ Measles	☐ Strep Throat
☐ Chicken Pox	☐ Frequent Colds	☐ Motion Sickness	☐ Swollen Glands
☐ Chronic Nasal Congestion	☐ Frequent Diarrhea	☐ Mouth Sores	☐ Tonsillitis
☐ Colic/Abdominal Pain	☐ Frequent Fevers	☐ Mumps	☐ Tummy Aches
☐ Constipation	☐ Gas	☐ Nausea/Vomiting	☐ Warts
☐ Cradle Cap	☐ Growing Pains	☐ Pneumonia	☐ Weight Loss/Failure to Grow
☐ Croup	☐ Headaches	☐ Psoriasis	☐ Whooping Cough
☐ Diaper Rash	☐ Insomnia	☐ Rashes	☐ Worms/Parasites
☐ Other:_____			

Please list any allergies/sensitivities and the symptoms they cause:

Drugs:

_____

Foods: _____

Environmental: _____

Do any of the following pertain to your household: ☐ Smoking ☐ Old Home ☐ Renovations ☐ Pets

Medical History:

For the following tables, please use the back of this page if more room is required:

Please indicate any hospitalizations, surgeries and injuries. Please include any past traumas or accidents:

Year	Hospitalization, Surgery, Injury	Outcome

Medical History (cont.)

List X-rays, CT Scans, EKGs, ECGs, MRIs done in the past, their date and why:

Date	Test	Reason	Result

List ALL medications or supplements your child takes or has taken on a regular basis:

Medication/Supplement	Dose (if known)	Length of Use	Prescribing Practitioner	Taking Presently?

Height of child: _____ Weight of child: _____ Date of last full physical exam: _____

What is your child's blood type? ☐ A ☐ B ☐ O ☐ AB ☐ Unsure

Nutritional History:

Was your infant breastfed? ☐ Y ☐ N If so, for how long? _____

Was your infant formula fed? ☐ Y ☐ N If so, which formula? _____

At what age was solid food introduced? _____ Any reactions? _____

Which foods were introduced first? _____

At what age was cow's milk introduced? _____ Any reactions? _____

Are there any foods that are excluded from the child's diet? If so, please explain: _____

_____

How does your child eat? (good, picky eater, often, eats little, eats a lot, etc.) _____

How much does your child drink? _____ What do they drink? _____

Vaccination History:

☐ DPT (Diptheria, Polio, Tetanus)	☐ Haemophilus B (HIB)	☐ MMR (Measles, Mumps, Rubella)	☐ Pneumococcal-7 (Pneu-C-7)
☐ Pentavac (DPT, Polio, Hib)	☐ Hepatitis A	☐ Varicella Vaccine (Var/Chickenpox)	☐ Meningococcal C (Men-C)
☐ Influenza Vaccine (Inf)	☐ Hepatitis B (HB)	☐ IPV (Inactivated Polio Virus)	☐ Gardasil (HPV)

Vaccination History (cont.):

Has your child had any adverse reactions to any of the vaccinations listed above? If so, please explain: _____

_____

General Health:

How many hours of sleep does your child get per night? _____ Is it restful? _____

Any trouble with the following?

☐ Awakens easily	☐ Bedwetting	☐ Trouble falling asleep
☐ Awakens often	☐ Nightmares	☐ Trouble getting out of bed

Briefly describe your child's personality/disposition: _____

Have there been any emotional traumas that have impacted your child? _____

Has your child been diagnosed with a learning disability? If so, please explain: _____

Prenatal History: (Note: if your child was adopted, please answer to the best of your ability.)

How long was the labour? _____ Where was the child delivered? _____

Please check any difficulties experienced during pregnancy:

☐ Bleeding	☐ Emotional Trauma (mother)	☐ Nausea & Vomiting	☐ Thyroid Condition
☐ Breech Presentation	☐ Gestational Diabetes	☐ Physical Trauma (mother)	☐ Toxemia
☐ Chromosomal Abnormality	☐ High Blood Pressure	☐ Threatened Miscarriage	☐ Umbilical Cord Prolapse
☐ Other: _____			

Were there any interventions during labour?

☐ C-section	☐ Episiotomy	☐ Induction	☐ Vacuum
☐ Epidural	☐ Forceps	☐ Medications	☐ Other: _____

Newborn Health:

How did your child appear at birth? _____ Weight: _____ Length: _____

Were there any health problems after birth? _____

When did your child achieve developmental milestones: ☐ Early ☐ Average ☐ Late

Family History:

Please list any illnesses of your child's relatives:

Family Member	Age	List of Illnesses
Mother		

HEAD TO TOE HEALTH CENTRE

Children's Patient Agreement Form
Naturopathic Medicine

Your signature below acknowledges the following:

1. *I understand that Naturopathic medicine is not covered by the provincial gouvernment (OHIP), though may be covered by private and extended insurance plans. Naturopathic medicine may also be tax deductible.*
2. *The fees and services have been clarified in advance. Payment is due at the end of each visit as the Head to Toe Health Centre does not bill insurance companies directly. Cash, Cheque, Interac, Visa, and Mastercard are acceptable methods of payment.*
3. *Twenty-four hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment fee.*
4. *Items purchased are non-refundable, whether or not they have been opened.*
5. *I understand that naturopathic care is a joint responsibility between the patient and practitioner. Improving lifestyle can be as important as the remedies and treatments.*
6. *I recognize that Naturopathic medicine is not an isolated system and that Naturopathic Doctors welcome teamwork with MDs, DCs, RMTs, and other health practitioners.*

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, spiritual and environmental factors, all of which play a role in an individuals' health. Gentle, non-invasive modalities of treatment are employed to stimulate the body's inherent healing capacity. These modalities include, but are not limited to; diet and nutritional supplements, botanical medicine, homeopathy, Traditional Chinese Medicine and acupuncture, hydrotherapy, massage, physical medicine, as well as psychotherapeutic and lifestyle counselling.

As the guardian of a patient of the Head to Toe Health Centre, I hereby acknowledge that I am willing to provide an ND with the information necessary for them to fully understand my dependant's medical history, presenting symptoms, and health goals we wish to achieve in our work together. I thereby consent to a thorough case history and relevant physical examination.

I understand that the Head to Toe Health Centre will keep a record of my dependant's personal health information and of the services provided to him/her. This record will be kept confidential and will not be released to others unless so directed by myself or unless required by law. I understand that the Head to Toe Health Centre will act as the Health Information Custodian for my dependant's personal and health information. If my dependant is seeing more than one practitioner at the Head to Toe Health Centre, I imply consent for them to share and discuss my dependant's file as deemed necessary by the practitioners, to ensure that my dependant receives care most appropriate for his/her condition.

I understand that naturopathic medicine can be employed in conjunction with other forms of therapy and need not be considered exclusively beneficial. I acknowledge that one method of treatment need not be chosen over others and that various methods often work best in conjunction with one another.

I recognize that even the gentlest forms of treatment potentially have their risks and complications. The risks associated with Naturopathic medicine include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, interactions with prescription medications, or pain, bruising, fainting or injury from acupuncture.

As with all forms of therapy, I understand that naturopathic treatment also has its limitations and thus I understand that the results are not guaranteed. Nor do I expect the naturopathic doctor at the Head to Toe Health Centre to be able to anticipate and explain all risks and complications prior to treatment.

With this knowledge, as the guardian of a patient of the Head to Toe Health Centre, I voluntarily consent to Naturopathic care and I intend for this consent form to cover my dependant's entire course of treatment. I understand that I am free to withdraw consent at any time.

Patient name (Please print): _____

Signature of Patient or Guardian: _____ Date: _____