CHILD INTAKE FORM

Name: _____ Date: _____

Date of birth (M/D/Y): _____ Age: _____ Gender: _____

Contacts (in order of preference) – please * beside the name whom the child lives with

Name: _____ Relationship: _____

Address: _____ City, Prov: _____

Postal code: _____ Email: _____ Occupation: _____

Phone (Home): _____ (Work): _____ __ (Other): _____

Name: _____ Relationship: _____

Address: _____ City, Prov: _____

Postal code: _____ Email: _____ Occupation: _____

Phone (Home): _____ (Work): _____ __ (Other): _____

May we leave messages regarding your visit? Y/N Which number? _____

Family Medical Doctor: _____ Phone: _____

Address (if possible): _____

Other Practitioners:

1. _____ Specialty: _____ Phone: _____

2. _____ Specialty: _____ Phone: _____

HEALTH HISTORY

Please list all concerns (physical, mental, emotional) in order of importance:

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

What screening tests has your child had from another doctor? (blood, hearing, vision, etc)

_____

Does your child have any allergies (medicines, environmental, etc.)?

_____

MEDICATIONS: Please list all current medications (prescription, over-the-counter), the dosages, how long the child has been taking them, and the reason:

Medication	Dosage (daily)	Duration	Reason

SUPPLEMENTS: Please list all current supplements (vitamins, herbs, homeopathics), the dosages, how long the child has been taking them, and the reason:

Supplement (including brand)	Dosage (daily)	Duration	Reason

Any adverse reactions to any medications or supplements? Y / N

If yes, please explain reaction:

_____

How many times has your child been treated with antibiotics? _____

Please list any serious conditions, illnesses/injuries, and any hospitalizations; and approx. dates:

Health Event/ Condition	Date(s)

Please indicate if your child has had any of the following illnesses (check box and indicate age if possible):

○ Asthma
○ Chicken pox
○ Ear infections
○ Eczema
○ Frequent colds and flus
○ Impetigo
○ Measles
○ Mumps
○ Mononucleosis
○ Polio
○ Rheumatic fever
○ Rubella (German measles)
○ Roseola
○ Scarlet fever
○ Strep throat
○ Whopping cough
○ Other: _____

Please indicate if you've had any of the following immunizations (check):

○ DPT (Diptheria, Pertusis, Tetanus)
○ Tetanus booster
○ Hemophilus influenza B (HiB)
○ Polio
○ Hepatitis A
○ Hepatitis B
○ "Flu" shot
○ HPV
○ MMR (measles, mumps, Rubella)
○ Chicken pox
○ Small pox
○ Other: _____

Have you ever had any adverse reactions to vaccinations? Y / N

If yes, which one and what was the reaction? _____

FAMILY HEALTH HISTORY

Please indicate if a close relative (mother, father, siblings, grandparents, etc) has, or has had any of the following:

Condition	Relation	Condition	Relation
Alcoholism/ Drug abuse		Epilepsy, seizures	
Allergies		High blood pressure	
Anemia		Juvenile arthritis	
Arthritis/ Rheumatism		Learning disability	
Asthma		Kidney disease	
Cancer (what type?)		Stroke	
Depression/ other mental illnesses		Thyroid disease	
Diabetes		Other	
Eczema			

⑥ I do not know the family history

DIET

Did your child ever experience colic? Y / N How severe? Mild/ moderate/ severe

Does your child have any food allergies or intolerances? Please list.

_____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

HEALTH AND DEVELOPMENT

Current height: _____ Current weight: _____

Energy level of your child (rate it from 1-10, 10 being the best): _____

Describe your child's sleep pattern:

_____

How would you describe your child's temperament?

_____

How would you describe your child's behaviour and performance at school?

_____

ENVIRONMENT

Is your child in: ○ school ○ daycare ○ home care ○ other _____

What are your child's favorite activities?

_____

Does your child exercise regularly? Y/ N What kind of exercise? How often? _____

Does anyone in the child's household smoke? Y / N Are there animal(s) in the home? Y / N

How is the child's home heated? _____ Number of years in current home? _____

Is your child regularly exposed to solvents, heavy metals, fumes, pesticides/herbicides or other toxins (work, home, hobbies, etc.)? Please describe:

_____

Is your child sensitive to perfumes, gasoline or other vapours (i.e. new furniture, paints, carpets etc)?

_____

How would you describe the emotional climate of your home?

_____

Please list your health goals in working together with me as your child's Naturopathic doctor:

_____

Is there anything that you feel is important that has not been covered?

_____

Thank you for taking the time to complete this extensive intake form.
This information will be kept confidential and will not be released to any person unless you have authorized us to do so.

For file use only.

INFORMED CONSENT TO NATUROPATHIC TREATMENT

Naturopathic medicine is the treatment and prevention of disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration the physical, mental, emotional, and spiritual aspects of the individual. Gentle and non-invasive techniques are used to stimulate the body's inherent capacity to heal.

During the first and subsequent naturopathic visits, the naturopathic doctor will take a thorough case history, do a screening or complaint oriented physical exam, and may analyze urine, blood samples and other laboratory tests where indicated.

Treatment modalities used by naturopathic doctors include Traditional Chinese Medicine (TCM) and acupuncture, nutrition, botanical (herbal) medicine, diet and lifestyle counseling and physical medicine.

Caution must be taken with some therapies in conditions such as pregnancy and lactation, people with diabetes, heart, liver or kidney conditions, people taking multiple medications, as well as working with very young children. Thus, it is very important that you inform your naturopathic doctor immediately of any disease you are suffering from, and if you are currently taking any prescribed or over-the-counter medications. Please also inform the naturopathic doctor right away if you are pregnant, planning to become pregnant, suspect that you may be pregnant, or if you are currently breastfeeding.

Some of the slight health risks associated with naturopathic medicine include, but are not limited to; aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, fainting, pain, and bruising or injury from acupuncture. As a patient, you must be aware that conventional medical treatment and naturopathic treatment are not mutually exclusive, and therefore, you are encouraged and free to seek or continue medical care from a medical physician.

Patient consent

I understand that my naturopathic doctor will answer my questions to the best of her ability and provide treatment that is in my best interest, based on clinical evidence. I understand that results are not guaranteed and that I have the ability to accept or reject this care of my own free will. I declare that I am not an agent of any private, local, provincial or federal agency or country attempting to gather information without so stating. I accept full responsibility for all fees incurred during care and treatment.

I ACKNOWLEDGE and DECLARE that I have read, understood and all of the above and that I have had the opportunity to clarify my concerns. I thereby authorize naturopathic examination and treatment by _____ (Naturopathic doctor's name).

_____	_____
Patient's name (print)	Name of Witness
_____	_____
Patient's/Guardian's signature	Signature of Witness or ND

Date Signed: D_____ M_____ Y_____

Bayview Village Wellness Centre | Professional Offices Suite 201 | 2901 Bayview Avenue, Toronto, ON M2K 1E6
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PATIENT PRIVACY CONSENT FORM

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an important part of our office 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. It is important to us to provide this service to our patients. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Our privacy policy outlines what our office 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

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- We may disclose your health information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations
- To identify and to ensure continuous high quality service
- To establish and maintain contact with you
- To communicate with other outside treating health-care providers, including specialists and referring doctors
- To send you newsletters and other information mailings
- 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, collect accounts and process payments
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

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 office 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 (print)	Name of Witness
Patient's/Guardian's signature	Signature of Witness or ND

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OFFICE POLICIES

Cancellation Policy – Scheduled appointments are reserved especially for you. If you need to reschedule or cancel an appointment we require a minimum of 6 hour notice prior to the appointment. **Patients with less than 6 hour notice will be charged half of their original appointment fee. For missed appointments without notification prior to the scheduled time, the full appointment fee will apply.**

Payment Policy – Payment is made at the time of your appointment. We offer the convenience of Visa, Mastercard, Interac, and Cash. Most insurance plans cover naturopathic medicine. You can submit the receipt to your health care insurance plan for reimbursement. You can also keep the receipt for your personal income tax purposes.

Email & Phone Policy – We understand that questions may arise after your office visit. We are more than happy to have a brief phone conversation or brief email reply to answer your questions. If this phone conversation goes beyond 10 minutes or the email or phone conversation substitutes for an office visit (such as changes made to your treatment plan), you will be billed the same as our normal office visit rates.

On Time Policy – Office visits will not be extended due to late arrival. We are happy to mail, fax or email forms to you in advance if you are unable to download them from our website. Please fill out forms online or print and fill out BEFORE your first office visit.

Fragrance Free Policy – To respect those who are sensitive to scented products, please refrain from wearing perfume, cologne or heavily scented body products when you are coming to the office.

Dispensary Policy – Payment in full is expected at time of purchase. Please note that supplements are dispensed only to patients who are directly under the care of their naturopathic doctor. Returns are accepted on **unopened items within 7 days of purchase with the original** receipt. **Refrigerated items are a final sale.** Our clinic carries a limited selection of professional quality products that may not be available in health food stores. Every effort has been made to ensure these products are of the highest quality and of reasonable cost. Please call ahead for refill of supplements to assure they are in stock. By purchasing supplements from us, your naturopathic doctor can ensure that you are taking the correct type of product and dosage for you. You are, of course, welcome to purchase your supplements elsewhere.

Emergency Care Policy – We do not provide emergency medical care or after-hours treatment at Bayview Village Wellness Centre. If you are concerned that you may be experiencing a medical emergency, please call 911. If you are not experiencing a medical emergency, you may leave a voice message on our office phone at 416-221-7724 and we will return your call the next business day.

I, _____, have fully read, understood and agree to the contents herein.
(Print Name)

Patient/Guardian Signature: _____ Witness Signature: _____

Date Signed: D_____ M_____ Y_____