YOUR HEALTH

Wellness Centre

200-1158 Winston Churchill Blvd
Oakville, ON L6J 0A3

Naturopathic Intake - Child

Patient Information (please print clearly)

Child's name _____

Date of Birth: mm/dd/yyyy ____/____/_____ Age: _____ Gender _____

Name of parents/guardians:_____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B)_____ (M)_____

Email: _____ (to receive appointment reminders)

□ Add me to the email newsletter (Our newsletter covers events at the clinic and highlights informative articles written by our therapists. You can unsubscribe from the newsletter at any time.)

How did you find out about us? _____

Emergency Contact: (Name) _____ (Relationship) _____ (Phone number) _____

May we leave messages relating to your visits? □Y □ N Which phone number? _____

Fee Schedule

Initial Assessment: $160.00 2nd visit - **45 minute follow-up:** $95.00 **30 minute follow-up:** $80.00

<u>Please Note:</u> Nutraceuticals Prescribed by the ND are not included in the fee schedule and are the patient's responsibility to purchase. There is an on onsite dispensary where most Nutraceuticals prescribed will be available. However you are in no way obligated to purchase them at the clinic and can go to your local health store to get them.

Payment is due at the time services are rendered. For your convenience, we accept cash, cheque, debit, Visa and Mastercard. This policy applies to all of our patients. We understand that unusual circumstances may arise and that payment in full at the time of service may not always be possible. Special payment needs should be discussed by the patient and a member of the business department. Payment plans are subject to approval by the administrator and your therapist. In such cases, you will receive a monthly statement showing all charges and payments. If you have not made payment in full, or made full financial arrangements with our office, your account will be reviewed for collection. If payment is not made on a bill from our office within forty-five (45) days after the date of the bill, interest may be charged to you on the balance of such bill commencing on the forty-fifth (45) day after the date of the bill. The interest rate will be eighteen percent (18%) per annum. Patients having health care coverage should remember that professional services provided are the patient's responsibility, not the insurance company. Our office does not file insurance claims for you; however, we would be happy to help you find the necessary documents and invoices upon complete payment of services for you to submit for reimbursement.

We require 24 hours notice if you are unable to make your scheduled appointment. After an initial warning, appointments cancelled with less than 24 hours notice will be charged in full, unless the appointment is rescheduled within 48 hours.

If you have any further questions regarding insurance, be certain to bring in your insurance book so we can determine your coverage and avoid confusion. We want your experience with YOUR HEALTH to be a pleasant one and we hope this information will help to make it so.

I have read the YOUR HEALTH Wellness Centre financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy. **I AGREE** to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as other applicable fees.

Parent/guardian Signature: _____ Date: _____

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Privacy Policy

Privacy of personal information is important to YOUR HEALTH. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be an open and transparent as to how we handle personal information.

Personal Information
Personal information is information about an identifiable individual. Generally, the information we collect is limited to your name, home contact information, gender, and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnoses; health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. Only necessary information is collected about you. We only share your information with your consent; the use, retention and privacy protection protocols. Privacy protocols comply with the privacy legislation, standards of our regulatory body, The Board of Directors of Drugless Practitioners – Naturopathy (BDDT-N).

Staff Members
Staff members who come into contact with your personal information are aware of the sensitive nature of the information you have disclosed to us. They are all trained in the appropriate uses and protection of your information. These individuals include the clinic records personnel that control access to your patient file, therapists, clinic administration, and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information
Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we outline below how our clinics use and disclose this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other health care providers
- For teaching and demonstrating on an anonymous basis
- To complete and submit claims on your behalf to third party payers
- To comply with legal and regulatory requirements under The Board of Directors of Drugless Practitioners – Naturopathy (BDDT-N) Act
- To process payments and collect unpaid accounts
- For research purposes

Please do not hesitate to discuss our privacy policy with any member of our clinic staff.

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent
I have reviewed the above information that explains how our clinic will use my personal information.

I agree that Your Health Wellness Centre can collect, use, and disclose my personal information as set out above in The Board of Directors of Drugless Practitioners – Naturopathy (BDDT-N) privacy code.

_____
(Signature of parent/guardian)

_____
(Print name of parent/guardian)

_____
(Date)

_____
(Signature of Witness)

YOUR HEALTH
WELLNESS CENTRE

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Is your child currently receiving healthcare? If yes, where and from whom?

Medical Doctor? _____ Phone: _____

Previous Naturopathic care? _____ Phone: _____

Other Practitioner? _____ Phone: _____

Other Practitioner? _____ Phone: _____

Current Health Concerns

What are your 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? ☐Excellent ☐Good ☐Fair ☐Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations, along with approximate dates:

_____

_____

_____

Please check off any condition(s) your child currently or has previously experienced.

- ☐ rubella (german measles)
- ☐ measles
- ☐ chicken pox
- ☐ mumps
- ☐ roseola
- ☐ scarlet fever
- ☐ whooping cough
- ☐ strep throat
- ☐ impetigo
- ☐ mononucleosis
- ☐ ear infections

Please indicate what immunizations your child has had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster; when? _____
- ☐ MMR (measles, mumps, rubella)
- ☐ Haemophilus influenza B
- ☐ "Flu"
- ☐ Polio
- ☐ Hepatitis B
- ☐ Hepatitis A
- ☐ Smallpox

Did your child experience any adverse effects following any of these immunizations?

_____

_____

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Please list any allergies or sensitivities (food, environment, medication) your child currently or has previously experienced:

_____
_____
_____

Please list all medications (prescription, over the counter) and natural products (vitamins, minerals, herbs, homeopathics) your child is currently taking:

Medication/Natural Product (please indicate brand)	Dose/quantity per day	Why are you taking this product?

List past medications and why they were prescribed:

_____
_____

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

<u>Prenatal health</u>

What was the health of the parents at conception? Please specify any relevant health conditions

Mother: _____

Father: _____

What was the health of the mother during the pregnancy?

☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

What was the mother's age at child's birth? _____

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

Did the mother receive prenatal medical care? ☐Y ☐N ☐Unknown

YOUR HEALTH
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Did the mother experience any of the following during the pregnancy:

□ Bleeding □ High blood pressure □ Nausea □ Vomiting

□ Diabetes □ Thyroid problems □ Physical or emotional trauma

□ Other, please specificy: _____

Did the mother use any of the following during the pregnancy?

□Tobacco □Alcohol □Recreational drugs: _____

□ Prescription medications: _____

□ Over-the-counter medications: _____

□ Supplements: _____

□ Other: _____

Birth History

Term length: □Full □Premature: _____ wks □ Late: _____ wks

Length of labour: _____ **Weight at birth** _____

Any complications? _____

Was the birth: □Vaginal □C-section □Induced □Forceps □Anesthesia used

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

□ Jaundice □ Rashes □ Seizures

□ Birth injuries _____

□ Birth defects _____

□ Other _____

Diet

How was your infant fed?

□ Breast fed. How long? _____ □ Formula. Milk/Soy/Other: _____

□ Other: _____

What foods were introduced before 6 months? (Please list approximate month as well.)

_____

_____

6–12 months?

_____

_____

_____

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Did your child ever experience colic? □Y □N How severe? □mild □moderate □severe
Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?
_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Health and Development

How was your child's health in the first year? □Poor □Fair □Good □Excellent □Unknown

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?
_____
_____

Family History

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

	Please specify the relative		**Please specify the relative**
Allergies		Depression (mental illness)	
Asthma		Heart disease	
Birth defects		Eczema or other skin condition	
Juvenille arthritis		Syphilis	
Diabetes		Epilepsy	
Kidney disorder		Hyperactivity	
Alcoholism		Learning disability	
Cancer		Tuberculosis	
Gout		Other	

Do either of the parents have a chronic illness? □Y □N **Please describe:**
_____

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Environment

Is the child in: □school □daycare □home care □other _____

How much television does your child watch? _____ hrs a day/week

Does anyone in the child's household smoke? □Y □N

Are there animals in the home? □Y □ N
Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.

_____
_____

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

_____
_____
_____

Review of Systems:

Please list any conditions that your child currently or has previously experienced in each of the following body systems:

SKIN (eg. eczema, psoriasis, hives, rashes, cradle cap):

_____

HEAD (eg. headaches):

_____

EYES (eg. itching, pain, infection, corrective lenses):

_____

EARS (eg. wax, discharge, hearing impairment, infection):

_____

NOSE (eg. sinus problems, pain, nose bleeds):

_____

MOUTH (eg. difficult dentition, cavities, loss of taste, problems swallowing):

_____

NECK (eg. stiffness, tenderness, hoarseness, tonsillitis, swelling):

_____

HEART (eg. rheumatic fever, murmurs, chest pain):

_____

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NEUROLOGICAL (eg. seizures, paralysis, clumsiness, memory, vision changes, speech problems, sensation alteration):

_____

LUNGS (eg. cough, asthma, wheezing):

_____

GASTROINTESTINAL (eg. vomiting, swallowing, diarrhea, constipation):

_____

URINARY (eg. pain, increased frequency, blood):

_____

MALE (eg. hernias, pain or masses in scrotum/testes):

_____

FEMALE (eg. urgency, menstruation/menarche, discharge, pain or masses in ovaries/uterus):

_____

MUSCLE AND SKELETON (eg. joint pain, stiffness, weakness, back pain, fractures):

_____

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

_____

_____

Thank you for answering all the questions.
Complete answers to all of the questions are to your benefit for the most effective naturopathic treatment.

This is a confidential record of your medical history. Information contained here will not be released to any person except when you have authorized us to do so.

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Informed Consent to Naturopathic Treatment

Naturopathic medicine is the treatment and prevention of diseases and disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used to stimulate the body's inherent healing capacity. Your child's Naturopathic Doctor at YOUR HEALTH Wellness Centre will take a thorough case history, perform a physical exam and may request urine samples or require blood tests.

It is very important that you inform your child's Naturopathic Doctor immediately of any disease process that your child is suffering from and any medications/over the counter drugs that your child is currently taking.

As a parent, you will receive information about your child's diagnosis and will be provided with a treatment protocol, alternative courses of action, the material effects, costs, expected benefits, risks, and side effects and in each case the consequences of not following the treatment advised.

There is some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short, however beneficial for your health.
- Some patients may experience previously unknown allergies to herbs or supplements.
- Pain, bruising, or injury from venipuncture, acupuncture.
- Fainting or puncturing of an organ with acupuncture needles.

I understand:

- That YOUR HEALTH Wellness Centre does not guarantee treatment results.
- That my child's Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- That I am free to withdraw my consent and to discontinue my child's treatment at any time.

I have read the above and hereby give consent to Naturopathic treatment for my child.

Patient name: _____

Parent/guardian's name:_____

Signature of Parent/guardian:_____ Date: _____

Naturopathic Doctor: (print) _____ (Signature) _____