NATUROPATHIC CHILD INTAKE FORM

Confidential Information

Child Name: ______________________ Date: ______________________

Parent/Guardian: ______________________ Relationship: ______________________

Address: ______________________ City: ______________________

Prov: ______ Postal Code: ______________ Email: ______________________

Phone: ______________ Emerg. Contact Name & Number: ______________________

Referred By: ______________________ Extended Health Coverage: ______________________

I hereby authorize Naturopathic Treatment of this child: ______________________
Signature

Child Birthdate: ______________ Age: ____ Height: ________ Weight: ________ Sex: **M F**

Chief Complaint(s):

1. ______________________
2. ______________________
3. ______________________

Medications:

____
____
____
____

Development:
- ❑ Pregnancy Problems
- ❑ Delayed Development
- ❑ Slow Growth
- ❑ Problems at Birth
- ❑ Birth Defects
- ❑ Delayed Puberty

Respiratory:
- ❑ Inhaled Allergies
- ❑ Asthma
- ❑ Colds
- ❑ Bronchitis
- ❑ Pneumonia
- ❑ Sore Throats

Circulatory:
- ❑ Valve Defects
- ❑ Anemia
- ❑ Nosebleeds
- ❑ Heart Murmur
- ❑ Cold Hands/Feet
- ❑ Dizzy/Faints

Urinary:
- ❑ Kidney Problems
- ❑ Bladder Infections
- ❑ Wets Bed

Digestion:
- ❑ Formula Fed
- ❑ Colic
- ❑ Gas
- ❑ Diarrhea
- ❑ Worms/Parasites
- ❑ Lactose Problem
- ❑ Nausea
- ❑ Bad Breath
- ❑ Constipation
- ❑ Poor Appetite
- ❑ Food Allergies
- ❑ Vomit Often
- ❑ Cravings
- ❑ Appendix
- ❑ Diabetes

Skin:
- ❑ Diaper Rash
- ❑ Psoriasis
- ❑ Moles
- ❑ Poor Nails
- ❑ Allergic Dermatitis
- ❑ Cradle Cap
- ❑ Dandruff
- ❑ Warts
- ❑ Poor Hair
- ❑ Bruises Easily
- ❑ Eczema
- ❑ Dry Skin
- ❑ Acne

Nervous System:
- ❑ Learning Difficulties
- ❑ Headaches
- ❑ Poor Concentration
- ❑ Sleep Problems
- ❑ Poor Memory
- ❑ Seizures
- ❑ Hyperactive
- ❑ Emotional Problems

EENT:
- ❑ Glasses
- ❑ Deaf
- ❑ Speech Difficulties
- ❑ Congested
- ❑ Eye Problems
- ❑ Hearing Problems
- ❑ Tubes in Ears
- ❑ Lots of Ear Wax
- ❑ Throat Aches

Immunity:
- ❑ Ear Infections
- ❑ Allergy Shots
- ❑ MMR
- ❑ DPT
- ❑ Childhood Illnesses
- ❑ Frequent Infections
- ❑ Thrush/Candida
- ❑ Frequent Antibiotics

Musculoskeletal:
- ❑ Broken Bones
- ❑ Arthritis
- ❑ Muscle Pain
- ❑ Cramps

Family Medical History:
- ❑ Diabetes
- ❑ Heart
- ❑ Cancer
- ❑ Allergies
- ❑ Asthma

Diet:

How many servings, on average, does your child have of the following:

Fruit ____ times per day/week/month
Vegs ____ times per day/week/month
Cereals ____ times per day/week/month
Pasta ____ times per day/week/month
Rice ____ times per day/week/month
Fish ____ times per day/week/month
Water ____ times per day/week/month
Milk ____ times per day/week/month

Red Meat ____ times per day/week/month
Chicken ____ times per day/week/month
Eggs ____ times per day/week/month
Cheese ____ times per day/week/month
Yogurt ____ times per day/week/month
Soy Products ____ times per day/week/month
Legumes ____ times per day/week/month
Junk Food ____ times per day/week/month

Other: ______________
____
____
____

INFORMED CONSENT TO TREATMENT

Dr. Jane Goehner ND · Dr. Jennifer Kaster ND · Dr. Janna Fung ND

Please list any treatment exceptions:

Please initial on the line beside each of the following to acknowledge that you have been informed and understand that:

_____ *Initial* — The ND keeps a record of services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate copy fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

_____ *Initial* — I must pay for all test, in-office supplements and services when rendered. I understand that I am responsible for the total charges incurred for each visit to be paid at the time of the visit unless specific arrangements have been made **prior** to my scheduled appointment. I understand that if I have coverage for Naturopathic Medicine, I am responsible for billing by own insurance company. I understand that a fee will be charged for any missed appointments or late cancellations (less than 24 hours).

_____ *Initial* — Any treatment or advice provided to me as a patient of the Naturopathic Doctor (ND) is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider; I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. The ND has not recommended for me to refrain from seeking or following the advice of another licensed health care provider;

_____ *Initial* — There are some risks, however rare, to Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms,
- Reaction to supplements or herbs,
- Bruising from an acupuncture needle.

_____ *Initial* — I intend for this consent form to cover the entire course of treatment presented for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures and treatments at any time in written or verbal format.

Naturopathic Doctors use a variety of therapeutic approaches, either alone, or in combination.
These include **nutritional and lifestyle counselling, nutritional supplementation, Asian medicine and acupuncture, botanical medicine, homeopathy.**

_____ *Initial* — I understand that my ND will answer my questions that I have to the best ability, in a manner which I can comprehend. I understand that the results are not guaranteed. I do not expect my ND to be able to anticipate and explain all risks and complications. I will rely on my ND to exercise the best judgement in my best interests, based on the facts and findings then known.

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for:

Please list any treatment exceptions: ____

Patient Name (please print): ____

____ ____________________________
Signature of Patient/Guardian *Date*

____ ____________________________
Signature of Naturopathic Doctor *Date*

Would you like to receive our newsletter? **Yes / No**

Balance Point Health Centre Inc.

PERMISSION FOR TELE-HEALTH VISITS

What is telehealth?

- Telehealth is a way to visit with healthcare providers, such as your naturopathic doctor.
- You can talk to your provider from any place, including your home.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Please use the secure video link sent to you from your naturopathic doctor **via Doxyme** to use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic to see your provider.
- You won't risk getting sick from other people.

Are there any risks to telehealth?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may recommend an office visit at a later date if a physical examination is needed.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- We use telehealth technology (doxyme) that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can arrange an in-person office visit to follow-up on any conditions that may require physical examination or if you prefer in-person appointments in the future.

What does it mean if I sign this document?
If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You consent to a telehealth visit.

Patient Name (please print): ____

______________________________ ______________________

Signature of Patient/Guardian *Date*