Naturopathic Family Practice of Niagara

CHILD INTAKE FORM

GENERAL INFORMATION

Child's First name:_____ Last name:_____
Today's Date (D/M/Y): ___/___/_____
Child's Age: _____ Child's Date of Birth (D/M/Y):___/___/_____ Sex: M / F
Who is filling out this form (name and relation)?_____
Contact Email:_____
Contacts (in order of preference):
1. Name:_____. Relationship to child:_____
Address:_____
_____
Phone: (H) _____(W)_____(Cell)_____

2. Name:_____. Relationship to child:_____
Address:_____
_____
Phone: (H) _____(W)_____(Cell)_____

May we leave messages relating to your visits? Y / N
Which Phone Number? _____
With whom does the child live?_____

How did you hear about the **Naturopathic Family Practice of Niagara**?_____
If referred, by whom?_____

Other Healthcare providers that you are seeing:
Name: 1._____ 2._____ 3._____
Title: _____ _____ _____
Phone: _____ _____ _____

CURRENT HEALTH CONCERNS

In order of importance, please list your child's primary health concerns:

1.
2.
3.
4.
5.

How would you describe your child's current state of health? Excellent / Good / Fair / Poor
What expectations do you have for your child in working with the Naturopathic Family Practice?

MEDICAL HISTORY

Please indicate any past medical illnesses, diagnosis, hospitalizations, injuries and/or trauma, along with the approximate dates:

Please place a check mark if your child has had any of the following:

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

Does your child have any allergies? Examples: medicine, food, environmental or other.

Current Medications: (please include all prescriptions, over-the-counter medicines, vitamins/minerals, herbal preparations, homeopathic remedies, etc.)

Past Medications:

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

Please indicate what immunizations your child has had:

□ DPT (Diptheria, Pertussis, Tetanus) □ MMR (Measles, Mumps, Rubella)
□ Gardasil/Cervarix (HPV Vaccine) □ Haemophilus influenza B
□ BCG (Tuberculosis) □ Varivax/Varilrix (Chicken Pox)
□ Hepatitis □ Polio
□ Flu Vaccine □ Pneumococcal Conjugate (Meningitis/Pneumonia)
□ Meningococcal C Conjugate (Meningitis) □ Other: _____

Please indicate if any caused adverse reactions:_____

What screening tests has your child had (blood, hearing, vision, etc.)?

PRENATAL HEALTH

What was the health of the parents at conception?
Mother: Poor / Fair / Good / Excellent / Unknown
Father: Poor / Fair / Good / Excellent / Unknown

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

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_____

Did the mother use any of the following during the pregnancy?
□ Tobacco □ Alcohol □ Recreational drugs:_____
□ Prescription medications:_____
□ Over-the-counter medications:_____
□ Supplements (vitamins/minerals, herbal preparations, homeopathic remedies, etc.):
_____
□ 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.)

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6–12 months?

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.)?

Describe a typical day's diet:
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks (and how often):_____
Beverages (and how often):_____

HEALTH AND DEVELOPMENT

How was your child's health in the first year? Poor / Fair / Good / Excellent / Unknown
At what age did your child first:
Sit up _____ Crawl _____ Walk _____ Talk _____

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

	Which family member?		Which family member?
□ Allergies	_____	□ Asthma	_____
□ Heart Disease	_____	□ High Blood Pressure	_____
□ Cancer	_____	□ Diabetes	_____
□ Depression	_____	□ Other Mental Illness	_____
□ Drug Abuse/Alcoholism	_____	□ Kidney Disease	_____
□ Other	_____	□ I don't know my family medical history	

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

ENVIRONMENT

Is the child in: □ school □ daycare □ home care □other _____
What are your child's favourite activities?_____
Does the child exercise regularly? Y / N How often?_____
How much television does your child watch? _____per day, or _____per 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?

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

REVIEW OF SYSTEMS:

Current Weight:_____ Current Height:_____
Please circle the condition if you have it now or have had it in the past:

- **Skin** – rashes, eczema, psoriasis, acne, itching, lumps, colour change, dry, moist, easy bruising
- **Nails** – colour changes, fungal infections, brittle/shear, vertical/horizontal lines, hangnails
- **Head** – migraines, headaches, dizziness
- **Eyes** – pain, tearing, dryness, blurring, redness, discharge, itching, cataracts, glaucoma
- **Ears** – impaired hearing, earache, dizziness, discharge, infections, ringing
- **Nose & Sinus** – frequent colds, nose bleeds, stuffiness, hay fever, sinus problems
- **Mouth & Throat** – frequent sore throat, gum problems, hoarseness, dental cavities, loss of taste
- **Neck** – lumps, swollen glands, pain or stiffness, enlarged thyroid
- **Lungs** – cough, phlegm, spitting up blood, wheezing, shortness of breath, pain on breathing
- **Cardiovascular** – heart disease, murmurs, palpitations, chest pain
- **Peripheral Vascular** – deep leg pain, cold extremities, varicose veins,
- **Upper Gastrointestinal** – indigestion, nausea, vomiting, belching, passing gas, stomach pain
- **Lower Gastrointestinal** – constipation, diarrhea, blood in stool, mucous in stool
- **Urinary** – frequent, inability to hold urine, infections
- **Musculoskeletal** – joint pain/stiffness, muscle pain/stiffness, broken bones
- **Neurologic** – fainting, seizures, paralysis, numbness/tingling
- **Neurologic**– loss of balance, involuntary movement, speech problems, memory loss
- **Endocrine** – fatigue, heat/cold intolerance, thyroid problems, excess thirst/hunger/sweating
- **Sleep** – difficulty falling asleep, frequent waking, nightmares

PAYMENT AGREEMENT & CANCELLATION POLICY

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

Payment Agreement:

- Payment is always due at the time of service.
- Your naturopathic visits are not covered by OHIP.
- We do not bill insurance companies directly. However, we will gladly provide you with a receipt of all necessary information for you to submit to your insurance company to request reimbursement.
- We accept the following forms of payment: cash, cheque, debit card, visa and mastercard.
- NSF cheques will receive an additional $25.00 fee.
- Naturopathic visits are exempt from HST.
- Laboratory testing and supplements are not included in the fees below. Prices vary and are subjected to HST.

Fee schedule: prices effective January 1, 2020

Visit Type	Approximate Visit Length	Fee
ADULT:		
1st Visit	50 minutes	$180
2nd Visit	50 minutes	$155
CHILDREN/PEDIATRIC (0-13 years of age)		
1st Visit	50 minutes	$155
2nd Visit	50 minutes	$155
SUBSEQUENT		
Regular follow-up	25 minutes	$80
Long follow-up	50 minutes	$155
MEDICAL RECORDS		
First 1-5 pages		$30.00
After first 1-5 pages		$0.50 per page

Phone Consultations:

- We bill for phone consultations. They require the same time and expertise as office visits.
- Billing for phone consultations is, however, at the doctor's discretion. Your doctor may choose not to bill you if the nature of the phone consultation is uncomplicated, such as requiring clarification on your treatment plan and/or prescription. For phone consultations requiring extra time and evaluation, you will receive a bill for the time required.

Extended appointments when required:

- We believe in taking the time to cover all of your concerns without rushing you. The doctor will do her best to keep to the original appointment time, however, issues or concerns may occasionally arise that require additional time. We bill for the time spent with the doctor if the appointment extends beyond the time allotted.

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On-Time Policy:

- Your time is valuable to us, thus we take pride in seeing you on-time. Should you arrive late, you will be seen for the remaining time allocated to your scheduled appointment; however, you will be billed the full amount of time that we reserved for you.

Cancellation Policy:

- Patient visits require the doctor to block out large time slots, making last-minute cancellations and rescheduling of visits very problematic. We spend an inordinate amount of time and energy with each patient because we are committed to providing the highest quality of naturopathic health care.
- We kindly ask that you provide the office with a minimum of 2-business days notice. This allows other patients to benefit from an available appointment.
- **Cancellations with less than 2-business days notice, or no-show appointments are billed for the FULL APPOINTMENT FEE.**

As a courtesy, we can provide you with an email or phone call reminder.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above.

_____	_____	_____
Signature	Print Name	Date

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INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of diseases. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and perform a medical physical examination. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams. If your case requires laboratory blood tests, your Naturopathic Doctor may refer you to a Medical Doctor or an appropriate lab where additional fees may or may not apply.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. There are 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.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parenteral therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa.
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by the Naturopathic Doctor prior to manipulating the neck.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

I understand:

- That the **Naturopathic Family Practice of Niagara** does not guarantee treatment results.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have to the best of his/her ability.
- That I am responsibly to pay the fees for naturopathic services and any products from the dispensary at the time of the visitation.
- I have reviewed the Payment Agreement & Cancellation Policy. This has also outlined the fee schedule to me.
- That I am not obligated to purchase products from the **Naturopathic Family Practice of Niagara** dispensary and that I may choose to purchase items elsewhere.
- I am free to withdraw my consent and to discontinue treatment at any time.

Patient Name (please print)_____

Signature of Patient or Guardian: _____ Date:_____

Naturopathic Doctor: _____Dr. Jennifer Cox, ND # 1812

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

Privacy of your personal information is an important part of the **Naturopathic Family Practice of Niagara**, 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.

All staff members of the **Naturopathic Family Practice of Niagara** and **Niagara Orthopaedic Institute** 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 trained in the appropriate use and protection of your information. In order to protect your privacy of personal information, we 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 of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

The **Naturopathic Family Practice of Niagara** will collect, use and disclose information about you for the following purposes:

- To assess your health concerns, provide healthcare and advise you of treatment options.
- To establish and maintain contact with you.
- To remind you of upcoming appointments.
- To communicate with other treating health-care providers.
- To allow us to efficiently follow-up for treatment, care and billing.
- To complete claims for insurance purposes.
- To invoice for goods and services, process credit card payments and to collect unpaid accounts.
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse and reporting diseases and individuals who may be an imminent threat to harm themselves or others.

I have read and understand how the **Naturopathic Family Practice of Niagara** will use my personal information and the steps in which the staff at both the **Naturopathic Family Practice of Niagara** and **Niagara Orthopaedic Institute** is taking to protect my information. I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

_____	_____	_____
Signature	Print Name	Date

Release of Personal Information: This is for your Naturopathic Doctor to discuss your case with a mutual healthcare provider.

I hereby fully authorize the Naturopathic Doctor, Jennifer Cox, to exchange medical and/or other information necessary with the healthcare provider(s) listed below. I understand that this information will be used to provide me with the most individualized and optimal healthcare treatment and will be confidential (Name/Title):

1._____ 2._____ 3._____

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