



Lakeside Natural Health
CENTRE
Pediatric Intake

Patient Information:

First Name: _____ Last Name: _____ Age: _____ Date of Birth: _____
 Gender: _____ Weight: _____ Height: _____ Email Address: _____
 Address: _____ Postal Code: _____
 Home phone number: _____ Guardian's business phone number: _____
 Medical Doctor/other health care providers: _____ Referred by: _____
 Who is filling out this form (name & relation)? _____

I authorize _____, Doctor of Naturopathic Medicine who has been engaged by me as she may select or approve, to examine and administer Naturopathic care and treatment to _____ whose relationship to me is as a _____. I have been given an explanation of and understand the nature of naturopathic medical care and treatment. I authorize _____, Naturopathic Doctor, to take whatever measures she considers necessary or desirable in connection with such Naturopathic care and treatment.

Dated in the province of Ontario, this _____ day of _____ (month), _____ (year).

Parent or Guardian of Minor (print name)

Signature

Witness (print name)

Signature

Contact(s):

Name: _____ Relationship to child: _____
 Address: _____ Postal Code: _____
 Home phone number: _____ Business phone number: _____

Whom does the child live with? _____

What are the 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? (Please check)

Excellent Good Fair Poor

How would you describe your child's usual energy level? ____/10 (0 = no energy, 10 = an abundance of energy)

Please indicate any serious condition, illnesses or injuries, and any hospitalizations/surgeries: along with approximate dates.

Which of the following has your child had?

- | | | | |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Mumps | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Roseola | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Frequent ear infections |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Impetigo | <input type="checkbox"/> Herpes Simplex |

Has there been a significant gain or loss of weight? Yes No

Has there been a failure to gain weight appropriate for child's age? Yes No

If the answer is yes to either of the above questions, please explain:

Does your child have any allergies (medicines, environmental, etc.). If yes, please record reaction to allergen (rash, itching, runny nose, watery eyes, difficulty breathing, etc.)?

Does your child have any food allergies and/or intolerance? Please list food item and reaction to allergen.

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.). Please list dose, frequency, and brand name.

Please list past prescription medications.

How many times has your child been treated with antibiotics?

Please indicate the immunizations your child has had; please indicate date(s) of immunizations:

- | | |
|--|---|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus): _____ | <input type="checkbox"/> Flu: _____ |
| <input type="checkbox"/> Tetanus booster: _____ | <input type="checkbox"/> Polio: _____ |
| <input type="checkbox"/> MMR (measles, mumps, rubella): _____ | <input type="checkbox"/> Hepatitis B: _____ |
| <input type="checkbox"/> Haemophilus influenza B: _____ | <input type="checkbox"/> Hepatitis A: _____ |
| <input type="checkbox"/> Other? _____ | |

Please indicate if any caused adverse reactions (for example, fever, rash, ear ache, behavioural disturbances, etc.), immediately or up to a month following vaccinations:

What is the date of your child's last physical examination _____, dental visit _____, vision examination _____, hearing examination _____, and blood test _____?

What is your child's sleep pattern? # of hours per night? _____ hrs, # of hours during the day? _____ hrs.

Is your child a sound sleeper? Yes No Is your child a wakeful sleeper? Yes No

What is your child's routine at bedtime? _____

Family History:

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

	Who?		Who?
Alcoholism		Hodgkin's	
Allergies		Hypertension	
Arthritis		Juvenile arthritis	
Asthma		Kidney disease	
Autoimmune disease		Learning disability	
Blood disorder		Mental illness	
Birth Defects		Seizure disorder	
Cancer		Sickle cell anemia	
Cardiovascular disease		Stroke	
Diabetes (I or II)		Tuberculosis	
Endocrine disease		Other?	

Do either of the parents/guardians and/or siblings have a chronic illness?

Grandparents' History:

Relative	Alive/Deceased?	Age/Age at Death	Major Health Conditions
Maternal grandmother			
Maternal grandfather			
Paternal grandmother			
Paternal grandfather			

Environment:

Is your child in: home-care (with whom?) _____ daycare school other? _____

What are your child's favourite activities? _____

How is your child's academic/social performance at school (if applicable)?

Does your child exercise regularly? Yes No

If so, how often and what type of exercise? _____

How often does your child play outside? _____ hours/weekday _____ hours/weekend day

How much television does your child watch? _____ hours/weekday _____ hours/weekend day

Does anyone in the child's household smoke? Yes No

Are there any animals in the home? Yes No

How is the child's home heated? _____

How old is the child's home? _____ Has it been newly renovated? Yes No

Do you know of any toxins/hazards the child is regularly exposed to (home, school, hobbies, etc.)? For example, mould, asbestos, lead paint, pesticides (lawn), bug repellent, rodent toxins, etc. Please describe.

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

Please indicate the number of hours each parent is away from home during the day?

Father _____ hours Mother _____ hours

Home safety: Are there precautions for poisons, medications, household cleaning products? Yes No

Is there the presence of gates for stairways, if applicable? Yes No

Is there a family safety plan in case of an emergency that the child is aware of? Yes No

Please record any recent stressful experiences (death, divorce, move, loss of special friend, etc.): _____

If so, has there been a change in behaviour or mood? Please describe. _____

Parents' Pre-natal History

Has the mother ever miscarried? Yes No

If so, please indicate date of miscarriage and at what point of the pregnancy it occurred?

Has the mother experienced any birth complications with any other siblings (e.g. pre-term labour, still-births, C-section, forceps, Rh compatibility complications, etc.)? Please describe.

What was the parents' age at birth? Mother _____ Father _____

What was the health of the parents before conception?

Mother : Poor Fair Good Excellent Unknown

Please describe the general health of the mother before conception, include the following: diet, lifestyle (stress, exercise), substance use (alcohol, cigarettes, over-the-counter drugs, and illegal drugs).

Father : Poor Fair Good Excellent Unknown

Please describe the general health of the father before conception, include the following: diet, lifestyle (stress, exercise), substance use (alcohol, cigarettes, over-the-counter drugs and recreational drugs).

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

Did the mother experience any cravings during pregnancy? Please describe.

Were there any difficulties with conception? Yes No

If so, what were the methods used to conceive (if any)? _____

Did the mother receive prenatal medical care? Yes No Unknown

How many ultrasounds did the mother receive, and in what week or month? _____

Did the mother have any x-rays during the pregnancy? Yes No

If yes, how many and in what month? _____

What was the weight of the mother before pregnancy?

under-weight average over-weight obese

What was the weight gain during pregnancy? _____ lbs

Did the mother experience any of the following during pregnancy?

- | | | | |
|-------------------------------------|---|-----------------------------------|---|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> High blood pressures | <input type="checkbox"/> Nausea | <input type="checkbox"/> Physical or emotional trauma |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Swelling of hands and feet |
| <input type="checkbox"/> Infections | <input type="checkbox"/> Other _____ | | |

What interventions were used for any of the above conditions?

Did the mother travel during pregnancy? Yes No

If so, describe location and timing in pregnancy? _____

What was the emotional environment during pregnancy (work, home, support network, etc.). Please describe.

What was the attitude toward the pregnancy? (of mother, father, siblings, other family members?) Please describe:

Did the mother use any of the following during pregnancy?

- Tobacco Alcohol Recreational drugs Prescription medications
 Supplements Homeopathics Botanicals Over-the-counter medications

Please list dose and frequency _____

Child's Birth History

Term length: Full Premature: _____ (weeks) Late: _____ (weeks)

Length of labour: _____ Weight at birth: _____ lbs/kg Head Circumference: _____ inches/cm

Blood type: _____ Rh +ve -ve Apgar Score: _____

Was the birth (please check all that apply): Vaginal C-section Induced Forceps Anesthesia (epidural)

Any complications? Please describe. _____

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

- Jaundice Rashes Seizures Birth injuries Birth Defects Other _____

If so, please explain: _____

Diet

How was your infant fed?

- Breastfed. How long? _____ Please record nursing frequency and duration: _____

Please describe age and method of weaning. _____

- Formula. Milk/Soy/Other?: _____ Please list any reactions (rash, colic, diarrhea/constipation, etc.)

Please record feeding frequency and amount: _____

- Other. Please describe: _____

Were there any feeding problems (eg/ spitting up, colic, diarrhea, etc.)? Please describe.

What foods were introduced before 6 months? (Please list which foods, amount given, approximate month and any reactions, if applicable). _____

What foods were introduced between 6-12 months? (Please list which foods, amount given, approximate month and any reactions, if applicable).

Were foods home or commercially made? _____

Did your child ever experience colic? Yes No If so, how severe? Mild Moderate Severe

How was it treated? _____

Please record the food and beverage intake of the child in the last 24 hours (with quantities, if possible):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks throughout day: _____

Water intake (number of glasses and source of water): _____

Other beverages (please specify type and amount): _____

Is this a typical day for the child? Yes No

If no, please explain: _____

Developmental History

Milestones: Please list the age at which the child reached these milestones:

First held head erect		Said his/her first words with meaning	
Rolled over		Spoke in sentences	
Sat alone		Was toilet trained	
Walked alone		Tied his/her own shoes	
Cut his/her first tooth		Dressed without help	

Does the parent believe this development has been normal? Yes No

If no, please explain: _____

How does this child's development compare with siblings or peers? Please explain. _____



Lakeside Natural Health

CENTRE

INFORMED CONSENT

I would like to take this opportunity to welcome you to Lakeside Natural Health Clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. If you are working with a naturopathic doctor a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

As a patient of this clinic I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. As Lakeside Natural Health Centre is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I understand that my treatment will be based in naturopathic medicine, which has a proven clinical foundation, yet may not be accepted practice by standard allopathic medicine. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

I, _____ have read, understood and acknowledge the above statements.

Date: _____ Signature: _____

Witness (if present): _____



Lakeside Natural Health CENTRE

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

Privacy of your personal information is an important part of providing you with quality naturopathic care. We understand the importance of protecting your personal information and 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.

The privacy policy outlines what the centre 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 of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

HOW THIS CENTRE COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

This centre understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how we are using and disclosing your information.

The centre will collect, use and disclose information about you for the following purposes:

- | | |
|--|---|
| <ul style="list-style-type: none"> • To assess your health concerns • To provide health care • To advise you of treatment options • To establish and maintain contact with you • To send you newsletters and other information mailings • 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 | <ul style="list-style-type: none"> • 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 <i>Drugless Practitioners Act</i> • To invoice for goods and services • To process credit card payments • To collect unpaid accounts • To assist this centre to comply with all regulatory requirements • To comply generally with the law |
|--|---|

PATIENT CONSENT

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

I have reviewed the above information that explains how your centre will use my personal information, and the steps your Clinic is taking to protect my information.

I agree that the Naturopathic Doctors at Lakeside Natural Health Centre can collect, use and disclose personal information about _____ (patient name) as set out above in the centre's privacy policy.

Signature

Print name

Date

Signature of Witness

Jessica Liu, ND, Kate Morrison, ND

Naturopathic Doctor
Lakeside Natural Health Centre
7 Elmwood Avenue North
Mississauga, ON L5G 3J8
Tel: 905-274-4375 Fax: 905-274-6209

**AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL
TO LAKESIDE HEALTH CENTRE**

(Please send a copy of this form back with records)

Section 1:

(Patient to complete Section 1 and 3 of this form)

To: Dr.(MD): _____
(please print)

From: Patient: _____
(please print)

Fax No#: _____

Date of Birth: _____

Address: _____

Address: _____

Telephone: _____

Telephone: _____

Section 2:

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _____

Laboratory Results _____
*most recent complete blood work up

Imaging Results _____

Other _____

Section 3:

I _____ give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.

Signature of patient: _____

Date: _____



Lakeside Natural Health CENTRE

FEE SCHEDULE, CANCELLATION POLICY & PAYMENT OPTIONS

PATIENT COPY

Fee Schedule

Visit Type	Adult	Child/Senior
Initial Consultation	170.00	145.00
Follow up Consult – 15 min	40.00	35.00
30 min	65.00	55.00
45 min	90.00	80.00
60 min	120.00	110.00
75 min	140.00	125.00
90 min	160.00	140.00
120 min	200.00	185.00

Telephone Consults

Charged according to above rates

Email Consults

Charged according to above rates for any new concerns (emails regarding treatment plans already prescribed are free of charge)

* All fees are subject to 13% H.S.T.

* Child/Seniors Rates: Children under 12, Seniors over 65

* Any Prescribed supplements/botanicals/homeopathics and /or appliances are not included in the above fees

Cancellation Policy

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours advance notice are subjected to a charge of 100% of the fee for the service scheduled. We appreciate your cooperation with this clinic policy.

Payment Options

At Lakeside we are pleased to be able to accept the following method of payments for your convenience:

Cash, Cheque, Debit, *Visa and *MasterCard

Patient Confirmation

By signing this form you have agreed to the conditions of our cancellation policy and acknowledge our fee schedule and payment options.

I _____ have reviewed the above information and understand that if I do not provide 48 hours notice to cancel my appointments I will be sent an invoice by mail that will be due 15 days from invoiced date.

Signature _____

Date _____



Lakeside Natural Health
CENTRE

Your Natural Health Solution

CANCELLATION POLICY & PAYMENT OPTIONS

CLINIC COPY

Cancellation Policy

Your appointment has been reserved especially for you therefore we ask that you provide the clinic with at least 48 hours advance notice if you need to cancel your appointment. Cancellations with less than 48 hours advance notice are subjected to a 100% charge for the appointment. We appreciate your cooperation with this clinic policy.

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I _____ have reviewed the above information and understand that if I do not provide 48 hours notice to cancel my appointments I will be sent an invoice by mail that will be due 15 days from invoiced date. A 1.5% interest charge will be applied to overdue invoices.

Signature _____

Date _____