Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
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Waterdown, ON L8B 0E5
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Naturopathic - Paediatric

File #: _____

Date: _____

General Information

How do you wish to be contacted by our office regarding your child's care?

☐ Email ☐ Text ☐ Phone

Child's Info:

Last: _____

First: _____ **Date of birth (d/m/yy)** _____/ _____ / _____

Parent(s) Names:

Last: _____ **First:** _____

Last: _____ **First:** _____

Parental Status: ☐ Married ☐ Divorced

Custodial Status: ☐ Joint ☐ Single Parent

Child's Address: _____

Town/City: _____ **Province:** _____ **Postal Code:** _____

Home Phone: ( ) _____ **Parents' Cell Phone: ( )** _____

( ) _____

Email: _____

_____ **Please Initial** I consent to receive email communication from the clinic

Family Dr. Name: _____ **Phone: ( )** _____

Previous Naturopathic Care? Y N

Referred by: _____

How did you decide to choose our office? _____

File #: _____

Medical Information

Please list any current prescription or over-the-counter medications:

1. _____
Reason

2. _____
Reason

3. _____
Reason

4. _____
Reason

5. _____
Reason

Please list any past serious illnesses, surgeries, or conditions:

1. _____
Date

2. _____
Date

3. _____
Date

4. _____
Date

5. _____
Date

Please list any known or suspected food allergies or intolerances:

1. _____

2. _____

3. _____

Please list any known or suspected environmental allergies or sensitivities:

1. _____

2. _____

3. _____

Number of antibiotic prescriptions in the past year: _____ in the past 5 years: _____

File #: _____

Current Supplements (multi, herbs, vitamins, minerals, etc.)

Supplement	Dose/Amount	Reason	How Long?

Chief Health Concern(s)

Please list, **in order of importance to you,** the areas of your child's health you would like me to help you address:

1. _____

2. _____

3. _____

4. _____

Prenatal/Natal History

MATERNAL HISTORY

Who provided prenatal care? OB midwife
Number of previous pregnancies:_____

Number of previous deliveries/live births: _____

Diagnostic tests during pregnancy (circle):
Ultrasound #____ Amniocentesis
X-ray Other (please list)
_____

Any significant events or trauma experienced during pregnancy/delivery?
_____

NATAL HISTORY

Circle: Natural conception Assisted conception

If assisted, which technique(s) were used?

_____

Circle**:** Home birth Hospital birth

Circle: Vaginal birth C-section

Circle**:** Forceps Vacuum

Weeks gestation at birth:_____

Weight: _____

File #: _____

Feeding History

Was/is your child breast fed? Y N **For how long?** _____	How would you describe your child's appetite? _____
If not, what was the substitute? (name of formula(s) used) _____	**Are they picky (circle)?** Y N
Was there a reaction to formulas? Y N	**Any cravings?** _____
Age at first food introduced: _____	**Any aversions?** _____
What food was first introduced? _____	
Any reactions to any foods introduced? Y N	
If yes, please list. _____	Please list all beverages you give your child _____ _____ Does your child drink caffeine? Y N

Vaccinations

Has your child been vaccinated? Y N

Vaccinated according to Ontario schedule? Y N

Vaccinated on an altered or delayed schedule? Y N

Any suspected or known reactions or complications from vaccinations (e.g. changes in sleep pattern, changes in temperament, eczema, asthma, allergies, rash, ear infection, autoimmune disease)?

_____

Please list any vaccine related question(s) or concerns you would like to talk about

_____

File #: _____

Current Health

How would you describe your child's state of health?
□ Excellent □ Very Good □ Average □ Fair □ Poor

How many times per week does your child engage in physical activity?
_____

How many minutes daily does your child spend outdoors? _____

What activities does your child enjoy (if applicable)_____

How many minutes of screen time does your child get per/day (include phones, ipads, computers, t.v.)
_____

SLEEP:
How many hours of sleep does your child get nightly?
_____
Does your child nap? Y N

List any concerns you have about your child's sleep
_____

BOWEL MOVEMENTS (BM)
How many BM does your child have a day_____
Any difficulty passing a BM? Y N
Anything to assist their bowels? Y N
Any blood in the stool?
Any mucus in the stool? Y N
Any undigested food in the stool? Y N

ENERGY (10= most energetic) Y N
On a scale of 1-10, how would you rate your child's energy level? _____

MOOD
How would you describe your child's general moods?
_____

Have you ever been concerned about your child's moods?
□ Yes □ No

DAILY DIET SUMMARY

Breakfast:
_____
Lunch:
_____
Dinner:
_____
Snacks:
_____
Drinks:
_____

Is your child exposed to cigarette smoke? Y N

File #: _____

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INFORMED CONSENT TO NATUROPATHIC CARE

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors (NDs) assess the whole person by taking into consideration the physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to promote healing. ND's use a variety of therapeutic approaches, either alone, or in combination. These approaches include nutritional and lifestyle counseling, nutritional supplementation, Traditional Chinese Medicine (TCM) and acupuncture, botanical medicine, homeopathy, hydrotherapy and physical medicine. Your Naturopathic Doctor will take a thorough health history, perform a screening physical examination, and take or request laboratory samples when necessary.

It is very important that you inform your naturopathic doctor of any disease you are suffering from, any known allergies you have, and any medications or over the counter drugs you are currently taking. Please advise your naturopathic doctor if you are pregnant, suspect you are pregnant, or if you are breastfeeding. As a patient, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the material effects, costs, expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.

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

- An allergic reaction to a supplement and/or herb.
- A worsening or aggravation of symptoms with homeopathic medicine. The duration is usually short and self-limiting.
- Pain, bruising, or injury from taking blood samples or acupuncture.
- Fainting or puncturing of an organ with acupuncture needles.

STATEMENT OF ACKNOWLEDGMENT

As a patient of Dr. Carly Wendler BA.Sc. N.D. I, _____ have read the information and understand that the form of medical care I will be receiving is based on naturopathic principles and practices. I hereby acknowledge that I have been informed and understand the recommended diagnostic and therapeutic procedure(s)/plan and have discussed them to my satisfaction. I also recognize that even the gentlest forms of therapies have potential complications, and I release Dr. Wendler from any responsibility of such complications. I acknowledge and confirm that I have been informed of the diagnostic/therapeutic procedures with respect to financial costs, potential risks and side effects, expected benefits, the likely consequences of not having/following the provided recommendations and what alternative course(s) of action are available to me.

File #: _____

I also acknowledge that:
1.) Any treatment or advice provided to me as a patient of Dr. Carly Wendler BASc, 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;
2.) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider qualified to practice in Ontario;
3.) Dr. Carly Wendler BASc, ND. has not suggested or recommended to me to refrain from seeking or following the advice of another licensed health care provider;
4.) The treatment and therapies rendered or recommended by Dr. Carly Wendler BASc, ND may be different from those usually offered by a medical doctor or other licensed health care provider.

I acknowledge that full payment is required at the time that services are provided or supplements are purchased.

CANCELLATION POLICY
While the clinic does provide regular appointment reminders, I acknowledge that I am responsible for my attendance and that 24 hours' notice is required should I wish to cancel or reschedule my appointment. If less than 24 hours' notice is given, or If I fail to show for my scheduled appointment, I understand that one of the following charges will be applied to my account:

- ☐ **A cancellation fee of $25.00** should I cancel an appointment with less than 24 hours' notice
- ☐ **A full appointment fee** should **I** not show for my scheduled appointment without notice

Please initial to confirm that you have read the cancellation policy and agree to pay any outstanding balances owing. _____ **(Initial Here)**

I declare that Dr. Carly Wendler BA.Sc., ND has explained, to the best of her ability, the treatment or services that I may receive and hereby authorize and consent to treatment by Dr. Carly Wendler BA.Sc, ND.

I intend this consent to apply to all my present and future naturopathic care.

Patient Name (print): _____

Parent/Guardian Signature (if under 16 years old): _____

Signature: _____

Date: _____