Naturopathic – Pediatric

File #: _____

Date: _____

Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

General Information

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

Child's Info:

Last name:_____ **First name:**_____

Date of birth (D/M/Y):_____

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:_____ _____ Initial here to consent to email communication from the clinic

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

Previous Naturopathic Care? ☐Y ☐N **If Yes, ND's name**:_____

How did you hear about us?_____

Why did you decide to choose our office?_____

Medical Information

Please list any current prescription or over the counter medication

Medication name	Dosage	Reason	Duration of use

File #: _____

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

Supp. and brand name	Dosage	Reason	Duration of use

Please list any current or past illnesses, surgeries or conditions, include diagnosis date:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any known or suspected allergies/sensitivities:

1. _____
2. _____
3. _____

Number of antibiotic prescriptions in the past year (please check): ☐ 0 ☐ 1-4 ☐ 5-9 ☐ 10+

Number of antibiotic prescriptions in the past 5 years (please check): ☐ 0 ☐ 1-4 ☐ 5-9 ☐ 10+

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Family History

Has anyone in your family been diagnosed with any of the following conditions?

☐ Alcoholism	☐ Diabetes	☐ Heart disease	☐ Multiple Sclerosis	☐ Alzheimer's disease
☐ Drug abuse	☐ High blood cholesterol	☐ Osteoporosis	☐ Asthma	☐ Eczema
☐ High blood pressure	☐ Arthritis	☐ Cancer	☐ Epilepsy	☐ Kidney disease
☐ Psoriasis	☐ Depression	☐ Fibromyalgia	☐ Mental illness	☐ Thyroid disorder
☐ Stroke	☐ Inflammatory bowel disease	☐ Irritable bowel syndrome	☐ Celiac disease	☐ Allergies
☐ Autoimmune diseases	☐ Dementia	☐ Parkinson's	☐ ALS or other motor neuron diseases	☐ Genetic disorders
☐ ADHD	☐ Autism			

Please list any other illnesses of your relatives, such as parents, siblings, grandparents, aunts and uncles:

_____

_____

Chief Health Concerns

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	**Natal History**
Who provided prenatal care? ☐ OB ☐ Midwife	☐ Natural conception ☐ Assisted conception
Number of previous pregnancies:_____	If assisted, which technique(s) were used?
Number of previous deliveries/live births: _____	_____
Diagnostic tests during pregnancy:	☐ Home birth ☐ Hospital birth

File #: _____

☐ Ultrasound #____ ☐ Amniocentesis ☐ X-ray Other (please list) _____ Any significant events or trauma experienced during pregnancy/delivery? _____	☐ Vaginal birth ☐ C-section ☐ Forceps ☐ Vacuum Weeks gestation at birth:_____ Birth weight: _____

Feeding History

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

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Current Health

How would you describe your child's current state of health? (check one)

☐ Excellent ☐ Very Good ☐ Average ☐ Fair ☐ Poor

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

What activities does your child enjoy (if applicable):_____

How many minutes of screen time does your child get per day (include phone, ipad, computer, tv)_____

Sleep

How many hours of sleep does your child get nightly?_____

Does your child nap? ☐ Y ☐ N

Please list any concerns you have about your child's sleep:_____

Bowel Movements (BM)

How many BMs 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? ☐ Y ☐ N

Any mucus in the stool? ☐ Y ☐ N

Any undigested food in the stool? ☐ Y ☐ N

Daily Diet Summary

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Drinks:_____

Energy

On a scale of 1-10 (10 being the MOST energetic), how would you rate your child's energy level?_____

Mood

How would you describe your child's general mood?_____

File #: _____

Have you ever been concerned about your child's moods? ☐ Y ☐ N

Stress

Are there any particular stressors that your child is exposed to?_____

Is your child exposed to cigarette smoke? ☐ Y ☐ N

INFORMED CONSENT TO NATUROPATHIC CARE

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors (ND's) 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 counselling, nutritional supplementation, Traditional Chinese Medicine (TCM) and acupuncture, botanical medicine, homeopathy, hydrotherapy and physical medicine. Your ND will take a thorough health history, perform screening physical examinations and request laboratory testing when necessary.

It is very important that you inform your ND 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 ND 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 acupuncture
- Fainting or puncturing of an organ with acupuncture needles

STATEMENT OF ACKNOWLEDGEMENT

I,_____(please print name) 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 with my ND to my satisfaction. I also recognize that even the gentlest forms of therapies have potential side effects and I release my ND from any responsibility or side effects. I acknowledge and confirm I have been informed of the diagnostic/therapeutic procedures with respect to potential risks and side effects, expected benefits, financial costs and the likely consequences of not having/following the provided recommendations and what alternative course(s) of action are available to me. I understand that this record will be kept confidential and will not be released to others unless so directed by myself or unless required by law. If seeing more than one practitioner at Waterdown Village Chiropractic and Wellness Group, I imply consent for them to share and discuss my file as deemed necessary by the practitioners to ensure that I receive the most appropriate care for my condition.

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I also acknowledge that:

1. Any treatment or advice provided to me as a patient of Naturopathic Medicine 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. My 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 my ND may be different from those usually offered by a medical doctor or other licensed health care provider.
5. I acknowledge that full payment is required at the time services are provided or supplements are purchased.

I declare that my ND has explained to the best of her ability, the treatment or services that I may receive and hereby authorize and consent to treatment. I intend this consent to apply to all my present and future naturopathic treatments.

Patient Name (print):_____ Date:_____

Signature:_____

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

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)**