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

Last Name: _____ **D.O.B.** _____

First Name: _____

How do you wish to be addressed in our office? *(First Name, Mr., Mrs., Dr., Nickname, Etc…)*

_____

Identify as? ☐ M ☐ F ☐ Other: **Sex at birth:** ☐ M ☐ F

Address: _____

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

Home Phone: _____ **Cell Phone:** _____

Email: _____ _____ **Please Initial** Consent to receive email communication from the clinic

How do you wish to be contacted by our office regarding your appointments?
Email Phone

Occupation: _____ **Spouse's name** *(if applicable)*: _____

Children: ☐ Y ☐ N **Number:** _____ **Ages:** _____

(Females) Are you pregnant? ☐ Y ☐ N **How many weeks?** _____ **Estimated due date:** _____

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

Current / Previous Wellness Care? *(check all that apply)*

Chiropractic Physiotherapy Naturopathy Massage Therapy Osteopathy

Location: _____

How did you hear about us? ***(referral, ad, Google)*** _____

Reason for consulting the office:

- ☐ I have a specific problem and require help only with this problem.
- ☐ After my specific problem has been relieved, I am interested in strategies for maintenance.
- ☐ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
- ☐ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

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Naturopathic – Paediatric (0 – 12 Yrs)

File #: _____

Date: _____

Medical Information

Please list any current prescription or over-the-counter medications and frequency of use (e.g. Tylenol, Advil, Allergy Meds):

1. _____
Reason

2. _____
Reason

3. _____
Reason

4. _____
Reason

5. _____
Reason

Please list any current or past illnesses, surgeries, or health conditions:

1. _____ **Diagnosis Date:** _____

2. _____ **Diagnosis Date:** _____

3. _____ **Diagnosis Date:** _____

4. _____ **Diagnosis Date:** _____

5. _____ **Diagnosis 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 ☐ Family MD

Number of siblings: _____

Number of previous deliveries / live births: _____

Diagnostic tests during pregnancy
Ultrasound # ____ Amniocentesis

Other: _____

Any significant events or trauma experienced during pregnancy / delivery for mom or baby?
☐ Y (explain) ☐ N

_____

NATAL HISTORY

☐ Natural conception ☐ Assisted conception

If assisted, which technique(s) were used?

_____

Check all that apply:

Home Birth	Hospital Birth
Vaginal Birth	C-Section
Forceps	Vacuum

Weeks of gestation at birth: _____

Weight of baby at birth: _____

File #: _____

Feeding History

Was / is your child breast fed? ☐ Y ☐ N

If yes, for how long?_____

If not, what was the substitute? Name of formula used:

_____

Was there a reaction to formulas? ☐ Y ☐ N

Age at which food was first introduced? _____

What food was introduced first? _____

Any reactions to any foods to date? ☐ Y ☐ N

If yes, please list: _____

_____

How would you describe your child's appetite?

_____

Is your child a picky eater? ☐ Y ☐ N

Does your child have cravings? ☐ Y ☐ N

Does your child have any aversions? ☐ Y ☐ N

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 ON schedule? ☐ Y ☐ N

Vaccinations altered or delayed? ☐ Y ☐ N

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

_____

_____

Please list any vaccine related questions or concerns you would like to discuss: _____

_____

_____

File #: _____

Current Health

How would you describe your child's state of health?

☐ Excellent ☐ Very Good ☐ Average ☐ Poor

How many times / week does your child engage in physical activity / extracurricular activities? _____

Do you feel that your child has a balanced schedule?

☐ Y ☐ N

How many minutes does your child spend outside? _____

What activities does your child enjoy? _____

_____

How many minutes of screen time does your child get per day? (Includes phone, ipod, computer, tv) _____

Do you have any concerns about your child's behaviour?

_____

_____

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 patterns: _____

_____

DIGESTIVE HEALTH

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

ENERGY

How would you rate your child's energy level on a scale of 1 to 10? (10 being the MOST energetic)

_____

MOOD

How would you describe your child's general moods?

_____

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

☐ Y ☐ N

Please describe the emotional climate of your home:

_____

_____

Is your child exposed to any cigarette smoke?

☐ Y ☐ N

Is your child exposed to any vaping?

☐ Y ☐ N

DAILY DIET SUMMARY

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Preferences: (keto, paleo, vegan, gluten-free)

_____

Overall, are you satisfied with your child's diet?

☐ Y ☐ N

Do you have any concerns or questions about your child's diet? _____

_____

_____

_____

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INFORMED CONSENT TO NATUROPATHIC CARE

A worsening or aggravation of symptoms with homeopathic Naturopathic Medicine is the treatment and prevention of diseases with natural medicines. Our Naturopathic Doctors (NDs) assess you as a *whole* person by taking into consideration your physical, mental, and emotional health. Gentle, non-invasive medicines are used in order to treat the underlying causes of your illness & disease, while promoting and supporting your healing process. Our Naturopathic Doctors use a variety of therapeutic approaches, either alone, or in combination.

These therapeutic approaches include nutritional and lifestyle counseling, nutritional supplementation, Traditional Chinese Medicine (TCM) and acupuncture, botanical medicine, homeopathy, hydrotherapy B12 injections, and physical medicine. Your Naturopathic Doctor will take a thorough health history, perform a screening physical examination if needed, and request laboratory testing when necessary.

It is very important you inform your Naturopathic Doctor of any diseases you are suffering from, any known allergies you have, and any prescriptions 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 your treatment plan may change in these stages of life. As a patient of Naturopathic Medicine, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.

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

An adverse reaction to a supplement and/or herb

An aggravation of symptoms with homeopathic medicine. The duration is usually short and self-limiting.

Discomfort or bruising with acupuncture.

I, _____ **(please type/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 Naturopathic Doctor to my satisfaction. I also recognize that even the gentlest forms of therapies have potential side effects, and I release my Naturopathic Doctor from any responsibility of 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 also acknowledge that:

File #: _____

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 Naturopathic Doctor. 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 Naturopathic Doctor 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 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 my Naturopathic Doctor 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: _____
(Typed name/signature implies consent)

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