Wellness for the Body
Massage Therapy & Healing Centre

Naturopathic Medicine - Pediatric

2418 Lakeshore Road West, Oakville, Ontario L6L 1H7
Phone: 905.465.4595 Web: www.wellnessforthebody.com

Patient Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/_____ Age: _____

Height/length: _____ Weight: _____ Gender: ☐ Female ☐ Male

Name of parents/guardians: _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Please consider giving us a daytime phone number, in the event we need to reach you the same day as your appointment.

Phone: (H)_____ (M)_____ (B)_____

Email: _____ Would you like to receive our monthly e-newsletter? ☐ Yes ☐ No

Where did you find our number? _____

If online, what site referred you? ☐ Google ☐ Facebook ☐ Instagram ☐ Twitter ☐ Other: _____

HEALTH CARE PROVIDERS

Medical Doctor: _____ Phone: _____ City: _____

Are you currently under his/her care? ☐ No ☐ Yes Date of last physical exam: _____

Other Health Care Providers you are seeing

Name	Specialty	Telephone Number

CURRENT HEALTH

What are your main health concerns, in order of importance to you?

1. _____

2. _____

3. _____

MEDICATIONS

Please indicate: **NOW** *if currently using,* **PAST** *if previously used OR* **Skip** *if it has never been administered*

	NOW	PAST		NOW	PAST		NOW	PAST
Aspirin	❑	❑	Ibuprofen	❑	❑	Other	❑	❑
Tylenol	❑	❑	Antibiotics	❑	❑	Please indicate: _____		
Decongestants	❑	❑	Antihistamine	❑	❑	_____		

MEDICAL HISTORY

- ❑ Measles
- ❑ Chicken Pox
- ❑ Mumps
- ❑ Rubella
- ❑ Scarlet Fever
- ❑ Pneumonia
- ❑ Frequent Colds
- ❑ Rheumatic Fever
- ❑ Tonsillitis (# of times: _____)
- ❑ Ear infections (# of times: _____)
- ❑ Other – Please list: _____

Please turn over…

Injuries/Surgeries/Hospitalizations (please indicate): _____

_____

Has your child ever had any of the following tests? When? What were results?

Electroencephalogram _____

Psychological evaluation _____

Hearing _____

Speech Loss _____

IMMUNIZATIONS

- ❑ Measles ❑ Polio ❑ MMR
- ❑ Mumps ❑ DPT ❑ Tetanus
- ❑ Diphtheria ❑ Small Pox ❑ Influenza

FAMILY HISTORY

- ❑ Heart Disease ❑ Diabetes ❑ Birth Defects
- ❑ Hypertension ❑ Arthritis ❑ Tuberculosis
- ❑ Cancer ❑ Allergies ❑ Mental Illness

PRENATAL HISTORY

Previous pregnancies by natural mother:

Number of live births? _____ Miscarriages? _____

Any complications? (Please explain) _____

Mother's age at child's birth: _____

Mother's health during pregnancy:

- ❑ Bleeding ❑ Physical or emotional trauma ❑ Cigarette smoking
- ❑ Nausea ❑ Thyroid problems ❑ Alcohol consumption
- ❑ Illness ❑ Diabetes ❑ Medications: _____

BIRTH HISTORY

Number of weeks pregnant: _____ Birth Weight: _____ Length of labor: _____

Complications: _____

Did your child have any of the following after birth?

- ❑ Birth Defects ❑ Birth Injuries ❑ Blue Baby
- ❑ Cerebral Palsy ❑ Seizures ❑ Jaundice
- ❑ Colic ❑ Fever ❑ Rashes
- ❑ Other (please explain): _____

_____

Child's sleep patterns for the first year: _____

_____

Food intolerances (if any): _____

Feeding:

❑ Breast Fed: How long? _____

❑ Formula: How long? _____ Type: Milk ❑ Soy ❑

Age began solid foods: _____ What type? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

DIET

Please describe your child's average diet

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Drink:_____

SYMPTOMS

Please indicate: **NOW** *if currently having,* **PAST** *if previously had OR* **Skip** *if have never had before*

	NOW	PAST		NOW	PAST		NOW	PAST
Hives	❑	❑	Burning of urine	❑	❑	Bloody urine	❑	❑
Eczema	❑	❑	Frequent urination	❑	❑	Cries easily	❑	❑
Bleeding gums	❑	❑	Heart murmur	❑	❑	Nervous	❑	❑
Nose bleeds	❑	❑	Vomiting spells	❑	❑	Sleep problems	❑	❑
Acne	❑	❑	Anemia	❑	❑	Night sweats	❑	❑
High fevers	❑	❑	Stomach aches	❑	❑	Sensitive to light	❑	❑
Chronic rash	❑	❑	Jaundice	❑	❑	Body/breath odor	❑	❑
Hearing loss	❑	❑	Easy bruising	❑	❑	Motion/car sickness	❑	❑
Diarrhea	❑	❑	Flat feet	❑	❑	No appetite	❑	❑
Sore throat	❑	❑	Constipation	❑	❑	Nightmare	❑	❑
Headache	❑	❑	Gas	❑	❑	Canker sore	❑	❑
Frequent colds	❑	❑	Bleeding tendencies	❑	❑	Unusual fears	❑	❑
Wheezing	❑	❑	Joint pains	❑	❑	Excessive fatigue	❑	❑
Coughing	❑	❑	Dizzy spells	❑	❑	Hair loss	❑	❑

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

_____

_____

_____

_____

Consent Regarding Personal Information

Your identity will be protected at all times and a record will be kept of the health services provided. Patients may look at their medical record at any time and can request a copy by paying the appropriate fee. The information from medical records may be analyzed for research purposes and all identities will be protected and kept confidential.

Privacy of your personal information is an important part of our clinic while providing you with quality naturopathic care. We understand that 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.

All staff members who come into 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 protection and appropriate use of your information.

Our privacy policy outlines what our clinic 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 the existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Drugless Therapy – Naturopathy.

Please turn over…

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

To help you understand how we protect your personal information, we have outlined here how our clinic is using and disclosing your information:

- To assess your health concerns.
- To provide health care.
- To advise you of treatment options.
- To establish & maintain contact with you.
- To send 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.
- To complete claims for insurance purposes.
- To invoice for goods and services.
- To process credit card payments.
- To collect unpaid accounts.
- To comply with legal and regulatory requirements of our regulatory body, the Board of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners act.*
- To assist this clinic to comply with all regulatory requirements.
- To comply generally with the law.
- To allow potential purchasers, practice brokers or advisors to conduct and audit in preparation for practice sale.

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

Consent to Treatment

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, including physical, mental and emotional aspects of the individual. Gentle techniques are used to stimulate the body's inherent healing capacity and correct any imbalances. Your visit may consist of a thorough case history and a screening physical examination, including breast examination for females. If your case requires, the physical examination may include more specific examinations such as rectal or genital exams. After collecting the necessary information, diagnosis, treatment and/or referral to other health care professional are made based upon the assessment of conditions revealed.

Treatment may include the performance of acupuncture and other procedures related to acupuncture, as necessary. In the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles. Only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment. Female patients please note that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible.

It is important that we are informed of any diseases that you are suffering from and if you are on any medication or over-the-counter drugs. If you are pregnant, suspect you are pregnant or you are breastfeeding, please let us know.

There are some light health risks to treatment by naturopathic medicine. These include but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; and pain, bruising or injury from acupuncture (as outlined above). Results are not guaranteed and not all risks and complications can be anticipated.

By signing the Patient Consent on this form, you have agreed that you read the above Consent to Treatment and had an opportunity to ask questions about its content. By signing below, you also agree to the above mentioned naturopathic treatment, understand the risks, and that you intend this consent form to cover the entire course of treatment for your present and future conditions for which you seek treatment.

Cancellation & Fee Policy (For a full detailed price list: www.wellnessforthebody.com)

We require 24 hours' notice if you are unable to make your scheduled appointment. After an initial warning, there is a charge of $45.00 for a second missed appointment. All subsequent missed appointments will then be billed at the full regular fee.

Payment is due at the time services are rendered. This policy applies to all our patients. Patients with extended health care coverage should note, our office does not file claims on your behalf, nor bill your insurance company directly.

By signing the Patient Consent on this form, you have agreed that you are aware of the Cancellation & Fee Policy. You have also agreed that if you are late for your appointment, you will receive the remainder of the appointment time and will be responsible for the full payment of the scheduled appointment.

Patient Consent

I _____, (patient name) have read and agree to the information stated above.

Signature: _____ Date: _____

Guardian Signature (patients under age 16): _____

Witness Signature: _____