



**Naturopathic
Pediatric Intake Form**
(905)828-2014 Fax (905)828-8822



Today's Date: _____ **Child's Date of Birth:** _____
Child's full name: _____ **Sex: Female / Male**
Parent/Guardian's Names: _____
Address: _____
City: _____ **Province:** _____ **Postal Code:** _____
Phone: _____ **Work phone:** _____
Cellular phone: _____ **Can we leave a message Y / N**
Email Address: _____
Emergency Contact: _____ **Relationship:** _____
Weight at birth: _____ **Present Weight:** _____ **Child's Height:** _____
Parent/Guardians' occupations: _____
Who referred you to our office? _____
Child's Chief Health Concerns: please include date of onset: _____

Prenatal Health:

Health at time of conception: 1-5 (5 being excellent health)
 Mother: 1 2 3 4 5
 Father: 1 2 3 4 5
 Mother's health during pregnancy: 1 2 3 4 5
 Mother's age at the time of child's birth: _____ Prenatal care: Y/N
 Duration of Pregnancy: _____ weeks

Did mother experience any of the following during pregnancy?

- Bleeding
- Nausea/Vomiting
- Physical Trauma (including forceps, epidural, c-section)
- Toxemia
- High Blood Pressure
- Emotional Trauma/Stress
- Thyroid Issues

Did mother use any of following during her pregnancy?

- Alcohol: _____
- Recreational Drugs: _____
- Prescription Meds: _____
- Other Medications: _____
- Tobacco: _____
- Supplements: _____
- _____

Herbs/Vitamins/Medications:



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Neonatal Health History:

APGAR Scores: 1 Minute: 5 Minutes
Birth: C-Section _____ Breech: _____

Has your child suffered any of the following:

- Infections: _____
- Rashes: _____
- Jaundice: _____
- Other: _____

Your child's Diet: _____

Vaccinations: Please check off:

- MMR
- DPT
- Hepatitis
- Chicken Pox
- Measles
- Typhoid
- Other: _____

Allergic responses to any? _____

Has your child had any difficulty with the following: (Please check off)

- Blood pressure
- Breathing
- Urination, Bowel movements
- Skin
- Bleeding
- Vision
- Hearing (ear infections? tubes?)
- Learning
- Headaches
- Nausea/Vomiting
- Appetite

Is your child in daycare? _____

How is the emotional climate of the home (happy, sad, busy etc)? _____

Describe the emotional disposition of your child. _____

Is there anything else we may have missed? _____



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INFORMED CONSENT TO NATUROPATHIC TREATMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors (N.D.'s) assess the whole person, including physical, mental, emotional and spiritual aspects of the individual. N.D.'s used a variety of therapeutic approaches, either alone, or in combination. These include nutritional and lifestyle counseling, nutritional supplementation, Asian medicine and acupuncture, botanical medicine, homeopathy and physical medicine.

This is to acknowledge that I have been informed and I understand that:

- 1) any treatment or advice provided to me as a patient of Kirsten Almon N.D., Erica Nikiforuk N.D., Aisling Lanigan N.D., Tiffany Wyse N.D., R.H., Ashley Chauvin N.D., AND Olivia Chubey N.D. 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 or surgeon or other health care provider qualified to practice in Ontario;
- 3) Kirsten Almon N.D., Erica Nikiforuk N.D., Aisling Lanigan N.D., Tiffany Wyse N.D., R.H., Ashley Chauvin N.D., and Olivia Chubey N.D. have 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 Kirsten Almon N.D., Erica Nikiforuk N.D., Aisling Lanigan N.D., Tiffany Wyse N.D., R.H., Ashley Chauvin N.D., and Olivia Chubey may be different from those usually offered by a medical doctor or other licensed health care provider.
- 5) There are some risks, however rare, to Naturopathic Medicine. These include but are not limited to:
 - aggravation of pre-existing symptoms,
 - allergic reaction to supplements or herbs,
 - pain, bruising or injury from acupuncture,
 - fainting or puncturing of an organ with acupuncture needles.

I declare that I have received a full and complete explanation of the treatment or services that I may receive at the Erin Mills Optimum Health by Kirsten Almon N.D., Erica Nikiforuk N.D., Aisling Lanigan N.D., Tiffany Wyse N.D., R.H., Ashley Chauvin N.D., and Olivia Chubey N.D. hereby authorize and consent to treatment by Kirsten Almon, Erica Nikiforuk, Aisling Lanigan, Tiffany Wyse, Ashley Chauvin, and Olivia Chubey. I intend this consent to apply to all my present and future naturopathic care.

Signature of patient

Date

Name of patient printed

Doctor's signature



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NATUROPATHIC FEE SCHEDULE

I understand that the fees are as follows:

VISIT	FEE
INITIAL EXAM	\$200.00 (adult) \$180.00 (*child)
Subsequent Visits	\$110.00 (adult) \$100.00 (child)
Acupuncture & Craniosacral	\$110.00
Phone consultation	\$30.00 to \$110.00

*Child is anyone under the age of 12 years.

Arranged telephone consultations with the doctor: \$10.75 for every 5 minutes (Based on an hourly rate).

There are separate fees for treatments involving the administration of specialized substances (e.g. B12/folic acid intra-muscular injection) based on the amount of substance used. The fee will be discussed before treatment is administered.

Extended health care benefits may also cover naturopathic treatment. Please check your plan details or call your human resources.

Please note that there is a 24-hour cancellation policy. If 24 hours notice is not given, a \$50.00 missed appointment fee will be charged.

I agree to pay my account in full at the time of each visit or treatment.

I acknowledge that I may purchase products prescribed by Kirsten Almon N.D., Erica Nikiforuk N.D., Aisling Lanigan N.D., Tiffany Wyse N.D., R.H., Ashley Chauvin N.D., and Olivia Chubey N.D. or any health food store.

Please sign that you have read the above and you acknowledge the fee schedule.

Signature _____ Date _____