Althea Wellness Centre

NEW PATIENT INTAKE FORM – CHILD (Age 0 – 11)

Patient Information: **(all fields required)**

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ (MMM/DD/YYYY) Age: _____ ◯ Male ◯ Female Gender/Self-identity: _____

Medical Services Number: _____

Primary Phone: _____ Other Phone: _____ May we leave messages? ◯ YES ◯ NO

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

Name of person filling in this form: _____ Relationship to Patient: _____

Do any family members attend our clinic? ◯ YES ◯ NO If yes, name: _____

How did you hear about us? _____

Parent/Legal Guardian Information:

First/Last Name: _____

Phone: _____

May we leave messages? ◯ YES ◯ NO

Street Address: _____

City: _____ Province: _____

Postal Code: _____

Email:_____

Parent/Legal Guardian Information:

First/Last Name: _____

Phone: _____

May we leave messages? ◯ YES ◯ NO

Street Address: _____

City: _____ Province: _____

Postal Code: _____

Email:_____

Who does the patient usually live with? Please include all family members, including ages. If the child lives with each parent separately, please briefly describe the parenting arrangements:

Is the patient named in any agreements or court orders regarding guardianship and/or parenting responsibilities? ◯ YES ◯ NO
If yes, please explain:

If there are no agreements or court orders regarding guardianship and/or parenting responsibilities for the patient, Althea Wellness Center, its doctors, and staff will assume both parents have joint guardianship, and equal ability to make medical decisions for the patient. Both parents will have equal access to the patient's medical record. Medical decisions being made for the patient must be consented to by both parents.

_____
Initials of Parent/Legal Guardian

I consent to receiving invoices, statements, treatment plans, and other information related to the services we offer to the provided e-mail addresses? ◯ YES ◯ NO

Extended Health Coverage:

Does the patient have extended health coverage? ◯ YES ◯ NO Insurer: _____

Policy #: _____ Certificate #: _____

Name of Primary insured: _____ Date of Birth: _____ (MMM/DD/YYYY)

Relationship to Primary: ◯ Child ◯ Step-Child ◯ Handicapped Dependent

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Other Healthcare Providers:

Family Doctor: _____ Phone: _____ Specialist: _____ Phone: _____

Chiropractor: _____ Phone: _____ Other: _____ Phone: _____

Current Health Concerns:

Please list the patient's primary health concerns, and the reason for visiting us today:

In general, how would you describe the patient's health?

Is the patient currently under the care of any medical specialists? ◯ YES ◯ NO If yes, please explain:

Please list all primary diagnoses, injuries, and/or hospitalizations the patient has had in their lifetime:

Please list all medications, supplements, and over-the-counter medicines the patient uses regularly:

Immunization History: *Check all that apply* Is the patient immunized according to the BC Vaccine Schedule? ◯ YES ◯ NO

Chicken Pox	☐	COVID-19	☐	Diphtheria	☐	Hepatitis A	☐	Hepatitis B	☐
HPV	☐	Influenzas (Flu)	☐	MMRV	☐	Meningococcal C	☐	Pertussis	☐
Pneumococcal	☐	Polio	☐	Rotavirus	☐	Tetanus	☐		

Other: _____ Has the patient ever had an adverse reaction to any vaccine? ◯ YES ◯ NO

Personal Health History:

Does the patient currently have a contagious disease? ◯ YES ◯ NO If yes, explain: _____

Does the patient have any allergies to drugs, chemicals, or foods? ◯ YES ◯ NO Is there a history of anaphylaxis? ◯ YES ◯ NO

If yes, please explain: _____

Context of Care:

What does the patient LOVE to do? _____

What does the patient spend the most time doing? _____

How much time does the patient spend outside every day? _____

How would you describe the patient's personality? _____

How does the patient interact with others? _____

What are potential obstacles to the patient's optimal health? _____

Patient's Medical History: *Select YES (Y) if the patient has experienced any of the following conditions or symptoms:*

Allergies	☐ YES	Anemia	☐ YES	Anxiety/Nervousness	☐ YES	Asthma	☐ YES
Autism	☐ YES	Bedwetting	☐ YES	Behavioural Issues	☐ YES	Bloating/Gas	☐ YES
Bronchitis	☐ YES	Cancer	☐ YES	Celiac Disease	☐ YES	Chicken Pox	☐ YES
Colic	☐ YES	Constipation	☐ YES	COVID-19	☐ YES	Cradle cap	☐ YES
Croup	☐ YES	Depression	☐ YES	Developmental Delay	☐ YES	Diabetes	☐ YES
Dry/Flaky Skin	☐ YES	Earache(s)	☐ YES	Ear Infection(s)	☐ YES	Eczema	☐ YES
Epilepsy/Seizures	☐ YES	Fatigue	☐ YES	Headache(s)	☐ YES	Heart Murmur	☐ YES
Hepatitis A	☐ YES	Hepatitis B	☐ YES	Hernias	☐ YES	High Fever	☐ YES
Hives/Rash	☐ YES	Hyperactivity	☐ YES	Impetigo	☐ YES	Jaundice	☐ YES
Juvenile Arthritis	☐ YES	Laryngitis	☐ YES	Learning Disability	☐ YES	Meningitis	☐ YES
Pinworm	☐ YES	Pneumonia	☐ YES	Psoriasis	☐ YES	Respiratory Syncytial Virus (RSV)	☐ YES
Ringworm	☐ YES	Roseola	☐ YES	Sleep Apnea	☐ YES	Strep throat	☐ YES
Thrush	☐ YES	Tonsilitis	☐ YES	UTI's	☐ YES	Yeast Infection(s)	☐ YES

Other: _____

Prenatal Health of Patient's Mother

Maternal age at birth: _____

During pregnancy, did the mother take:

Prescription medications?

_____

Over-the-counter medicines?

_____

Supplements?

_____

Other?

_____

Mother's health during pregnancy: *Check all that apply*

☐ Bleeding ☐ Cholestasis ☐ Diabetes

☐ High BP/Toxemia ☐ Injury/Trauma ☐ Nausea

☐ Stress Other: _____

During pregnancy, did the mother use: ☐ Tobacco ☐ Marijuana ☐ Alcohol

Describe the mother's pregnancy? (mood, stress, etc)

Birth History:

Gestational Term:

◯ Full ◯ Preterm _____ weeks ◯ Postterm _____ days/weeks Patient's weight at birth: _____

Type of delivery: *Check all that may apply* ☐ Vaginal ☐ Cesarean ☐ Forceps ☐ Vacuum ☐ Home ☐ Water

Medications used during labour/delivery:
(Check all that may apply)

☐ Induction ☐ Epidural ☐ Morphine/Fentanyl

☐ Antibiotics ☐ Nitrous Oxide ☐ None

Length of labour: _____ hours

Were there any complications during labour and delivery?

Was the patient breastfed? ◯ YES ◯ NO If yes, how long? _____ Did the patient experience colic? ◯ YES ◯ NO

Formula fed? ◯ YES ◯ NO If yes, what types? (cow/goat/soy/other) _____

At what age were solid foods introduced? _____ Explain: _____

Patient's Developmental History:

At what age did the patient first, if known:

Roll over: _____ Sit up: _____

Crawl: _____ Walk: _____

Talk: _____ Feed self with hands: _____

Use a cup: _____ Use a spoon: _____

Additional comments regarding the patient's development?

Does the patient participate in any extracurricular activities? Explain:

If yes, how often per week? ☐1 ☐2 ☐3 ☐4 ☐5+

Can the patient participate in group activities without one-on-one supervision/assistance? *(if applicable)*

Describe the patient's sleep pattern:

Does the patient wake without assistance at night to use the toilet?

Does the patient experience nightmares/night terrors? Explain:

Describe the patient's mood upon waking up:

Describe the patient's behaviour and performance at (pre)school and/or daycare: *(if applicable)*

Can the patient follow multi-step instructions?

Does the patient need reminders, timers, and/or assistance to complete multi-step activities?

Does the patient play/interact well with their peers?

Family Medical History: *Select YES (Y) if anyone in the patient's IMMEDIATE family was diagnosed with any of the following:*

ADHD	☐YES	Allergies	☐YES	Anemia	☐YES	Anxiety Disorder	☐YES
Asthma	☐YES	Autism	☐YES	Birth Defect(s)	☐YES	Bleeding Disorder	☐YES
Cancer	☐YES	Celiac Disease	☐YES	Crohn's Disease	☐YES	Depression	☐YES
Developmental Delay	☐YES	Diabetes	☐YES	Eating Disorder(s)	☐YES	Eczema	☐YES
Epilepsy/Seizures	☐YES	Hearing Loss	☐YES	Heart Murmur	☐YES	Juvenile Arthritis	☐YES
Kidney Disease	☐YES	Learning Disability	☐YES	Mental Illness	☐YES	Neurological Disorder(s)	☐YES
Obesity	☐YES	Sleep Apnea	☐YES	Speech Disorder	☐YES	Stroke	☐YES
Substance Abuse	☐YES	Thalassemia	☐YES	Tourette's Syndrome	☐YES		

Other: _____

PROTECTION OF PERSONAL HEALTH INFORMATION:

Our clinic understands the importance of protecting your personal information. Our privacy protocols comply with the Personal Health Information Protection Act (PHIPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the standards and guidelines from the College of Naturopathic Physicians of British Columbia (CNPBC).

Your personal information is kept strictly confidential and is part of your medical record in our clinic. There are rare circumstances that require us to disclose information from your file. This is only limited to a request to access your file by the regulatory authorities mandated by law and/or authorized by you. For any other type of disclosure, we require a consent form signed by you. Our office will not, under any circumstances, disclose any of your personal confidential information to insurance companies.

_____ _____

Parent or Legal Guardian Signature Date (mmm/dd/yyyy)

PAYMENT POLICY

A current credit card is required to be kept on file to minimize contact with the front desk staff. This also ensures timely processing of payments for all virtual and phone visits. Receipts and other documentation will be emailed to all patients at the end of their appointment. All appointment fees are due upon rendering of services. This includes Naturopathic appointments, VEGA testing, Acupuncture sessions, and laboratory fees.

We accept payment by cash, Debit, Visa, MasterCard, and *E-transfer.

Any late payments past due by 30 days are subject to a 2% per month monthly interest accrual fee until balance is paid in full.

*All e-transfer payments for appointment fees must be received PRIOR to your scheduled appointment time. If this is your preferred method of payment, please discuss this with clinic staff at the time of booking.

FEE SCHEDULE

In Person, Telemedicine, and Phone Consultations	**Fee Amount**
Initial Consultation (50 minutes) *In Person or Telemedicine only*	$ 195.00
Extended Subsequent Consultation (up to 45 minutes)	$ 150.00
Subsequent Consultation (25 minutes)	$ 95.00
Mini Subsequent Consultation (10 minutes)	$ 65.00
Physical Consultation (25 minutes) *Existing patients only*	$ 105.00
Acupuncture (25 to 40 minutes) *Existing patients only*	$ 95.00
ACUTE Initial Consultation (up to 30 minutes) **At the doctor's discretion*	$ 105.00

In House Treatments and Lab Work *(in addition to consultation fee)*	**Fee Amount**
B12 Intramuscular Injection	$ 15.50
Glutathione Intravenous Injection, 1cc	$ 37.50
Glutathione, each additional 1cc	$ 8.15
In-House Urinalysis	$ 20.00
Myers Intravenous Push, 30cc	$ 65.00
Vega Electrodermal Screening (varies, call clinic for more information)	$ 50.00 - $ 140.00

LATE & MISSED APPOINTMENT CANCELLATION POLICY

Your appointment time is confirmed and reserved just for you! We understand unforeseeable emergencies do occur. If an appointment is missed or broken in less than 48-hours or no notice is given, we'll simply note it on your account and send you a reminder of the cancellation policy.

However, if a second missed appointment/late cancellation occurs, you will be subject to a cancellation fee equal to the cost of your scheduled appointment(s). Your account must be paid in full prior to booking further appointments, and our 2% per month monthly interest accrual fee will apply. Any subsequent missed appointment/late cancellations after this will result in immediate billing of the cancellation fee equal to the cost of your scheduled appointment(s) to the credit card on file. An invoice will be sent to you with a detailed explanation of the billed cancellation fees.

_____

Initials acknowledging *Cancellation Policy*

SUPPLEMENT RETURN POLICY

Unopened supplements that do not require refrigeration may be returned within 30 days of purchase. All opened and customized products are final sale, and no refunds or credits will be given. Custom products include but are not limited to botanical tinctures, creams, homeopathic remedies, botanical powders, and phenolics. You will be advised at the time of purchase if an item is final sale.

LABORATORY FEE RETURN POLICY

Uncompleted labs are eligible for in-house credit within 90 days of purchase, or a refund within 30 days of purchase. Patients must provide the original receipt and return the original lab requisition form(s) and lab kit(s) to the clinic for a credit to be issued.

Patients are responsible for following specimen collection instructions for at home tests. Please contact the clinic with any questions you may have prior to collection, as there are no credits or refunds for user error. Labs are non-transferable.

USE OF EMAIL CORRESPONDENCE

Our clinic offers patients the opportunity to communicate via email. Transmitting patient information poses several risks of which patients must be aware. Patients should not agree to communicate with the clinic staff via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- Security and privacy of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the identity of the sender or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the doctor or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in the cloud.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.

CONDITIONS OF USING EMAIL

Our clinic will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, our clinic and its doctors cannot guarantee the security and confidentiality of email communication and will not be liable for improper disclosure of confidential information that is not the direct result of intentional misconduct. Consent to the use of email includes agreement with the following conditions:

- While our clinic will endeavor to respond promptly to email correspondence, email should never be used for medical emergencies or other time-sensitive matters. We will strive to respond to email enquiries within 24 hours on regular business days. Our clinic will not initiate email correspondence to patients.
- Emails to or from the patient concerning laboratory results, supplement enquiries, and treatment will be printed in full and made part of the patient's medical record. Because they become part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
- As necessary, clinic staff may forward emails internally for healthcare operations, and other handling. The clinic will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Email communication is not an appropriate substitute for clinical visits, examinations, or treatment. The patient is responsible for scheduling appointments when required.

- If a patient's email invites a response from the doctor, a flat fee of $30 may apply. This fee is billed at the doctor's discretion and will be applied to your account and charged to the credit card on file.
- If a patient has not received a response within a reasonable time period it is the patient's responsibility to follow up to determine whether the intended recipient received the email.
- The clinic and its doctors are not responsible for information loss due to technical failures.
- It is the patient's responsibility to inform clinic staff of any changes to their contact information.

PATIENT CONSENT AND AGREEMENT

Naturopathic medicine is founded on the belief that the body has the innate ability to heal itself. Naturopathic doctors combine the wisdom of nature with the rigours of modern science. Naturopathic doctors look at more than symptoms; we seek to identify the underlying cause of the symptoms. Naturopathic doctors assess the whole person and consider the physical, mental, and emotional aspects of wellness and disease. Gentle, non-invasive techniques are often used to stimulate the body's ability to heal itself. The following are some of the approaches that may be used: physical examination and diagnostic assessment; ordering and interpreting labs; nutrition, diet, and lifestyle counselling; botanical medicine; homeopathy; professional quality supplement recommendations, and naturopathic physical manipulation.

Naturopathic doctors take a thorough case history, complete a screening and complaint oriented physical exam as needed, and may collect urine and/or blood samples for diagnostic purposes.

It is very important that you inform your naturopathic doctor of any existing health conditions and provide a complete list of medications and supplements, including all over-the-counter products you may be taking. Additionally, it is important to advise your naturopathic doctor if you are pregnant, suspect you may be pregnant, are planning to become pregnant, and/or are actively breastfeeding.

Some health risks associated with naturopathic medicine include, but are not limited to, aggravation of pre-existing symptoms, allergic reaction to supplements and/or herbs, and mild discomfort or bruising from acupuncture, intravenous, and/or intramuscular injections. Your naturopathic doctor will explain to you any risks of adverse effects and advise you, as well as answer any questions you may have, to the best of their knowledge and ability. Results are not guaranteed and differ from person to person.

As a patient, you must be aware that naturopathic treatment and conventional medical treatment are not mutually exclusive, and therefore, you are free to seek or continue medical care from a qualified medical doctor. You must communicate any intentions to discontinue any prescribed pharmacological agents (medications) to your medical doctor and your pharmacist.

By signing below, you agree with the following:

a. I hereby request and consent to services rendered, and treatment provided by the doctors at Althea Wellness Centre, Inc.
b. I recognize that they are board certified Naturopathic Doctors registered by the College of Naturopathic Physicians of British Columbia.
c. I have the right to consent or refuse any treatment that I am uncomfortable with.
d. The doctors have the right to treat me within the scope of their practice and the right to refuse treatment.
e. The doctors may make referrals to outside practitioners if they feel it may be beneficial to my health care goals.

_____ _____

Patient or Legal Guardian Signature Date (mmm/dd/yyyy)