Child Intake

Please complete this form and return to reception. Please print clearly.

Demographic Information

Name of Child: ______________________________ Date: ____________ (MM/DD/YYYY)

Child's Date of Birth: ______________________________ (MM/DD/YYYY) Gender: M F

Address: ______________________________ Apt/Unit #: ________

City: ________________ Province: ________________ Postal Code: ____________

Home: (____) ____________ Work: (____) ____________ Cell: (____) ____________

May we leave messages relating to your visits? Y N Which Number: ______________

Who is completing this form (name and relation)? ______________________________

Contact(s) Information in Order of Preference

Name: ______________________________ Relation: ____________

Address: ______________________________ Apt/Unit #: ________

City: ________________ Province: ________________ Postal Code: ____________

Home: (____) ____________ Work: (____) ____________ Cell: (____) ____________

Name: ______________________________ Relation: ____________

Address: ______________________________ Apt/Unit #: ________

City: ________________ Province: ________________ Postal Code: ____________

Home: (____) ____________ Work: (____) ____________ Cell: (____) ____________

How did you hear about us? ______________________________

Has your child ever consulted a complimentary health care practitioner? (please check all that apply)

Naturopathic Doctor Acupuncturist Homeopath Nutritionist Counsellor Dietician

Chinese Medicine Practitioner Other: ______________________________

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Other Health Care Providers that your child sees

Name: ______________________________________ Name: ______________________________________

Specialty: ___________________________________ Specialty: ___________________________________

Address: ____________________________________ Address: ____________________________________

Phone: (____)_________________________________ Phone: (____)_________________________________

What are your child's **health concerns**, **goals** and **expectations** for working with us? (in order of importance to you)

1.____

2.____

3.____

Medical History

Please indicate any **serious conditions**, **illnesses**, **injuries** and **hospitalizations** that your child has experienced (with dates):

1.____

2.____

3.____

Please list any **allergies** that your child has (medication, environmental, food, sensitivities):____________________________________

What screening tests has your child had (vision, hearing, blood, etc)? ____

Please list all current **medications** and **natural health products** (e.g. prescriptions, over the counters, vitamins, herbs, homeopathics)

Medications and Natural Health Products	Dose	Reason for Taking
___________________________________	___________	____________________
___________________________________	___________	____________________
___________________________________	___________	____________________
___________________________________	___________	____________________
___________________________________	___________	____________________

How many times has your child been treated with **antibiotics**? ____________________________________

Please indicate which immunizations your child has had:

- DPT (diphtheria, pertussis, tetanus)
- Haemophilus influenza B
- Hepatitis A
- Hepatitis B
- HPV
- Rotavirus
- Meningitis
- Pneumococcal
- MMR (measles, mumps, rubella)
- Polio
- Small pox
- Other: ________________

Please indicate if there were any adverse reactions: ____

Birth History

Term length (please circle): Full Premature: ____________ weeks Late: __________weeks

Weight at birth: ______________________________ Birthing method: Vaginal C-section Induced Forceps Vacuum

Any complications? ____

How was your child fed?

Breastfed, how long? __________________ Formula milk/soy/other: _________

Does your child have any dietary restrictions (vegetarian, religious, etc)? ____

Health and Development

At what age did your child first:

Sit up: ________________ Walk: _______________________

Crawl: ________________ Talk: ________________________

Describe your child's **sleep pattern**: ____

Describe your child's **temperament**: ____

Describe your child's **behaviour** and **performance at school**: ____

Environment

Is your child in: School Daycare Homecare Other: ________________

What are your child's favourite activities?

____

____

Does the child get regular activity? Y N If so, what is it, how much and how often?

____

____

How much screen time does your child get each day (TV, computer, tablet)? ____

How often does your child read (not for school) or have someone read to them? ____

Does anyone in the child's household smoke? Y N Do they smoke around the child? Y N

How would you describe the emotional climate of your child's home?

____

____

Has your child experienced any of the following?

		If yes, please explain:
General (Failure to Gain Weight, Fatigue, Night Terrors)	Y / N	
Eyes/Head (Vision Changes, Headache, Dizziness)	Y / N	
Ear/Nose/Throat (Hearing Loss, Sinus Problems, Infections)	Y / N	
Thorax (Irregular Heartbeats, Murmur, Wheezing, Coughing, Asthma)	Y / N	
GI (Heartburn, Diarrhea, Constipation, Vomiting, Abdominal Pain)	Y / N	
Urinary (Frequent or Painful Urination, Incontinence, Blood in Urine)	Y / N	
MSK (Arthritis, Swollen Joints, Cramps, Stiffness, Weakness)	Y / N	
Skin/Hair/Nails (Rashes, Excessive Dryness, Sores, Itching, Hair Loss)	Y / N	
Neurological (Numbness, Tingling, Weakness, Paralysis)	Y / N	
Psychiatric (Depression, Anxiety, Bipolar Disorder, Temper Tantrums)	Y / N	
Endocrine (Excessive Hunger, Thirst, or Sweating, Thyroid Problems)	Y / N	
Hematological/Lymphatic (Anemia, Bruising, Bleeding Problems)	Y / N	
Female (Breast Development; If started Menses: Heavy /Painful, PMS)	Y / N	
Male (Testicular Pain/Lump)	Y / N	
Other:	Y / N	

What potential obstacles do you foresee when adhering to a therapeutic protocol or achieving your child's goals?

____

____

Family History

Please indicate all known, diagnosed medical conditions, illnesses and surgeries of any of the following family members: mother, father, grandmother, grandfather, siblings Please indicate if it is a current condition or a condition in the past.

Family Member	**Diagnosis**

I do not know my child's family medical history

Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor (ND) will take a thorough case history, perform a physical examination, and if your case requires; the physical may include more specific examinations such as gynecological, breast, rectal, prostate or genital exams.

It is very important that you inform your ND immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your ND immediately if you are pregnant, suspect you are pregnant, or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

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

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your doctor of any allergies you may have.
- Pain, bruising, or injury from acupuncture or injection therapy.
- Fainting or puncturing of an organ with acupuncture needles.
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by the ND prior to manipulating the neck.

Your Naturopathic Doctor is trained to handle emergencies should the need arise.

I understand that:

- The clinic does not guarantee treatment results
- My ND will explain to me the exact nature of any treatment provided and will answer any questions I may have
- I am free to withdraw my consent and to discontinue treatment at any time

Date: ______________________________ (MM/DD/YYYY)

Patient Name (please print): ______________________________ Signature: _________________________

ND Name: _________________________________ Signature: _________________________ Lic#__________

Patient Consent for Collection, Use, and Disclosure of Personal Information

Privacy and protecting your personal information is important to us at New Roots Therapy. 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 appropriate use and protection of your information.

Our privacy policy outlines what New Roots Therapy and the ND do 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 existing legislation, and privacy protection protocols
- Our privacy protocols comply with privacy legislation and standards of the naturopathic professions regulatory body.

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

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To assess your health concerns, provide health care and advise you of treatment options
- To establish and maintain contact with you
- To remind you of upcoming appointments
- To allow us to efficiently follow-up for treatment
- To complete claims for insurance purposes
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts and follow up on billing as required
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

I have reviewed the above information that explains how New Roots Therapy and the ND will use my personal information, and the steps that New Roots Therapy and the ND are taking to protect my information.

I agree that New Roots Therapy can collect, use and disclose personal information about myself, ____ (print name) as set out above in the information about New Roots Therapy's privacy policies.

Patient Signature: ________________________Date: ____________________(MM/DD/YYYY)

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Cancellation Policy

When you schedule an appointment at New Roots Therapy, we commit to reserving the time slot for you and only you, and you commit to paying for the reservation of time. We require a credit card number at the time of scheduling your first appointment in order to reserve your time slot. Your credit card information will be stored securely in our PHIPA-compliant practice management system and will only be charged in the event of a late cancellation or if you do not show up for your scheduled appointment. In an effort to avoid late cancellations and missed sessions, New Roots Therapy provides appointment reminders via email and/or text message 48 hours before your scheduled appointment (provided with your consent). New Roots Therapy will notify you of any charges made to your card.

We understand that there may be times when you need to cancel or change your appointment. You will not be charged for the appointment if you provide New Roots Therapy with **a minimum of 24 hours' notice** for the cancellation/change. If you do not provide a minimum of 24 hours' notice, or do not show up for your scheduled appointment, you will be charged **the full rate** of your appointment. If you're unable to attend your appointment at the last minute as the result of a *crisis/emergency*, please speak with us; we will assess your situation to determine if an exception to the cancellation policy applies. In the case of an exception, your credit card will still be charged at the time of the late cancellation/missed session and a credit will be applied to your account for your next appointment.

By respecting the cancellation policy as outlined here, it allows other clients who may be awaiting service to schedule an appointment during the available time slot, providing fair and equal access to services for all our clients. It also allows your service provider to be compensated for the time they have reserved for you. This cancellation policy is intended to respect the time of both our clients' and our service providers' alike, which we sincerely value.

Please note that insurance providers do not cover late cancellations/missed appointments.

Late Arrivals

If you are running behind, we may not be able to overrun your scheduled appointment time, as there may be another client booked after you. In this case, the full amount of your initially scheduled appointment will be charged.

There may be times when your service provider is running behind. In this case, we will do our best to see you for the length of your initially scheduled appointment. If this is not possible, you will only be charged for the actual length of your appointment time.

By signing below, I indicate that I understand and agree with the above cancellation policy. I understand how my credit card information will be stored and used.

____________________________________	____________________________________
Client's Signature and Date	*Service Provider's Signature and Date*

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Email Communication Consent Form

I hereby acknowledge that I have requested the opportunity to communicate by email. I understand that in communicating in this manner, I am exposing myself to certain risks that may include:

- The privacy and security of email communication cannot be guaranteed
- Employers and online services may have a legal right to inspect and retain emails that pass through their systems
- It is impossible to verify the true 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 and potentially damage/disrupt the computer
- Email is indelible; even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or in cyberspace
- It is the policy of the ND to respond to emails within 1-2 business days. If the patient's email requires or invites a response from the ND and the patient has not received a response within 1-2 business days (with the exception of posted out-of-office notifications), it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond
- The patient is responsible for informing the ND and New Roots Therapy of any types of information the patient does not want sent via email

The ND and staff at New Roots Therapy will use reasonable means to protect the security and confidentiality of email information sent and received; however because of the risks just outlined, the ND and New Roots Therapy 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.

No new diagnosis will be communicated via email. Patients should not use email for medical emergencies or other time-sensitive matters. Email communication is not an appropriate substitute for clinical inquiry, examinations or a thorough assessment by the ND; it may be required that the patient's questions or concerns be addressed through an in office visit, which if required, will be communicated to the patient by the ND.

Patient Acknowledgment and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication by email between the ND and/or New Roots Therapy and myself. I consent to communicating by email with the ND and New Roots Therapy in spite of these risks.

Date: ____________________ (MM/DD/YYYY) Patient Email: ______________________________________

Patient Name (please print): _________________________________ Signature: _______________________

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