NORFOLK CHIROPRACTIC WELLNESS CENTRE

☐ **Dr. Katie Thomson Aitken BAS, ND**
☐ **Dr. Alaina Gair, B.Sc., ND**

86 Norfolk St., Guelph 519-827-0040

Naturopathic Intake Form (Child 0 – 13 years)

Contact Information

Child's Name: _____ Gender: _____ Birth Date (dd/mm/yy): _____
Address: _____ City: _____ Postal Code: _____
Parent/Guardian name(s): _____
Address (if different from Child's) _____ City: _____ Postal Code: _____
Phone – Home: ( ) _____ Work: ( ) _____ Ext.: _____ Cell: ( ) _____
Okay to leave a message? No / Yes (which number) **Email:** _____
May we email you regarding appointments and information that may be useful to you? Y / N
Siblings (Names and ages): _____
How was this child referred to our office? _____

Child's Other Health Care Practitioners (e.g. Family Doctor, Midwife, Pediatrician)

Name: _____ Profession: _____
Phone: ( ) _____ Fax: ( ) _____ Address: _____
Date of last visit: _____ Findings of concern? _____

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Phone: ( ) _____ Fax: ( ) _____ Address: _____
Date of last visit: _____ Findings of concern? _____

What is your child's chief health concern?

1. _____
   _____
   _____ Date of Onset: _____

Please list in order of importance any other health concerns that are troubling your child:

2. _____ Date of Onset: _____
   _____
3. _____ Date of Onset: _____
   _____
4. _____ Date of Onset: _____
   _____
5. _____ Date of Onset: _____
   _____

Have the above condition(s) been diagnosed by a health practitioner? Y / N If yes, when and by whom?

_____

Does your child receive an annual physical exam or well-child check-up? Y / N

How would you describe your child's current overall state of health? Excellent / Good / Fair / Poor

On a scale of 0 – 10 (10 being highest) what is your child's overall level of energy? _____

Child's Health History

Allergies: _____

Sensitivities: _____

Hospitalizations & Surgeries (reasons and dates): _____

_____

Please indicate whether your child has experienced any of the following conditions:

Allergies		Asthma		Bed wetting		Bladder infections	
Bloody urine		Body/breath odor		Bronchitis		Burning urine	
Chicken pox		Cold		Constipation		Cough	
Cradle cap		Croup		Diarrhea		Ear infections	
Easy bleeding		Easy bruising		Eczema		Emotional trauma	
Eye infections		Fatigue		Fever		Fractures	
Frequent urination		Fungal infections		Gas		Growing pains	
Hair loss		Hearing problems		Lice		Measles	
Meningitis		Mood changes		Mumps		Nausea	
Nervousness		Night sweats		Nose bleeds		Pneumonia	
Physical trauma		Rash		Rheumatic fever		Rubella	
Scarlet fever		Seizures		Sleeping problems		Sore throat	
Stomach flu		Strep throat		Tonsillitis		Unusual fears	
Vision problems		Vomiting		Coordination problems		Whooping cough	
Learning difficulties		Behaviour problems		Eating problems		Other	

If OTHER, please describe: _____

Is there any condition from which you feel your child has **never been well since**? _____

Medication & Supplement History

Taking CURRENTLY:	**Dose:**	**Reason for Use:**	**Dates of Use:**

Nutritional History

Was your child breastfed? Y / N If yes, for how long? _____
Any breastfeeding concerns? _____
Please outline your child's typical daily food intake:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Water intake: _____ Other fluids: _____

Family History

Relative:	**Age if Living:**	**Health Conditions:**	**Age at Death:**	**Cause of Death:**
Mom				
Dad				
Sister(s)				
Brother(s)				
Mom's mother				
Mom's father				
Dad's mother				
Dad's father				
Other blood relatives with notable health history (e.g. cancer, heart disease, stroke, mental illness, etc.)				
Relative:	**Age if Living:**	**Health Conditions:**	**Age at Death:**	**Cause of Death:**

Social History

How would you describe your child's temperament? _____
_____
How does your child interact with other children? _____
With adults? _____
Please indicate any emotional traumas your child has experienced: _____
_____

How does your child handle stress? _____
_____
How does your child express his or her emotions? _____
_____
How is your child's performance in school? _____
_____
Have any behavioral or learning problems been noted? _____
_____
What are your child's favorite activities? _____
_____
How much physical activity does your child get? _____
_____
Which countries outside of Canada has your child travelled to? _____
_____
Is there anything else you feel may be important to your child's health? _____
_____
_____
_____

Thank you,

Dr. Katie Thomson Aitken BAS, ND
Dr. Alaina Gair B.Sc., ND

NORFOLK CHIROPRACTIC
WELLNESS CENTRE

INFORMED CONSENT TO TREATMENT

Please note that this form must be signed in our office PRIOR to the rendering of any treatment or service. At any time during the course of your naturopathic care you may discuss with your Naturopathic Doctor (ND) any questions or concerns that you may have regarding your treatment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors are regulated primary care providers who assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. The gentlest and most non-invasive techniques available are generally used in order to stimulate the body's inherent healing capacity and achieve health care goals.

Your practitioner will take a thorough case history, perform a relevant physical examination and may order blood or urine testing. If required, the physical exam may include more specific examinations such as gynecological, breast, rectal or genital exam.

It is very important to inform your Naturopathic Doctor immediately of any illness from which you or your child are/is suffering and any medications or over-the-counter drugs that you or your child are/is taking. As a patient, or parent of your child who is a patient, you will receive information about diagnosis and/or treatment, alternative courses of action, expected benefits, risks, side effects, costs and 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 and temporary.

Some individuals may experience allergic reactions to supplements and herbs. Please advise your ND of any known or suspected allergies.

Acupuncture treatment may be associated with pain, bruising around the insertion site; fainting; or puncturing of an organ with acupuncture needles. Your ND is trained to handle emergencies should the need arise.

I, (print name) _____ confirm that I have read, understood and agree:

- That treatment results cannot be guaranteed
- That I am free to withdraw my consent in full or in part, and to discontinue treatment at any time.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- That I have read and understood the Fee Schedule and Cancellation Policy and I agree to take responsibility for the fees incurred in treatment.

_____ _____

Parent/Guardian Signature Date

NORFOLK CHIROPRACTIC
WELLNESS CENTRE

PRIVACY POLICY

Privacy of personal information is important at Norfolk Chiropractic Wellness Centre (hereafter: "the clinic"). In providing you with quality Naturopathic Care, we are committed to the responsible collection, use and disclosure of your personal information in accordance with current regulations *(Personal Health Information Protection act (PHIPA), Ontario 2004).*

Your personal information will be collected and used for the following purposes:

- ✓ To assess your health concerns
- ✓ To provide health care
- ✓ To advise you of treatment options
- ✓ To establish and maintain contact with you
- ✓ To send you newsletters and other information mailings
- ✓ To remind you of upcoming appointments
- ✓ To communicate with other treating healthcare 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
- ✓ Disclosure: 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
- ✓ To use for educational and research purposes (this includes case summaries, photographs, lab results and other pertinent medical information)

Your identity will be protected at all times and, where required, identifying information will be altered to protect your privacy in all the above instances. In the event that your file with us becomes inactive, your personal information will be retained securely for a period of 10 years after your last visit, at which time it will be destroyed.

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

CONSENT TO COLLECTION AND USE OF PERSONAL INFORMATION:

I, (print name) _____, have reviewed the above information and agree that my practitioner and the clinic can collect, use and disclose my personal information for the purposes outlined in this privacy policy, as described above.

_____ _____

Parent/Guardian Signature Date