# WELCOME TO OUR HEALTH CLINIC

KINGSTON INTEGRATED HEALTHCARE INC.

## We're glad you're here!

THANK YOU for taking time to explore our clinic and your healthcare options. We're passionate about our work and look forward to working with you over the coming months!

**HEALTH CANADA** estimates that more than half of all Canadians use some form of integrative medicine. Integrative medicine combines the strengths of multiple medical perspectives and perceives the person as a whole, integrated unit.

People request our services for a variety of reasons:

- Disease management, prevention, or education
- Chronic pain or disability
- Drug or surgery alternatives
- Desire to improve quality of life
- Physical, mental, or emotional, concerns

We help the body restore optimal function by addressing underlying causes of illness for effective, long-lasting results.

Current information about our services and workshops is offered in our e-newsletter which you may sign up for on our website. Our team members share unique health articles here in what we hope you'll find to be a fun and educational resource worth sharing.

Please take your time when completing the following new patient forms. They are an important initial step toward defining your healthcare needs and achieving your health goals.

**We're a team of health professionals offering expertise in complementary, alternative, and integrative medicine.**

- Naturopathic Medicine
- Physiotherapy
- Massage Therapy
- Osteopathy
- Acupuncture
- Counselling
- Holistic Nutrition
- Reiki and Bioenergy
- Homeopathy
- Medical testing
- Community Workshops

With your permission, your KIHC health practitioner may consult other clinic professionals or refer you for co-care.

**All practitioners offer complimentary 15 minute introductory appointments** to help you find the right professionals for your personal healthcare team.

Naturopathic Medicine (Pediatric)
541 Palace Road Kingston, Ontario K7L 4T6
613.547.KIHC (5442) ● www.kihc.ca

# PEDIATRIC INTAKE FORM (UP TO 12 YEARS)

*Every detail you provide on this form will remain confidential and will contribute to achieving your child's health goals. Where possible, we ask that the child's primary caregiver fill out this form.*

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Child's name: ______________________ Height: __________ Weight: __________

Age: _________ Date of birth: ______________________ Gender: ______________________

Child's address: ____________________________________________

____________________________________________ Postal Code: ____________________

Home Tel: ________________ Please indicate your relationship to the child: ____________________

**PARENT/GUARDIAN CONTACT INFORMATION**

Name: ____________________________________________

Address: ____________________________________________

Home Tel: ___________________ Work Tel: __________________ Email: ________________________

What is the best way for us to contact you? ____________________________________________

May we leave telephone messages at home or work? ____________________________________________

Would you like to receive our clinic email newsletter? ____________________________________________

How did you hear about this naturopathic medical practice? ____________________________________________

Emergency contact information:

Name: ____________________________ Relationship: __________________ Tel: _________________

Please circle the name of the Naturopathic Doctor you are seeking healthcare services from:

Dr. Sonya Nobbe Dr. Angela Hunt Dr. Oscar Hernandez

Please list all other practitioners on your child's healthcare team (e.g. medical doctor, dentist, etc.):

| 1. | 2. | 3. |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |
| (   ) ____________ | (   ) ____________ | (   ) ____________ |

Please list your primary concerns about your child, in order of importance:

1. ____________________________________________ Date of onset: __________________
2. ____________________________________________ Date of onset: __________________
3. ____________________________________________ Date of onset: __________________

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## MEDICAL HISTORY

Please list your child's hospitalizations, surgeries, traumas or major illnesses:

1. ______________________ Date started: __________ Date Resolved: __________
2. ______________________ Date started: __________ Date Resolved: __________
3. ______________________ Date started: __________ Date Resolved: __________
4. ______________________ Date started: __________ Date Resolved: __________

Do you believe that any of these experiences still negatively influence your child's life:

Please indicate which of the following immunizations was received **and *when*:**

O DTP: ______________ O Hep A: ______________ O Pneumococcal: __________
O Polio: ______________ O MMR: ______________ O Meningococcal: __________
O Hib: ______________ O Varicella: ______________ O Influenza (flu): __________
O Hep B: ______________ O HPV: ______________ O Other:

Please describe any complications or reactions to the immunizations: ______________________

______________________________________________________________

Please list any allergies, sensitivities, or adverse reactions your child may have (e.g. to medications, food, scents): ______________________________________________

______________________________________________________________

Please list any medications or supplements (e.g. vitamins, herbs) your child is **currently taking**:

1. ____________________ Date started: ________ Dose: ________ Time of day: ______
2. ____________________ Date started: ________ Dose: ________ Time of day: ______
3. ____________________ Date started: ________ Dose: ________ Time of day: ______
4. ____________________ Date started: ________ Dose: ________ Time of day: ______

Please list any medications or supplements your child has taken **in the past**:

1. __________________________ Date started: __________ Completed: __________
2. __________________________ Date started: __________ Completed: __________
3. __________________________ Date started: __________ Completed: __________
4. __________________________ Date started: __________ Completed: __________

Approximately how many times has your child been treated with antibiotics? ______________

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**Prenatal History**

Were there any complications during the pregnancy (e.g. nausea and vomiting, high blood pressure, gestational diabetes)? ____________________________________________

____________________________________________

What medications (including supplements, herbs, recreational drugs or alcohol) did the birth mother take during pregnancy?

1. ______________________ Dose: __________ Reason: ____________________
2. ______________________ Dose: __________ Reason: ____________________
3. ______________________ Dose: __________ Reason: ____________________

Did the birth mother experience any illness, traumas, or hospitalizations during her pregnancy?

1. ____________________________________ Date of onset: ______________
2. ____________________________________ Date of onset: ______________

**Natal History**

Your child's delivery was (please circle): Vaginal C-section Induced Early Late

Your child was delivered at (please circle): Home Hospital Other

Were there any complications during labour and/or delivery? Please describe: ______________

____________________________________________

____________________________________________

Please indicate your child's weight at birth: ________________ Length: ______________

**Breastfeeding History**

How long was your child breastfed? ____________________________________________

At what age were solid foods introduced? ____________________________________________

Did any complications occur with the introduction of solid foods? ____________________

**Developmental History**

Please describe any concerns you have about your child's behaviour or development: __________

____________________________________________

____________________________________________

At what age did your child experience the following milestones:

Lift his/her head alone: ______________ Develop his/her first tooth: ______________

Roll over: ______________ Walk (with hand held): ______________

Crawl: ______________ Speak his/her first word: ______________

## Lifestyle

Please describe a typical day's diet:

Breakfast: ____________________

Lunch:____________________

Dinner: ____________________

Snacks: ____________________

Beverages: ____________________

Please describe what forms of exercise your child participates in, and how often:

____________________

____________________

____________________

How many hours does your child sleep each night? ____________________

How many times does he/she wake up in the middle of the night? ____________________

How often does he/she experience nightmares? ____________________

Please give a brief description of your child's daily routine (e.g. do they attend daycare, public school, wake/sleep schedule etc.):

____________________

____________________

____________________

____________________

Where has your child traveled to outside of this country? ____________________

What (if any) pets reside in the child's home? ____________________

## Environment

Was or is your child *ever* regularly exposed to any of the following (please circle)?

Tobacco smoke Chemicals/toxins Radiation Well water

Please describe:____________________

Has your child or child's birth mother **ever** been exposed to a constant source of heavy metals or environmental contaminants (e.g.stained glass making, farming, **manufacturing**)?____________________

____________________

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## EMOTIONAL HEALTH

*Your child's home environment plays a significant role in their health and well-being. Please answer the following questions regarding your home and family situation. Your answers will remain confidential.*

Has your child suffered any emotional trauma (e.g. divorce, death, moving homes)? ____________

______________________________________________________________________

Is there any alcohol or drug use in your child's home? ________________________________

Have you ever felt sad or depressed for two weeks or more at a time in the past year? Yes No

Do you feel that your home is a safe place for your child? ____________________________

## FAMILY HISTORY

Please indicate whether the following health conditions **pertain to anyone in your child's family**:

| Condition | Relative | Age of Onset | Details |
|---|---|---|---|
| Heart problems or stroke (e.g. high blood pressure) | | | |
| Lung problems (e.g. asthma) | | | |
| Nervous system problems (e.g. seizures) | | | |
| Digestion problems (e.g. lactose intolerance) | | | |
| Allergies (moderate/severe) | | | |
| Skin problems | | | |
| Cancer | | | |
| Autoimmune disease (e.g. Type I Diabetes, lupus, Crohn's disease) | | | |
| Mental illness (e.g. depression) | | | |
| Difficulties with drugs and/or alcohol | | | |
| Other: (e.g. birth defect, Lyme disease, bleeding disorder) | | | |

Is there anything else you would like to include on this form? ______________________

______________________________________________________________________

*Thank you.*

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# INFORMED CONSENT FOR TREATMENT

Naturopathic Medicine is a distinct system of primary care that addresses the whole body and underlying cause of illness. It promotes health by assisting the body's own healing mechanisms according to current medical research and time-tested healing knowledge. Naturopathic doctors integrate standard medical diagnostics with a broad range of natural therapies, including botanicals (herbs), acupuncture, clinical nutrition, counseling, and homeopathy. They work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your child's first naturopathic appointment will generally last 30 to 60 minutes and may include a physical exam and referral for laboratory tests. (For young children, please bring another care-giver with you to watch your child during the latter part of the appointment.) Follow-up appointments may range from 15 to 60 minutes each, according to your child's individual health requirements. The first consultation fee is $150 and does not include the cost of laboratory testing or prescription items. OHIP does not cover the fees of a naturopathic doctor, however many extended healthcare providers do. Services offered by Naturopathic Doctors are exempt from HST.

## STATEMENT OF ACKNOWLEDGEMENT

As the parent or legal guardian of ____________________________, I, ____________________________, understand that the form of medical care is based on naturopathic principles and practices. I will inform my Naturopathic Doctor of all health concerns, medications and medical interventions, including over-the-counter drugs and supplements because safe care requires that I truthfully and completely disclose this information.

As the parent or legal guardian of ______________________________, I understand that I am entitled to know about my child's diagnosis and treatment, including the costs, benefits, risks and potential side-effects. I am entitled to know consequences of *not* accepting treatment and of alternative courses of action. I am encouraged to request more information as needed, and to take an active role in my child's care. I am always at liberty to seek or continue care from another qualified healthcare provider.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, and bruising or injury from acupuncture.

I understand that the Naturopathic Doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at any time. I accept full responsibility for any fees incurred during care and treatment, **including a 50% late cancellation fee if providing less than 24 hours' notice for cancelling appointments**.

| ______________________________ | ______________________________ |
|---|---|
| FULL NAME OF PATIENT | DATE |
| ______________________________ | ______________________________ |
| SIGNATURE OF PARENT OR LEGAL GUARDIAN | WITNESS |

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## CONSENT FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Health privacy for you and your child is a primary concern for us. The personal health information you disclose to your Naturopathic Doctor will be handled in accordance with current privacy legislation and standards determined by the regulatory body, the College of Naturopaths of Ontario. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your Naturopathic Doctor, employees, and health practitioners of 541 Palace Road will collect, use, and disclose information about you and your child for the following purposes:

- To assess your child's health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you and your child;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Employees and health practitioners of 541 Palace Road will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. Staff members and practitioners will collect, use, and disclose your personal health information accordingly to protect your privacy and the confidentiality of your information.

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I have reviewed the above information and authorize ___________________________, Doctor of Naturopathic Medicine, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information and that of my child, as outlined above. I acknowledge that I have the legal authority to do this on behalf of my child.

| ____________________________________ | ____________________________________ |
|---|---|
| NAME | DATE |
| ____________________________________ | ____________________________________ |
| SIGNATURE | WITNESS |