Pinewood Natural Health Centre

220 Duncan Mill Road, Unit 110, Toronto ON M3B 3J5 **416.656.8100**
1295 Wharf Street, Unit 11, Pickering ON L1W 1A2 **905.427.0057**

Naturopathic Pediatric Intake Form

To be completed by Parent or Guardian

Date _____

Name _____ _____ Age ____ Date of Birth _____
First Last dd / mm / yyyy

Address _____ City _____ Postal Code _____

Phone: (Home) _____ Gender ❑ Male ❑Female

Name of parent /guardian _____ _____
First Last

Address _____ City _____ Postal Code _____
(if different from child)

Phone: (Home) _____ (Work) _____ (Cell) _____

Email _____

Medical doctor or referral _____

Found out about clinic by: ❑ family ❑ friend/coworker ❑ internet ❑ practitioner ❑ other

MAJOR COMPLAINT(S) List in order of importance:

_____

_____

_____

_____

_____

Please relate any relevant history to the major complaint(s):

_____

_____

_____

PAST HISTORY

Family History (check the appropriate boxes if present in family):

- ❑ allergies
- ❑ cancer
- ❑ hypertension
- ❑ arthritis
- ❑ diabetes
- ❑ mental illness
- ❑ birth defects
- ❑ heart disease
- ❑ tuberculosis
- ❑ syphilis
- ❑ rheumatism
- ❑ goiter
- ❑ Alzheimer's disease
- ❑ kidney disease
- ❑ stomach or gastro-intestinal disorders

A. Please fill in the following family table:

Family Member	**Living (L) or Dead (D)**	**Age at Death**	**Cause of Death**
Grandmother (maternal)			
Grandfather (maternal)			
Grandmother (paternal)			
Grandfather (paternal)			
Father			
Mother			
Brother 1			
Brother 2			
Sister 1			
Sister 2			

Does mother or father have a chronic disease? If so, please fill in details below:

Mother	**Father**

B. Ante-natal History (before birth period)

Age of mother at child's birth: _____

Mother's health at conception: ❑ Poor ❑ Fair ❑ Good ❑ Excellent
Father's health at conception: ❑ Poor ❑ Fair ❑ Good ❑ Excellent

If poor, why: _____
_____

Was pregnancy planned? ❑ Yes ❑ No

Birth order of child (e.g. eldest or youngest): _____

Number of pregnancies: _____

Number of live births: _____

Mother's health during pregnancy (please check appropriate box):

- ❑ bleeding
- ❑ hypertension
- ❑ diabetes
- ❑ cigarette/alcohol/drug consumption. If so, quantity per day _____
- ❑ illnesses
- ❑ thyroid problems
- ❑ physical or emotional trauma
- ❑ medications (prescribed AND over the counter) _____
  _____

How was the diet over pregnancy? ❑ Poor ❑ Fair ❑ Good ❑ Excellent

Supplements taken during pregnancy: _____
_____

C. Birth History:

Term: ❑ Full ❑ Premature ❑ Late Number of weeks of pregnancy _____
Weight at birth: _____ kg _____lb
Length of labour _____ hours
Please check: ❑ vaginal birth ❑ Cesarean birth (reason) _____
Complications: _____ Resolved? ❑ Yes ❑ No

Was the mother ill at labor with other disease?

- ❑ genital herpes
- ❑ diabetes
- ❑ hypertension
- ❑ other sexually transmitted disease (specify) _____
- ❑ other disease (specify) _____

Were there any significant findings at birth?

- ❑ congenital disease. What? _____
- ❑ birth injuries. Specify _____
- ❑ blue baby syndrome
- ❑ jaundice/icterus
- ❑ physical malformations or birth defects What? _____
- ❑ low birth weight _____ kg/lb
- ❑ Others (specify) _____

How was your overall feeling about the whole pregnancy and childbirth experience?

❑ poor ❑ fair ❑ good ❑ excellent

Why? _____
_____

D. Post-Natal History:

Immunizations (check ones that child has had)

- ❑ measles, mumps, rubella
- ❑ polio
- ❑ influenza
- ❑ smallpox
- ❑ hepatitis
- ❑ tuberculosis
- ❑ diphtheria, pertussis, tetanus

Was there any severe reaction to any of the above immunizations? If so, please circle the entire word and give description below:

_____

_____

**Please supply a copy of the immunization records to the clinic.

Childhood Illnesses (check all illnesses child has had):

- ❑ chickenpox
- ❑ mumps
- ❑ tonsillitis
- ❑ scarlet fever
- ❑ rubella
- ❑ ear infection
- ❑ pneumonia
- ❑ rheumatic fever
- ❑ allergies
- ❑ measles
- ❑ strep throat
- ❑ impetigo
- ❑ mononucleosis
- ❑ frequent colds
- ❑ seizures
- ❑ rashes
- ❑ colic
- ❑ whooping cough/pertussis
- ❑ others _____

How many times has your child been treated with antibiotics? _____ times

If you know the names of these antibiotics, please list them and the length of time the child took them for. Please include in this list all other medical prescriptions and medical conditions up the present time.

Antibiotic or drug name	Illness	Number of times with condition	Duration (in days)	Adverse reaction?

E. Diet of Child

Post-natal diet for first year:

- ❑ breast fed How long? _____ months
- ❑ formula Specify type _____
- ❑ cow's milk
- ❑ soy milk
- ❑ nut milk Specify type _____

First liquid introduced (besides water) when weaned from breast feeding: _____
Age began solid foods _____

List the foods and age when solids were introduced into the child's diet within the first 12 months of life:

Solid food	Month introduced	Allergic reaction?

Please write out the child's diet in a typical present day. Include all snacks and fluids:

Breakfast	Lunch	Dinner	Vitamins/Medications

Food allergies/intolerances? ❑ Yes ❑ No If yes, name the food allergen and how it was diagnosed.

Food allergen	**Age discovered and year discovered**	**Test used to diagnose**

F. Environment of Child

Was your child's **physical** development:

❑ slower than average
❑ average
❑ faster than average

Was your child's **mental** development:\

❑ slower than average
❑ average
❑ faster than average

How is the child's behaviour and performance in school/home?

_____

_____

Child's natural parents:

❑ married
❑ divorced
❑ common law
❑ remarried
❑ separated

What is the emotional climate of the child's home presently?

❑ very stable ❑ stable ❑ stressful ❑ very stressful

Does child sleep by him/herself? ❑ Yes ❑ No

What was the child's sleep patterns like?

_____

_____

Does any member in the house take the following recreational drugs? Check ones that apply:

❑ smoking
❑ alcohol
❑ marijuana
❑ other, specify _____

Do you live near any high tension electrical wires: ❑ Yes ❑ No
If yes, please indicate the distance these wires are from your house: _____ meters/feet

What form of heating do you use?

❑ oil ❑ electricity ❑ gas

Do you have any of the following inside the house? Check where present:

❑ air conditioner ❑ wood stove ❑ electric stove ❑ central heating
❑ gas stove ❑ air purifier ❑ humidifier ❑ fireplace

Do you live near any of the following?

❑ industrial plant Specify _____
❑ commercial business (e.g. nurseries, labs) Specify _____
❑ dump sites Specify _____
❑ non-residential property (e.g. highways, hospitals) Specify _____

Have you acquired or done the following chores in your house? Check where applicable:

❑ new furniture
❑ new carpet
❑ refinished furniture
❑ remodeling your home
❑ weatherizing the home
❑ pesticides and herbicide use on garden,
❑ home and pets
❑ new car
❑ house deodorant spray
❑ colognes or perfumes
❑ potpourri
❑ plants
❑ flowers

How old is the house? _____

Describe the general area of your house. For example, rural and near the water/stream, etc

_____

_____

General activities/hobby of child during day. Include all activities:

Activity	**Time**	**Location**

Source of drinking water _____

Please list the products/brand that you use on the child:

1. soap _____
2. shampoo _____
3. bubble bath _____
4. body lotion _____
5. talcum powder _____
6. diapers _____
7. clothing _____
8. hair products _____
9. others. Specify _____

Temperature of child's bath water _____

Is the child chilly, medium or hot all the time? _____

What kind of toys does the child play with? List the main ones:

Toy	**Description**	**Share with others?**	**Age of toy**

If there is anything that is missed by this intake form and that you think is relevant to the case of the child, please fill in this space:

Thank you for filling out this intake form. The information you provided will help us greatly in the recommendation of holistic treatment of the child.

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STATEMENT OF ACKNOWLEDGEMENT AND CONSENT TO EXAMINATION AND TREATMENT

N.B. This form must be signed before any treatment will be rendered.

Patient Name: _____ _____ Date of Birth: _____
First Name Last Name dd / mm / yyyy

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Phone: _____

Naturopathic medicine uses non-invasive methods of assessing the bodily functions and the use of natural therapeutics for correction. The methods used at this clinic include the use of FUNCTIONAL BIOMETRY, such as German electro-acupuncture feedback techniques and aid in assessment with structural, nutritional, electromagnetic and lifestyle techniques as therapeutic methods.

The current health care system in Ontario is under scrutiny. In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your cooperation in signing this statement of acknowledgement, in so doing:

1. That you understand that I am a Naturopathic Doctor, and not a conventional medical doctor; that I use non-invasive, natural methods of assessment and treatment of body dysfunctions. That any treatment you receive is not mutually exclusive from any treatment or advise you may now be receiving or may receive in the future from another licensed health care provider.

2. That you understand that methods that I may use have a proven clinical foundation, yet may not be accepted by standard (allopathic) medicine.

3. That you understand that I am required by my licensing board to perform a physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is deemed acceptable.

4. That you understand that treatment and/or referral to other health practitioners is based on the assessment of your health, revealed through personal history, physical examination, laboratory testing and other appropriate methods of evaluation, including electromagnetic evaluation. Note that you may be requested to see other Naturopathic Doctors at Pinewood to provide diagnostic and treatment strategies as deemed necessary or appropriate by your primary Naturopathic Doctor. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

5. That you understand I reserve the right to determine which cases fall outside my scope of practice, in which event the appropriate referral will be recommended.

6. That you are not an agent of any private or government agency attempting to gather information without so stating your intentions.

7. That while changes in dietary habits are not an absolute prerequisite for treatment, that you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.

8. That you are accepting or rejecting this care of your own free will.

9. That the supplements/products sold to you through our dispensary are for your personal use only and are to be taken according to the instructions outlined on the Prescription/Recommendation Form I provide to you at your consultations.

   The supplements/products are available through our dispensary as a convenience to you. You may choose to purchase the supplements/products elsewhere being diligent to purchase the correct formula/dose that I have prescribed/recommended.

10. That you understand that the ultimate responsibility for your health care is your own, and that I am here to support you in this. I reserve the right to discontinue my services where it is apparent that your expectations and what I can provide are not in agreement.

11. That you understand that all fees for services and supplements/products are payable at the time of the appointment/purchase by the patient or the guardian. If you arrange to have Pinewood mail your supplements/products to you (in Canada only) you will be billed for the postage/shipping fees and acknowledge you are financially responsible for this cost. **That there is a fee for completing insurance forms, letter writing and telephone consultations of greater than 10 minutes. Notice of 24 hours is required for appointment cancellations, otherwise you will be charged an administrative fee of $35.00.** Any special financial arrangements may be made clear in advance and documented in your chart.

I, _____ have read and understood and acknowledge the above statements.
(print first and last name)

_____ Date: _____
Signature of patient or Guardian or Lawful Representative

❑ This consent was discussed and any questions or concerns have been addressed.

_____
Primary ND's Signature or Intake ND's Signature

Rev. June 1/18

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Privacy Information Consent Form

For Collection, Use and Disclosure of Personal Information

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, the Privacy Information Officer is:

Michael Rahman N.D.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

In this consent form, we have outlined what our office is doing 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 protocols;
- our privacy protocols comply with privacy legislation, standards of our regulatory body and the law.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

How Our Office Collects, Uses and Discloses patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined below how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services
- To communicate with other treating health-care providers, including specialists and referring doctors
- To allow us to maintain communication and contact with you to distribute healthcare information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes on an anonymous basis
- To complete and submit claims for third party adjudication and payment

- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act
- To comply with agreements/undertakings entered into voluntarily by the member with governing bodies, including the delivery and/or review of patients' charts and records in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to evaluate the practice.
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the office's insurance carrier to enable the insurance company to assess liability and quantify damages, if any
- To prepare materials for the Health Professions Appeal and Review Board (HPARB).
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirement
- To comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Your information may be accessed by regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and the process.

Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office has a Privacy Code, and I can ask to see the code at any time.

I agree that Pinewood Natural Health Centre can collect, use and disclose personal information about

_____ as set out above in the information about the office's privacy policies.
(Patient's name – please print)

_____ Date: _____
Signature of patient or Guardian or Lawful Representative.

☐ This consent was discussed and any questions or concerns have been addressed.

_____
Primary ND's Signature or Intake ND's Signature

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Privacy Information Sheet

How to Access the Privacy Process in Our Office

Privacy of your personal information is an essential part of our office providing you with quality care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open and transparent as possible about the way we handle your information.

Our privacy information officer can be reached at:

Pinewood Natural Health Centre
220 Duncan Mill Road, Unit 110
Toronto, ON
M3B 3J5
416 656-8100 (tel)
416 656-8107 (fax)
email: toronto@pinewoodhealth.ca

Our privacy information officer will attempt to answer any questions or concerns that may arise. If you have a concern and/or wish to make a complaint to us about our privacy practices, including asking questions about the contents of your charts or records, you must make your request in writing. Please send it to our office's Privacy Information Officer by surface mail, fax, or email.

Our Privacy Information Officer will promptly acknowledge receipt of your complaint in writing, and will ensure that it is investigated thoroughly. You will be provided with a formal decision in writing, and the reason for the decision. If you are dissatisfied with the decision, you may seek further information from the Privacy Commissioner of Canada. We have included all the necessary contact information listed below.

Postal Address:
Privacy Commissioner of Canada
112 Kent Street
Ottawa, ON K1A 1H3

General Inquiries:
Phone: 613-995-8210
Toll Free: 1-800-282-1376
Fax: 613-947-6850

Our privacy policies and procedures comply with federal legislation called the Personal Information Protection and Electronic Documents Act (PIPEDA). This very complex law does provide some exceptions to the privacy principles that are too detailed to outline here. Our privacy code sets out this office's commitment to protecting your private health and personal information. It is available on request by asking any of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality care.

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INFORMED CONSENT TO NATUROPATHIC DIAGNOSTIC PROCEDURES

Patient Name: _____ _____ Date of Birth: _____
First Name Last Name dd / mm / yyyy

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Phone: _____

Name of Primary ND or Intake ND: _____

Recommended Diagnostic Procedure(s)

During initial and subsequent visits:

- Physical examination, including vitals testing
- Electrodermal testing
- Urinary analysis

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic procedure(s) and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the diagnostic procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily confirm my informed consent for the recommended diagnostic procedure(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

_____ _____
Patient or Guardian or Lawful Representative Signature Date Signed (dd / mm / yyyy)

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Phone: _____

_____ _____ _____
Witness Signature* *Witness signature is advised but not necessary Witness Relation to Patient

❑ This consent was discussed and any questions or concerns have been addressed.

_____
Signature of Naturopathic Doctor / Clinical Assistant performing the diagnostic procedure(s)

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INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

Patient Name: _____ _____ Date of Birth: _____
First Name Last Name dd / mm / yyyy

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Phone: _____

Name of Primary ND or Intake ND: _____

Recommended Therapeutic Procedure(s) / Plan:
(including those by referral to another Pinewood practitioner)

During initial visit and subsequent visits:
- Nutritional/Botanical/Homeopathic supplementation
- Diet and Lifestyle modification
- Medical education

During subsequent visits:
- Presso therapy
- Ionized Oxygen therapy
- Acupuncture

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic procedure(s)/plan and have discussed to my satisfaction this and any requests for related information with the naturopathic doctor named above and/or with his/her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of, and understand the therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me.

As a result, I do hereby voluntarily consent/my informed consent for the recommended therapeutic procedure(s)/plan as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

_____ _____
Patient or Guardian or Lawful Representative Signature Date Signed (dd / mm / yyyy)

Address: _____ City/Town: _____

Province: _____ Postal Code: _____ Phone: _____

_____ _____ _____
Witness Signature* *Witness signature is advised but not necessary Witness Relation to Patient

☐ This consent was discussed and any questions or concerns have been addressed.

_____
Signature of Naturopathic Doctor / Clinical Assistant performing the diagnostic procedure(s)