PINEWOOD NATURAL HEALTH CENTRE

220 Duncan Mill Road, Unit 110
Toronto, Ontario M3B 3J5
(416) 656-8100

1295 Wharf Street, Unit 11
Pickering, Ontario L1W 1A2
(905) 427-0057

PEDIATRIC INTAKE FORM

To be completed by Parent or Guardian

Date: _____

Name of Child: _____
Age: _____ Sex: M F
Date of Birth: _____
Address: _____
_____
_____
Phone: _____

Name of parent/guardian: _____
Address (if different from child):
_____
_____
_____
Phone (home): _____
Phone (work): _____
E-mail: _____
Pinewood Online Newsletter is available by email. □ Yes, I would like to receive a copy.
Occupation: _____

Medical doctor or referral _____

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

Please fill in the following family table:

Family Member	Living (L) or Dead (D)	Age of 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 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
__ medications (prescribed AND over the counter) _____
_____
__ diabetes
__ cigarette/alcohol/drug consumption. If so, quantity per day _____
__ illnesses
__ thyroid problems
__ physical or emotional trauma

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 __ physical malformations or birth defects
__ jaundice/icterus __ 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 __ smallpox __ diphtheria, pertussis tetanus
__ polio __ hepatitis
__ influenza __ tuberculosis

Where 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 ones that 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?

Diet of Child

Post-natal diet for first year:
__ breast fed. How long? _____ months
__ formula. Specify _____
__ cow's milk
__ soya milk
__ nut milk

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? If so, name them and where it was diagnosed from:

Food allergen	Age discovered and year discovered	Test used to diagnose

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
__ others 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 holistic treatment of the child with your help.

Statement of Acknowledgement and Consent to Treatment

THIS FORM MUST BE SIGNED BEFORE ANY TREATMENT WILL BE RENDERED

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. 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 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.

10. That you understand that all fees, for services and supplements are payable at the time of the appointment by the patient or the guardian. **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 cancellation, otherwise you will be charged an administrative fee of $35.00.** Any special financial arrangements may be made clear in advance.

I, _____ have read and understood and acknowledge the above statements.

_____ Date: _____

Signature of patient or guardian.

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

Primary ND's Signature

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)

Signature _____

Print Name _____

Date _____ Witness _____

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: pinewood@rogers.com

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.

INFORMED CONSENT TO NATUROPATHIC DIAGNOSTIC PROCEDURES

Patient Name_____

Address_____ Phone No._____

City/Town_____ Attending N.D._____

Province_____ Assistant_____

Recommended Diagnostic Procedure(s):

(including those by referral to another Pinewood practitioner)

During initial visit:

- Physical examination
- Electrodermal Testing

Subsequent visits, if recommended

- BTA(Biological Terrain Assessment) and/or
- Microscopy and/or
- Thermography and/or
- Hair Analysis and/or
- Blood Testing and/or
- Heart Rate Variability

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 consent/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 Lawful Representative Signature Date Signed

_____ _____

Witness Signature* Witness Relation to Patient

Address_____ _____

City/Town_____ Phone No.

Province_____ _____

Postal Code_____ Attending N.D./Assistant

*Witness signature is advised but not necessary

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

_____ Primary ND's Signature

INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES

Patient Name_____

Address_____ Phone No._____

City/Town_____ Attending N.D._____

Province_____ Assistant_____

Recommended Therapeutic Procedure(s) / Plan:

(including those by referral to another Pinewood practitioner)

During initial visit: Subsequent visits, if recommended

- Nutritional/Botanical/Homeopathic supplementation and/or
- Diet and Lifestyle modification

Subsequent visits, if recommended:

- Ion cleanse, Sauna, Presso Therapy, Magnetic Field Therapy, Ionized Oxygen Therapy, Pulsation Therapy, Accupuncture.

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 Lawful Representative Signature Date Signed

_____ _____

Witness Signature* Witness Relation to Patient

Address_____ _____

City/Town_____ Phone No.

Province_____ _____

Postal Code_____ Attending N.D./Assistant

*Witness signature is advised but not necessary

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

_____ Primary ND's Signature