Welcome to our health facility.

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 that includes a physical, emotional, spiritual, social, and environmental component. Much of this philosophy came to the West as "Alternative" medicine and is now part of a broader, encompassing movement that includes mainstream medical science.

WE'RE QUALITY-OF-LIFE EXPERTS. Our integrative team of ten health professionals offers a variety of services designed to treat the whole person, whether for the short or long-term. Our patients request our services for a variety of reasons, including chronic pain or disease management, disease prevention, and drug or surgery alternatives. We work *with* the body's intrinsic healing ability to address underlying causes of illness and produce effective, long-lasting results. We take the time to help you understand your state of health and treat it safely.

DEVELOP A PERSONAL HEALTHCARE TEAM THAT SUPPORTS YOUR HEALTH PHILOSOPHY. With your permission, your KIHC health practitioner may consult other clinic professionals or refer you for co-care. However, you are welcome to explore the variety of healthcare services available here without a referral. ***All of our practitioners offer complimentary 15 minute introductory appointments*** to help you find the right professionals for your personal healthcare team. Our multi-disciplinary team includes Naturopathic Doctors, Registered Massage Therapists, Osteopathic Manual Practitioners, a Reiki and Brennan Healing Science practitioner, and Psychotherapist. We also have an on-site medical laboratory, IV therapy room, acupuncture room, and workshop space for meditation, Qi gong classes, and health-specific education classes.

Up-to-date information about our services and educational workshops is offered in our free email newsletter which you may sign up for on our website, www.kihc.ca, or with our receptionists. Our team members write and share relevant health articles here in what we hope you'll find to be a fun and educational resource worth sharing.

Thank you for taking the time to complete the following new patient forms. They are an important step toward defining your healthcare needs and achieving your health goals.

Sincerely,

Kingston Integrated Healthcare Team

Explore your healthcare options… and discover your best self.

Kingston Integrated Healthcare
541 Palace Road, Kingston, ON K7L 4T6
613.547.KIHC • www.KIHC.ca

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Naturopathic Medicine (Pediatric)
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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.

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? _____

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

Dr. Sonya Nobbe Dr. Christina Vlahopoulos Dr. Gerann Murphy Dr. Holly WhiteKnight

How did you hear about this naturopathic medical practice? _____

Please list all other healthcare practitioners caring for your child:

1. _____ 2. _____

_____ _____

_____ _____

( ) _____ ( ) _____

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

1._____ Date of onset: _____

2._____ Date of onset: _____

3._____ Date of onset: _____

4._____ Date of onset: _____

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MEDICAL HISTORY

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

1._____ Date of onset: _____

2._____ Date of onset: _____

3._____ Date of onset: _____

4._____ Date of onset: _____

5._____ Date of onset: _____

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

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 or sensitivities 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: _____
2. _____ Date started: _____ Dose: _____
3. _____ Date started: _____ Dose: _____
4. _____ Date started: _____ Dose: _____
5. _____ Date started: _____ Dose: _____

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

1. _____ Dose:_____ Start: _____ Finish:_____
2. _____ Dose:_____ Start: _____ Finish:_____
3. _____ Dose:_____ Start: _____ Finish:_____
4. _____ Dose:_____ Start: _____ Finish:_____
5. _____ Dose:_____ Start: _____ Finish:_____

On average, how many times a year is the child on 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 mother take during pregnancy?

1. _____ Dose:_____ Reason: _____
2. _____ Dose:_____ Reason: _____
3. _____ Dose:_____ Reason: _____
4. _____ Dose:_____ Reason: _____

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

1._____ Date of onset: _____
2._____ Date of onset: _____
3._____ Date of onset: _____

What prenatal tests were performed during pregnancy (e.g. ultrasound, amniocentesis)?

1. _____
2. _____
3. _____

NATAL HISTORY

Your baby's delivery was (please circle): Vaginal C-section Induced Early Late
Your baby 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? _____
Did any complications occur during this time? _____
At what age were solid foods introduced? _____
Did any complications occur with the introduction of solid foods? _____

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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 home? _____

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FAMILY HEALTH HISTORY

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

Condition	Relative	Age of Onset	Details
Heart or blood problems			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			
Digestion problems (e.g. Celiac disease)			
Allergies (moderate/severe)			
Skin problems			
Cancer			
Concerns about weight			
Mental illness (e.g. depression)			
Learning difficulties			
Difficulties with drugs and/or alcohol			
Other			

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)?

_____

_____

_____

Does anyone is the child's home or place of regular attendance smoke? _____
Is there any alcohol or drug use in the 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? _____

Thank you.

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INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

Naturopathic Medicine is a distinct system of primary care that addresses the whole body and root cause of illness and disease. It promotes health by assisting the body's own healing mechanisms according to current medical research and ancient healing knowledge. Naturopathic doctors integrate standard medical diagnostics with a broad range of natural therapies, including botanicals (herbs), acupuncture, medical 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 $140 and does *not* include the cost of laboratory testing or prescription items. Follow-up consult fees are prorated at approximately $140 per hour. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare providers do.

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 for my child 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

You and your child's health privacy is a primary concern and the personal health information you disclose to your Naturopathic Doctor during your appointments will be handled in accordance with current privacy legislation and standards determined by the naturopathic regulatory body, the Board of Directors of Drugless Therapy – Naturopathy. 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.

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 as outlined above.

_____ _____
NAME DATE

_____ _____
SIGNATURE WITNESS