
SURNAME

FIRST NAME

DATE

DOB: MONTH

DAY

YEAR

EMAIL:

(TO RECEIVE OUR NEWSLETTER)

HOME ADDRESS

CITY

PROVINCE

POSTAL CODE

(_____) _____
HOME PHONE

(_____) _____
WORK PHONE

(_____) _____
CELL

Which number is best to reach you in person during the day? (Circle one) HOME / WORK / CELL

Which contact number is best to remind you of your appointment? (Circle) HOME / WORK / CELL

FAMILY PHYSICIAN NAME

ADDRESS

(_____) _____

TELEPHONE

Did your Doctor refer you for treatment for this problem / injury? Yes / No

If **yes** which one....

Physiotherapy

Massage Therapy

Osteopathy

Other: _____

HOW DID YOU HEAR ABOUT US?

Referred by Physician or Practitioner (name): _____

Yellow Pages

Internet

PhysioPlus Health Group Website

Building Signage

Return Patient

Newspaper Ad

Fitness Club/Gym

Running Club

Other: _____

Friend/Family member (name): _____

The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information, please feel free to ask. Your written permission is required to release any information, unless required by law.

PRIMARY REASON FOR FIRST VISIT

DESCRIBE YOUR GENERAL HEALTH

ARE YOU RECEIVING TREATMENT FROM OTHER HEALTH CARE PROFESSIONALS? YES / NO (Please Explain)

PEDIATRIC NATUROPATHIC INTAKE FORM

Patient Name: _____

Date: _____

Parent/Guardian: _____

Relation to Patient: _____

CHILD'S MEDICAL HISTORY

MEDICAL:

- Please describe any past concerns

- Please describe any hospitalizations / surgery/ current and past medications

IMMUNIZATION:

(Please ✓ those received)

- | | | | | |
|--------------------------------------|---------------------------------------|---------------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Pneumococcal | <input type="checkbox"/> Hemophilus B | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Influenza | | | | |

ALLERGENS:

(Please ✓ all that apply)

- past experiences:
 eczema hives wheezing asthma stuffy nose (constant cold)

- Please describe any known allergies (i.e. to medications, injections, food, etc.)

CONDITIONS/ILLNESSES: Please (✓) and if "Yes", detail in space provided

	No	Yes	Details
Chicken pox?			
Measles?			
Mumps?			
Whooping cough?			
Rubella?			
Convulsions?			
Jaundice?			
Infections (eg. Pneumonia)?			
Rashes?			
Diarrhea/constipation?			
Colic?			
Eczema?			
Dental caries?			
Anemia?			
Adequate weight gain?			
Poor feeding?			
Discharges?			
Growing pains?			
Bloody nose?			
Broken bones?			
Congenital abnormalities?			
Motion sickness?			
Ear infections?			
Frequent colds?			
Respiratory distress?			
Household pets?			
Sensitivities (foods, light, etc.)?			

FAMILY

	Age	General Health	Specific Disease
Mother			
Father			
Siblings			
Grandparents			

MOTHER: PRENATAL

Difficulties: (Please ✓ those experienced)

- | | | |
|---|---|---|
| <input type="checkbox"/> gestational diabetes | <input type="checkbox"/> thyroid conditions | <input type="checkbox"/> nausea/vomiting |
| <input type="checkbox"/> emotional trauma | <input type="checkbox"/> physical trauma | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> toxemia | <input type="checkbox"/> bleeding | <input type="checkbox"/> nutritional deficiencies |
| <input type="checkbox"/> weight gain | <input type="checkbox"/> stress | <input type="checkbox"/> infections |

At time of conception

Mother's Age: _____ Health: _____
 Father's Age: _____ Health: _____

Mother's Exposure: Please (✓) and if "Yes", detail in space provided

	No	Yes	Detail
Alcohol			
Drugs (recreational/smoking)			
Medications/Supplements			
Toxins			
Diseases			

Travel during your pregnancy? Yes / No (If yes, describe: _____)

Work during your pregnancy? Yes / No (If yes, detail: _____)

Have any of your children died? Yes / No

BIRTH

Did baby deliver on time? Yes / No (If "No", how early or late? _____)

Delivery method? Hospital / Other (explain): _____

Any interventions? pain medications / epidural / forceps / vacuum / pitocin
 other: _____

Length of Labour: _____ Spontaneous? Induced? Caesarean?

Birth weight (lbs.): _____ Length: _____ Head circumference: _____ Apgar Score: _____

Number of pregnancies? _____ Number of Miscarriages? _____

Please describe any post-partum state/incidents?

Detail any problems child had during delivery (breathing, etc.):

FEEDING

Breast-fed? Yes / No How long? _____ On demand? Yes / No

Formula used? Yes / No If yes, when introduced? _____
 Exclusive or with supplementation? (please ✓)
 Type of formula used: _____

Introduced to solid foods? Yes / No If yes, what & when? _____

When was cow's milk introduced? _____

List foods excluded from diet: _____

BEHAVIOUR & EMOTIONAL HISTORY

At school: Performance anxiety / separation anxiety
 other: _____

At home: (Please describe the following)

- relationship with friends, family, siblings:
- potty training:
- interests/activities:

Please ✓ any of the following that your child has:

- | | | | |
|--------------------------------------|---|---|---|
| <input type="checkbox"/> nail biting | <input type="checkbox"/> thumbsucking | <input type="checkbox"/> nightmares | <input type="checkbox"/> bad temper |
| <input type="checkbox"/> fears | <input type="checkbox"/> irritability | <input type="checkbox"/> wets bed | <input type="checkbox"/> speech problems |
| <input type="checkbox"/> jealousy | <input type="checkbox"/> can't toilet train | <input type="checkbox"/> breath holding | <input type="checkbox"/> self abuse <input type="checkbox"/> habits |

MILESTONE AGES

Sitting: _____ Walking: _____ Talking: _____
 Rolling over: _____ First tooth: _____ Dressed self: _____

Is there anything that you feel is important that had not been covered?



Consent Form for Collection, Use and Disclosure of Personal Information

The Naturopathic Doctor, as named above, understands the importance of protecting your personal information and is committed to collecting, using, and disclosing your personal information responsibly. The Doctor will try to be as open and transparent as possible about the way your personal information is handled.

The privacy policy adheres to the Personal Health and Information Protection Act 2004 (PHIPA), and outlines what the Doctor is doing to ensure that:

- Only necessary information is collected about you;
- She only shares your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

The Naturopathic Doctor will collect, use and disclose information about you 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 remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up treatment, care and billing
- To assist your insurance company and completing claims
- To comply with the legal and regulatory requirements of your regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners Act*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply generally with the law
- To allow potential purchasers, practice brokers, or advisors to conduct an audit in preparation for a practice sale

I have reviewed the above information and I agree that Dr. Christine Dychangco N.D. can collect use and/or disclose personal information about _____ as set out above in the information regarding the privacy policy. (Patient Name)

Patient or Guardian Name

Patient or Guardian Signature

Date

Witness Signature

