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 2418 Lakeshore Road West
 Oakville, ON L6L 1H7

Pediatric Naturopathic Medicine

Patient Information (please print clearly)

Name: _____ Date of Birth: mm/dd/yyyy ____/____/____ Age: ____

Mothers Name: _____ Fathers Name: _____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (B) _____ (M) _____

Email: _____

Occupation: _____ Please select: Male Female

Where did you find our number? _____ If online, what site referred you? _____

HEALTH HISTORY

Other health care providers you are seeing

	Name	Specialty	Telephone Number
1.			
2.			
3.			

What are your main health concerns, in order of importance to you?

- _____
- _____
- _____

MEDICATIONS

Please indicate: **NOW** if currently using, **PAST** if previously used OR **Skip** if it has never been administered

	NOW	PAST		NOW	PAST
Asprin	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Tylenol	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamine	<input type="checkbox"/>	<input type="checkbox"/>
Decongestants	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>	Please indicate: _____		

MEDICAL HISTORY

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Tonsillitis - # of times: _____ |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Ear infections - # of times: _____ |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Other - Please list: _____ |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Rheumatic Fever | |

Has your child ever had any of the following tests? When? What were results?

Electroencephalogram _____

Psychological evaluation _____

Hearing _____

Speech Loss _____

Injuries/Surgeries/Hospitalizations: (please indicate): _____

IMMUNIZATIONS

- Measles Polio MMR Small Pox Diphtheria
- Mumps DPT Tetanus Influenza

FAMILY HISTORY

- Heart Disease Diabetes Birth Defects
- Hypertension Arthritis Tuberculosis
- Cancer Allergies Mental Illness

PRENATAL HISTORY

Previous pregnancies by natural mother
 Number of live births?: _____ Miscarriages?: _____
 Any complications? (Please explain) _____
 Mother's age at child's birth: _____
 Mother's health during pregnancy:
 Bleeding Physical or emotional trauma Cigarette smoking
 Nausea Thyroid problems Alcohol consumption
 Illness Diabetes Medications: _____

BIRTH HISTORY

Number of weeks pregnancy _____ Birth Weight: _____
 Length of labor: _____ Complications: _____
 Did your child have any of the following after birth?
 Birth Defects Birth Injuries Blue Baby
 Cerebral Palsy Seizures Jaundice
 Colic Fever Rashes
 Other: (please explain) _____

 Child's sleep patterns for the first year: _____

 Food intolerances (if any): _____

Feeding
 Breast Fed: How long? _____ Formula: How long? _____ Type: Milk Soy
 Age began solid foods: _____ What type? _____
 Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS

*Please indicate: **NOW** if currently using, **PAST** if previously used OR **Skip** if it has never been administered*

	NOW	PAST		NOW	PAST		NOW	PAST
Hives	<input type="checkbox"/>	<input type="checkbox"/>	Burning of urine	<input type="checkbox"/>	<input type="checkbox"/>	Bloody urine	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Cries easily	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Nervous	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting spells	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>
Acne	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
High fevers	<input type="checkbox"/>	<input type="checkbox"/>	Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive to light	<input type="checkbox"/>	<input type="checkbox"/>
Chronic rash	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Body/breath odor	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>	Motion/car sickness	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Flat feet	<input type="checkbox"/>	<input type="checkbox"/>	No appetite	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Nightmare	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Gas	<input type="checkbox"/>	<input type="checkbox"/>	Canker sore	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Unusual fears	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Joint pains	<input type="checkbox"/>	<input type="checkbox"/>	Excessive fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>

DIET

Please describe your child's average diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drink: _____

CONSENT TO TREATMENT & FEE POLICY

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, including physical, mental and emotional aspects of the individual. Gentle techniques are used to stimulate the body's inherent healing capacity and correct any imbalances. Your visit may consist of a thorough case history and a screening physical examination, including breast examination for females. If your case requires, the physical examination may include more specific examinations such as rectal or genital exams. After collecting the necessary information, diagnosis, treatment and/or referral to other health care professional are made based upon the assessment of conditions revealed.

It is important that we are informed of any diseases that you are suffering from and if you are on any medication or over-the-counter drugs. If you are pregnant, suspect you are pregnant or you are breastfeeding, please let us know.

There are some light health risks to treatment by naturopathic medicine. These include but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising or injury from acupuncture. Results are not guaranteed and not all risks and complications can be anticipated.

Payment is made at the time of visit:

- \$25 fee for NSF cheques
- Rescheduling fee of \$45.00 applies to any appointment changes with less than 24 hours notice.
- Supplements and products are individually priced. Patients are not required to purchase the recommended supplements in their treatment protocol from this office and are free to choose where they are purchased.

Your identity will be protected at all times and a record will be kept of the health services provided. Patients may look at their medical record at any time and can request a copy by paying the appropriate fee. The information from medical records may be analyzed for research purposes and all identities will be protected and kept confidential.

CONSENT REGARDING PERSONAL INFORMATION

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

At this office, Samantha S. Ristimaki ND acts as the Privacy Information Officer. All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the protection and appropriate use of your information.

Our privacy policy outlines what our clinic 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 the existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Drugless Therapy – Naturopathy.

Please turn over...

HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENTS PERSONAL INFORMATION

To help you understand how we protect your personal information, we have outlines here how our clinic is using and disclosing your information:

- To assess your health concerns.
- To provide health care.
- To advise you of treatment options.
- To establish & maintain contact with you.
- To send newsletters and other information mailings.
- To remind you of upcoming appointments.
- To communicate with other treating health-care providers.
- To allow us to efficiently follow-up for treatment, care and billing.
- To complete claims for insurance purposes.
- To comply with legal and regulatory requirements of our regulatory body, the Board 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 assist this clinic to comply with all regulatory requirements.
- To comply generally with the law.
- To allow potential purchasers, practice brokers or advisors to conduct and audit in preparation for practice sale.

By signing the consent section of this Patient Consent Form, you have agreed that you have given informed consent to the collection, use and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I _____, (patient name) agree that Samantha S. Ristimaki ND may collect use and disclose personal information as set out above regarding the clinic’s privacy policy. I also consent to diagnosis and therapeutic procedures for the entire course of treatment for my present condition(s), and understand that I am free to withdraw consent and to discontinue participation in these procedures at any time. I have read, fully understood and agree to the outlined fees and policies, and understand that the fees may change without prior notice.

Signature _____ Date: _____

Guardian Signature (patients under age 16): _____

Witness Signature: _____

Thank you for taking time to complete this form.