Integral Health Clinic

Naturopathy and Homeopathy Client Agreement and Intake Form

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CHILD INTAKE FORM
Confidential
Please complete this form about the health of your child.

Child's Name: _____ Date:_____

Age of child:_____ Date of birth d/m/y: _____Gender: M F

Contact Information
Name of Parent(s)/Guardian(s): _____
Address: _____
_____
_____
Preferred phone number for contact: _____
Email: _____
Person to be contacted in Case of Emergency: _____Relationship: _____
Please indicate if the emergency contact information is different than above:
_____
_____
Child's Primary Care Physician/Pediatrician:_____
Other Health Care Providers:_____
_____
_____
Other health care regimes the child is currently following: _____
_____
_____

Health Concerns
Please briefly outline the child's health concerns (in order of importance):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Medical History
Childhood illnesses: please indicate which illness(es) or condition(s) your child has had by using a **N** if (s)he has the condition now, **P** if (s)he had it in the past and **B** for both now and in the past

___Measles	___Herpes	___Frequent Infections
___Mumps	___Bed Wetting	___Anxiety
___Strep Throat	___Indigestion/Gas	___Influenza
___Chicken Pox	___Mononucleosis	___Frequent Runny Nose
___Cough	___Headaches	___Dizziness
___Wheezing	___Pneumonia	___Colitis
___Hives/Rashes	___Recurrent Ear Infections	___Scarlet Fever
___Diarrhea	___Jaundice	___Bladder Infection
___Constipation	___Colic or irritability	___Rubella (German Measles)
___Whooping cough	___Eczema	___Insect hypersensitivity

___Impetigo ___Abdominal pain ___Diarrhea
___Anal itching ___Excess thirst ___Itchy scalp
___Dark Urine/Blood in Urine ___Seizures ___Fainting
___Aching joints or muscles

Please list any complications that resulted from any of the above illnesses:_____
_____
Does the child suffer from any serious or chronic illness? _____
_____

Please indicate any injuries, hospitalizations or surgeries (please add dates, reasons, and complications):
_____
_____
_____
_____

How many times a year does the child suffer from the following?:
Ear Infections:_____ Strep Throat:_____ Colds:_____

Does the child have any allergies (medications, supplements, contact agents, foods, environment, etc.)?:_____
_____
_____

Vaccinations (please check)

Vaccination	✓	**Age received**	**Reaction to vaccine?**
Hepatitis B (HBV)	_____	_____	_____
Measles/Mumps/Rubella (MMR)	_____	_____	_____
Injected/Oral Polio (IPV/OPV/TOPV)	_____	_____	_____
Diptheria/Tetanus/Pertussis (DTP)	_____	_____	_____
Chicken Pox (Varivax)	_____	_____	_____
Haemophilus influenza B (HiB/HbCV)	_____	_____	_____
Pneumococcal	_____	_____	_____
Flu shot	_____	_____	_____
Meningitis	_____	_____	_____
Prevnar (pneumonia)	_____	_____	_____
Other:	_____	_____	_____

Medications
Please indicate which medication(s) the child is now using or has used in the past:

	now	past	frequency	types used/notes
Pain/Fever Medication	____	____	_____	_____
Antibiotics (include approx. # of rounds)	____	____	_____	_____
Decongestants	____	____	_____	_____
Other _____	____	____	_____	_____
_____	____	____	_____	_____

Please list all vitamins, herbs, homeopathic, or other supplements currently being taken (or has been taken with some frequency in the past): _____
_____
_____
_____

Prenatal History

Were there any genetic concerns before/during pregnancy?: Y/N _____
How would you describe the health of the parents at conception?: _____
_____
_____

How would you describe the health of the mom during pregnancy (physical/emotional stress)?:
_____
_____
Did the mother suffer any traumas during pregnancy?: _____
_____
Was there an excess intake of any certain food during pregnancy? _____
_____
_____
Please list exposure to any of the following substances during pregnancy - drugs, alcohol, smoke, second-hand smoke:
_____
Please list the supplements and/or medications the mother was taking during pregnancy:
_____
_____
_____

Labour and Delivery

Was the birth pre-term or post-date pregnancy? _____
Were there any complications of labour (placenta previa, breech, hypotension, etc.)? _____
_____
Type of delivery (vaginal, caesarean; breech, vertex): _____
Was an epidural used?: Y/N
Was there any need for resuscitation of the child? Y/N
Was the baby discharged with the mother? Y/N
Did the child experience any of the following at or shortly after birth?
___Jaundice ___Rashes ___Seizures ___Birth Injuries
___Other: _____

Developmental History

Have there been any developmental delays? _____
_____

Have there been any periods of rapid weight gain or weight loss? _____
_____

Milestone	Age	Milestone	Age
Supports self in standing position	_____	Toilet trained	_____
Weaned off breast milk	_____	Ties shoes	_____
First Tooth	_____	Dresses without help	_____
Crawls	_____	Hits Puberty	_____
First word (besides mama, dada)	_____	First menstruation	_____
Walks	_____		_____

Nutrition and Lifestyle

Was/is the child breastfed? Y/N For how long?
_____
Was the child fed formula? Y/N Type (milk, soy, other):_____

At what age was the formula was introduced?: _____
Were/is there any feeding difficulties? _____
Did the child ever have any difficulty gaining weight? Y/N
What foods were introduced before 6 months? _____
_____
What foods were introduced between 6-12 months? _____
_____
_____
Did the child react to any of the new foods introduced?_____
_____
Are there any nutritional restrictions (due to ethnicity, ethics, religion, etc.)?
_____
If applicable, please indicate the child's frequency and intake of the following substances:
Pop:_____ Water:_____ Caffeine (incl. Chocolate)_____

Typical diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages:_____

What is the sleeping pattern of the child? Are there any difficulties sleeping?_____
_____

How regularly does the child get exercise?_____
_____

Are there any toxins or other hazards to which the child is regularly exposed?_____
_____

Family Health History
Please indicate the conditions the child's family members (immediate or otherwise) have experienced.

Condition	Relation	Condition	Relation
Allergies		Liver disease	
Anxiety		Lung disease	
Arthritis		Nervous system disorder	
Asthma		Pneumonia	
Cancer		Skin disease	
Depression		Stroke	
Diabetes		Substance abuse	
Epilepsy		Syphilis	
Gonorrhea		Tuberculosis	
Gout		Other:	
Heart disease			
High Blood Pressure			
Inflammatory Bowel Disease			
Kidney disease			

Social History

Day care/school grade of the child: _____

Has the child been assessed or diagnosed with any learning disabilities?_____

_____

How would you describe the child's performance at school?:_____

_____

Please comment on the child's behaviour and personal experience at school (has it been positive, negative): _____

_____

Does the child have any notable fears, anxieties, or worries? _____

_____

Home Environment

Marital status of parents: _____

How many siblings are there at home? _____

How would you describe the emotional climate of the child's home? Is there any stress in the household?

_____

_____

Is the child exposed to smoke?: Y/N

Are there pets in the household?: Y/N Type(s):_____

How is the home heated? _____

_____

Travel History

Has the child ever travelled abroad to any other countries? To where and for how long? _____

_____

_____

Did the child suffer from any illnesses during or immediately after? _____

_____

If there is anything else you would like to add that has not already been covered, please outline it below:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Client Agreements: Please read and sign (Parent or Guardian to sign if client is under Age 18):

I understand that the services offered by Integral health Clinic are not covered by the provincial government; however, some of the services may be covered by private insurance plans or be tax deductible. It is the responsibility of the client to verify with their Insurance provider of their coverage for services offered at Integral Health Clinic.

2. The fees and services have been clarified in advance. I have verified them with the receptionist or my practitioner. **Payment is due prior to, or at the end of each visit. The clinic does not bill insurance companies directly.** Cash, cheque, interac, Master Card and Visa (no other credit cards) are acceptable payment methods. Interest will be charged to overdue accounts.

3. I understand that natural health care is a joint responsibility between myself (the client) and the practitioner. Improving my lifestyle can be as important as remedies and treatments.

4. My health records may be used in research providing that my name is not revealed. At all other times, my health records will be held in strictest confidence.

5. I realize that the services offered by the Integral Health Clinic are not an isolated system and that our practitioners welcome teamwork with Medical Doctors, Chiropractors and other Health Practitioners.

6. The decision to discontinue prescription drugs or any other prescribed medical treatment is my responsibility. If I forgo standard medical treatment in favour of natural healing, I assume responsibility for any potential risk that may entail. Integral Health Clinic practitioners will explain procedures, probable outcomes and possible risks in advance.

7. For Homeopathic and Naturopathic consultations I am aware that **appointments that run over the scheduled time may be charged the difference in 15 minute increments.**

□ I have read and understand the above terms.

8. Video Recording
I am informed that the consultations will be video recorded for the strict personal use of the Doctor and if at any time my information is going to be used for any research or teaching purposes, my permission will be requested first.

□ I have read and understand the above terms.

Date: _____ □ I do not wish to be video recorded.

9. Integral Health Clinic Cancellation Policy
We try to provide exceptional service to our clients. To help us achieve this we ask that you provide us with **at least 48 hours notice if you need to reschedule or cancel your appointment.** This enables us to make your time slot available to others who may need to see us, and to be able to maintain our consultation fees at the present rate. Appointments missed or cancelled without 48 hours notice inconvenience us and other clients, and we reserve the right to charge you for the appointment if we cannot allocate the time reserved for you to another client. Even though we try our best to send you a reminder by phone or via email, it is ultimately your responsibility to remember your scheduled appointments. We will be there for you at the time reserved for you; we hope you can be there too.

□ I am aware of the Cancellation Policy. I have read and understand the above terms.

10. Accuracy of Information
□ I certify that the above medical information is correct to my knowledge.

11. Privacy and Sharing of Information
I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial

treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

□ I agree.

Signature (client or guardian):_____

Date: _____