

Introduction Letter

Thank you for choosing the **Naturopathic Clinic** to help you with your child's medical needs. We are here to help in any way possible. If you have any questions, please feel free to ask.

We are enclosing a new patient information packet, which contains required and provided information regarding:

- 1) Pediatric Intake forms and Health History,
- 2) Patient Payment Responsibility,
- 3) Acknowledgment of Receipt of Notice of Privacy Practices and Consent to Treatment,

All of these forms need to be filled out as completely as possible.

If the forms are not filled out completely we will ask you to finish them before you see your doctor. This may take up some of the appointment time reserved for you.

Please give 24 hours notice to cancel an appointment. There is a \$25.00 missed appointment fee.

If you have any questions please feel free to contact the office during our office hours.

We also ask that you please not wear any perfume or strong smelling lotions.

Thank you.

In Health,

Dr. Ana G. Lara N.D.

SUCCESSFUL HEALTH AND PREVENTIVE MEDICINE ARE ONLY POSSIBLE WHEN THE DOCTOR HAS A COMPLETE UNDERSTANDING OF THE PATIENT PHYSICALLY, MENTALLY AND EMOTIONALLY. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE. PRINT ALL INFORMATION AND MARK ANYTHING YOU DON'T UNDERSTAND WITH A QUESTION MARK.

Pediatric Intake Form

Please fill out the form below as detailed as possible

Date of 1st Appointment: / /
dd mm yy

Name (of child):

(Last)

(First)

(Middle)

Name of parent(s) or guardian(s):

(Last)

(First)

(Middle)

Date of Birth (of child): / / Sex: M F
dd mm yy

Address:

(Street # / P.O. Box)

(Apartment #)

(City)

(Province)

(Postal Code)

(Home Phone)

(Work Phone)

(Fax)

(Cell Phone/e-mail address)

When was your child's last physical? _____
(Month) (Year)

Who is your child's physician? _____
(Name) (City)

Is your child under the care of any specialists? Yes No

Is your child receiving any other form of health care? Yes No

What are your child's main health concerns? (Please list all major health concerns in order of importance)

Concern	How long has this been a concern	Possible cause(s)

Medical History

What medications or supplements is your child currently taking or has taken within the last six months (include all prescriptions, vitamins, minerals and over the counter products – ex. Children’s Tylenol®)

Medication/Supplement	How long has your child been taking this	Has your child had any reaction to this product

How many times has your child been on antibiotics?

Less than 5x Less than 10x More than 10x

List any major injuries or surgeries your child has experienced:

Injury/ Surgery	Year or Age	Any noted long term effects?

How would you describe your child’s general state of health?

Excellent Good Fair Poor

Which of the following has your child ever had? (Please check box on right-hand side for all that apply)

Abscesses	Diabetes	Kidney Disease	Psoriasis	Sunstroke	
Allergies	Frequent ear infections	Leukemia	Rheumatic Fever	Thyroid Disease	
Anemia	Emphysema	Measles	Roseola	Tonsillitis	
Asthma	Epilepsy	Migraines	Rubella (German Measles)	Tuberculosis	
Bronchitis	Headaches (recurring)	Mononucleosis	Scarlet Fever	Typhoid	
Cancer	Heart Disease	Mumps	Sexual Abuse	Whooping Cough	
Chicken Pox	Hepatitis	Parasites	Skin Disease	Warts	
Cold Sores	High Blood Pressure	Pleurisy	Sinusitis	Worms	
Constipation (chronic)	Influenza	Pneumonia	Strep Throat	Yellow Fever	

Birth History

Not known (adoption)

Term length: Full Premature How many days? ____ Late How many days? ____

Length of labour? _____ Weight at birth? _____

Any complications? _____

Was the birth: Vaginal C-Section

Did your child experience (or was diagnosed with) any of the following shortly after birth?

Jaundice

Seizures

Birth defects

Rashes

Birth injuries

Genetic disorder

Diet

Was your infant breast fed? Yes No How long was your infant breast fed? _____

Did formula used to feed your infant? Yes No

What type of formula was your infant fed? _____

What foods were introduced before 6 months? (Please list approximate month as well)

What foods were introduced between 6-12 months? (Please list approximate month as well)

Did your child ever experience colic? Yes No

If Yes, was it: Mild Moderate or Severe

Does your child have any dietary restrictions? _____

Describe a typical day's diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (please include total quantity): _____

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Naturopathic Clinic 

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Has your child ever craved or eaten any odd foods or objects? _____

How are your child's bowel movements & how frequent are they? _____

Health and Development

At what age did your child first?

Sit up _____ Crawl _____ Walk _____ Talk _____

How many hours does your child sleep? _____

What time does your child go to sleep? _____ PM

What time does your child wake up? _____ AM

Does your child have night terrors/ nightmares? _____

How would you describe your child's temperament? _____

How would you describe your child's behaviour and performance at school? _____

Has your child experienced any psychological, mental or emotional traumas? Yes No

Informed Consent

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include: diet, nutritional supplements, botanical medicine, homeopathy, Asian medicine and acupuncture, hydrotherapy, physical medicine, and lifestyle counselling.

Individual diet and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, increased gastrointestinal function, improved immunity, and general well-being.

Botanical medicine is a plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars – that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal, or mineral origins are used to *stimulate the body's ability to heal itself*. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

Physical medicine refers to the use of hands-on techniques such as soft tissue, and spinal manipulation for the purpose of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental and emotional environment.

During your initial visits, your Naturopathic Doctor will take a thorough case history, do a physical examination, and when indicated require blood and urine tests performed within the last 3 months. The physical examination may include more specific examinations such as gynaecological (e.g. PAP), rectal, prostate, or genital exams.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g. pregnancy, lactation, very young children, or those taking multiple medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important, therefore, that you inform your doctor immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding advise your doctor immediately.

There are some slight **risks** associated with Naturopathic Medicine. These include but are not limited to:

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Aggravation of pre-existing symptoms
Allergic reactions to supplements or herbs
Pain, bruising, or injury from acupuncture
Fainting or puncturing of an organ with acupuncture needles
Muscle strains and sprains or disc injuries from spinal manipulation

Please initial the following:

_____ I understand that a record will be kept of the health services provided to me. This record will be **kept confidential** and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____ I understand that the Naturopathic Doctor will answer any questions that I have to the best of their ability. I understand that the results are NOT guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions): _____

_____ I understand that charges are to be paid at the time of the visit unless specific arrangements have been made. (Initial Consultation \$150.00) (2nd Visit \$75)(Follow-up visits up to 30 minutes \$65.00). Payment for all dispensary items is due at the time they are received.

As the patient, you are responsible for the total charges incurred for each visit. If you have coverage for Naturopathic Medicine through an insurance company, you are responsible for billing your own insurance company – your doctor will provide you with all of the information necessary to send your claim for reimbursement.

Your Naturopathic Doctor may prescribe supplements that can be purchased at the clinic or elsewhere. Most insurance companies DO NOT cover the supplements that we prescribe and dispense.

I have read and understood the above-stated information and policies. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw consent and to discontinue participation in these procedures at any time.

Patient Name (please print): _____

Signature of Patient or Guardian: _____

Date: _____