Waterdown Village Chiropractic Group

5 Mill Street South
Waterdown, ON L0R 2H5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

Naturopathic - Paediatric

File No: _____

Date: _____

General Information

How do you wish to be contacted by our office regarding your child's care?

☐ **Email** ☐ **Phone**

Child's Name:

Last: _____

First: _____

D.O.B. (d/m/yr) _____/ _____ / _____

Parent(s) Names:

Last: _____ **First:** _____

Last: _____ **First:** _____

Parental Status: M☐rried Divo☐ed

Custodial Status: Jo☐t ☐ **Single Parent**

Child's Address: _____

Town/City: _____ **Province:** _____ **Postal Code:** _____

Home Phone: (**)** _____ **Parent's Cell Phone: (** **)** _____

(**)** _____

Email: _____ _____ **Please Initial** Expressed consent to receive email communication from the clinic

Family Dr. Name: _____ **Phone: (** **)** _____

Previous Naturopathic Care? Y N If Yes, Doctor's name: _____

Referred by: _____

How did you decide to choose our office? _____

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Medical Information

Please list any current prescription or over-the-counter medications (i.e. inhaler, Advil, Tylenol, etc.):

1. _____
   Reason
2. _____
   Reason
3. _____
   Reason
4. _____
   Reason
5. _____
   Reason

Please list any past serious illnesses, surgeries, or conditions:

1. _____
   Date
2. _____
   Date
3. _____
   Date
4. _____
   Date
5. _____
   Date

Please list any food allergies or intolerances:

1. _____
2. _____
3. _____

Please list any environmental allergies or sensitivities:

1. _____
2. _____
3. _____

File No. _____

Number of antibiotic prescriptions in the past year: _____

Number of antibiotic prescriptions in the past 5 years: _____

Current Supplements (multi, herbs, vitamins, minerals, etc.)

Supplement	Dose/Amount	Reason	How Long?

Chief Health Concern(s)

Please list, in order of importance, the areas of your child's health you would like me to help you address:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

File No. _____

Prenatal/Natal History

MATERNAL HISTORY

Did Mom receive prenatal care (circle): Yes No
If yes, please list the type of care provider
(OB/GYN, midwife)

Number of previous pregnancies:_____

Number of previous deliveries/live births: _____

Diagnostic tests during pregnancy (circle):
Ultrasound #____ Amniocentesis
X-ray Other (please list)
_____

Any significant events or trauma experienced during pregnancy/delivery?

List any medication(s) /supplement(s) taken during pregnancy, dose and duration?

Was mom exposured to alcohol, cigarette smoke, or recreational drugs during pregnancy? Y N

NATAL HISTORY

Circle: Natural conception Assisted conception / IVF

If assisted, which technique(s) were used?

_____

Circle: Home birth Hospital birth

Circle: Vaginal birth C-section

Circle: Forceps Vacuum

Weeks gestation at birth:_____

Birth complications (please check):

- ☐ Respiratory difficulties
- ☐ Cleft palate
- ☐ Down's syndrome
- ☐ Congenital defect: (Pls List)
- ☐ Fetal Alcohol Syndrome
- ☐ Congenital Hip Dysplasia
- ☐ Jaundice
- ☐ Hypospadia/Epispadia
- ☐ Other (Please List)

Feeding History

Was your child breast fed? Yes No
For how long? _____+_____

If no, what was the substitute? (name of formula(s) used)
_____

Was there a reaction with any of the above formulas? Yes No

Age at first food introduced: _____

What food was first introduced?_____

Any reactions to any foods introduced (circle)? Yes No

If yes, please list. _____

_____

How would you describe your child's appetite?

_____

Are they picky (circle)? Yes No

Any cravings? _____

Any aversions? _____

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Vaccinations

Has your child been vaccinated? Y N

Vaccinated according to recommended schedule? Y N

Vaccinated on an altered or delayed schedule? Y N

Any suspected or known reactions or complications from vaccinations?

_____

_____

_____

_____

Current Health

How would you describe your child's state of health?

□ Excellent □ Very Good □ Average □ Fair □ Poor

How many times per week does your child engage in physical activity?

_____

Does your child eat regular meals and/or snacks? Y N

Does your child consume caffeine? Y N

SLEEP:

How many hours of sleep does your child get nightly?

_____

Does your child nap? Y N

BOWEL MOVEMENTS (BM)

How many BM does your child have a day?

_____

Any difficulty passing a BM? Y N

Anything to assist their bowels? Y N

Any blood in the stool? Y N

Any mucus in the stool? Y N

Any undigested food in the stool? Y N

ENERGY (10= most energetic)

On a scale of 1-10, how would you rate your child's energy level? _____

MOOD

How would you describe your child's general moods?

_____

Have you ever been concerned about your child's moods?

□ Yes □ No

DAILY DIET SUMMARY

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Is your child exposed to cigarette smoke? Y N

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INFORMED CONSENT TO NATUROPATHIC CARE

A worsening or aggravation of symptoms with homeopathic Naturopathic Medicine is the treatment and prevention of diseases with natural medicines. Our Naturopathic Doctors (NDs) assess you as a *whole* person by taking into consideration your physical, mental, and emotional health. Gentle, non-invasive medicines are used in order to treat the underlying causes of your illness & disease, while promoting and supporting your healing process. Our Naturopathic Doctors use a variety of therapeutic approaches, either alone, or in combination.

These therapeutic approaches include nutritional and lifestyle counseling, nutritional supplementation, Traditional Chinese Medicine (TCM) and acupuncture, botanical medicine, homeopathy, hydrotherapy B12 injections, and physical medicine. Your Naturopathic Doctor will take a thorough health history, perform a screening physical examination if needed, and request laboratory testing when necessary.

It is very important you inform your Naturopathic Doctor of any diseases you are suffering from, any known allergies you have, and any prescriptions medications or over the counter drugs you are currently taking.

Please advise your Naturopathic Doctor if you are pregnant, suspect you are pregnant, or if you are breastfeeding, as your treatment plan may change in these stages of life. As a patient of Naturopathic Medicine, you will receive information about your diagnosis, your treatment, and alternative courses of action. You will also be advised of the expected benefits, risks, side effects, and consequences of not acting upon your diagnosis or treatment.

There are some slight health risks associated with treatment in naturopathic medicine. These include, but are not limited to:

- An adverse reaction to a supplement and/or herb
- An aggravation of symptoms with homeopathic medicine. The duration is usually short and self-limiting.
- Pain or bruising with acupuncture.

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I, _____ **(please print name)** understand that the form of medical care I will be receiving is based on Naturopathic principles and practices. I hereby acknowledge that I have been informed and understand the recommended diagnostic and therapeutic procedure(s)/plan and have discussed them with my Naturopathic Doctor to my satisfaction. I also recognize that even the gentlest forms of therapies have potential side effects, and I release my Naturopathic Doctor from any responsibility of side effects. I acknowledge and confirm I have been informed of the diagnostic/therapeutic procedures with respect to potential risks and side effects, expected benefits, financial costs, and the likely consequences of not having/following the provided recommendations and what alternative course(s) of action are available to me.

I also acknowledge that:

1.) Any treatment or advice provided to me as a patient of Naturopathic Medicine is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider;
2.) I am at liberty to seek or continue medical care from a physician, surgeon, or other health care provider qualified to practice in Ontario;
3.) My Naturopathic Doctor. has not suggested or recommended to me to refrain from seeking or following the advice of another licensed health care provider;
4.) The treatment and therapies rendered or recommended by my Naturopathic Doctor may be different from those usually offered by a medical doctor or another licensed health care provider.

I acknowledge that full payment is due at the time services are provided or supplements are purchased.

CANCELLATION POLICY

I acknowledge 24 hours' notice is required should I wish to cancel or reschedule my appointment. If less than 24 hours' notice is given, **a cancellation fee of $25.00** will be applied to my account. If I fail to cancel an appointment and do not show for my scheduled appointment, I will be charged in full for type of appointment booked.

Please initial to confirm you have read the cancellation policy and agree to pay any outstanding balances owing.

_____ **(please initial)**

I declare that my Naturopathic Doctor has explained, to the best of her ability, the treatment or services that I may receive and hereby authorize and consent to treatment.

I intend this consent to apply to all my present and future naturopathic treatments.

Patient Name (print): _____ Date:_____

Signature: _____

Parent/Guardian Signature (if under 16 years old): _____