Naturopathic Treatment Informed consent

Naturopathic medicine and care is a unique primary health care system that combines standard medical diagnostics and knowledge with traditional, natural and gentle therapies. The goal is to understand the individual, address the underlying cause and improve health and well-being.

I, _____, understand that the form of medical care is based on naturopathic principles and practices.

I will completely disclose and inform my Naturopathic Doctor of all my health concerns and conditions, allergies, medications, supplements and medical interventions.

I understand that my identity will be protected and kept confidential.

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 release to others without my consent, unless required by law.

I understand that I may look at my medical record and can request a copy by paying a 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 Naturopathic Doctor to be able to anticipate and explain all risks and complications.

I understand that although the naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to:
- Aggravation of pre-existing conditions and symptoms
- Allergic reactions to supplements or botanical prescriptions
- Pain, bruising, fainting or puncturing or an organ with acupuncture needles

I understand that fees and supplements are to be paid for at the time of the consultation.

I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice.

PATIENT CONSENT
- I have read and understand the above-stated policies and information
- I intend this consent form to cover the entire course of treatment
- I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time (written or verbal format)

Patient Name: _____ Date: _____

Parent's signature: _____

Naturopathic Doctor: _____

CHILD INTAKE FORM
GENERAL PATIENT INFORMATION

Date: _____

Name: _____ Age:_____ Date of birth:_____ Sex: F / M
Address:_____ City:_____ Postal Code:_____
Parents email: _____
Parents phone number: _____

How did you find out about naturopathic services at the centre? If referred, please indicated from whom _____

Person to notify in case of emergency: _____

Phone number: _____ Relationship: _____

Other health care providers (name and phone number):

1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

HEALTH CONCERNS
What is the main reason for the visit today? _____

What are the health concerns or health goals, in order of importance:

Concern	When did it start	Any treatments and the result
1		
2		
3		
4		
5		

How would you describe the child's general state of health? Poor Fair Good Excellent

Allergies
Any hypersensitivity or allergy to drugs? _____
Any food allergies or intolerances? _____
Any environmental sensitivity? _____

MEDICAL HEALTH HISTORY

Current medications (prescription, over the counter, birth control)

Medication	Dose per day	What purpose	Date when started

Current Supplements or Herbs

Supplement or Herbs	Dose per day	What purpose	Date when started

Has your child ever experienced any of the following? (Please check)

☐ Rubella	☐ Diaper rash	☐ Stomach aches
☐ Mumps	☐ Cradle cap	☐ Headaches
☐ Measles	☐ Diarrhea	☐ Ear infections
☐ Chickenpox	☐ Constipation	☐ Hives
☐ Whooping cough	☐ High fever	☐ Rashes
☐ Scarlet fever	☐ Bedwetting	☐ Eczema
☐ Polio	☐ Strep throat	☐ Other illness/disease:
☐ Rheumatic fever	☐Frequent colds	_____
☐ Colic	☐Sleep problems	_____

Vaccinations (Please check)

☐DPT (Diphtheria, Pertussis, Tetanus)	☐ Flu shot
☐ MMR (Measles, Mumps, Rubella)	☐ Hepatitis A
☐Chicken pox	☐ Hepatitis B
☐Polio	☐ Other: _____

Has your child experienced any adverse effects from vaccinations? Yes No (Please circle one)
If yes, please explain _____

Does your child have any medical allergies or sensitivities?
Please list: _____

List all hospitalizations, surgeries and accidents

Description	Year	Outcome

Date of last physical exam: _____

FAMILY HEALTH HISTORY (Grandparents, parents, siblings —insert where applicable)

	Who & Age		Who & Age
Allergies		High blood pressure	
Arthritis		High cholesterol	
Asthma		Heart disease	
Cancer		Mental illness	
Depression		Osteoporosis	
Drug abuse or alcoholism		Stroke	
Diabetes		Thyroid problems	
		Other	

PERSONAL HEALTH HABITS

Height: ____ Weight: ____lbs Weight 1 year ago: ____

Parental health history

Was the child adopted? Y N If yes, at what age? _____

Mother's age at time of child's birth _____ Father's age at time of child's birth _____

Did the mother receive medical care during the pregnancy? Y N

Did the mother experience any of the following during pregnancy?

☐ Bleeding ☐ Vomiting ☐ High blood pressure	☐ Nausea ☐ Thyroid problems ☐Diabetes	☐ Physical/emotional trauma ☐ Other: _____

Were any of the following interventions used during pregnancy?

☐ Ultrasound ☐ Amniocentesis	☐ Chorionic Villi Sampling ☐ Maternal serum screening	☐ Triple screen ☐ Other: _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐Alcohol ☐ Recreational drugs	☐ Prescription medications: _____ ☐ Over the counter medications: _____ ☐ Vitamins and/or supplements: _____

Birth history

Term length

☐ Pre-term (less than 37 weeks) ____ weeks
☐ Full term (38-42 weeks) ____ weeks
☐ Post term (43+ weeks) ____ weeks

Type of birth

☐ Vaginal
☐ C-section

Intervention

☐ Induction ☐ Use of forceps	☐ Epidural/anesthesia ☐ Episiotomy	☐ Other: _____

Were there any complications during delivery? (Eg. breech) _____

Length of labour: _____ hours Weight of infant at birth: _____

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Difficulties with feeding	☐ Infections ☐ Birth injuries ☐ Birth defects ☐ Other: _____	

Health and development

At what age did your child first:
Sit up: _____ Crawl: _____ Walk: _____ Talk: _____

At what age did your child start teething? _____

Nutritional history

How was your infant fed?

□ Breastfed For how long? _____

□ Formula: cow's milk/soy/other For how long? _____

Did your infant experience any reactions to the breast milk or formula?

If yes, please explain: _____

What foods were introduced before 6 months? Please list the approximate month and any reactions:

_____

What foods were introduced between 6 and 12 months? Please list the approximate month and any reactions:

_____

Typical food intake

Diet (typical day)

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluid intake: _____

Toxin exposure

Does the child live near power lines? Yes / No

Has the child lived in a house more than 50 years old? Yes / No

Has the child been exposed to mould, lead paint, heavy metals or other toxic substances? Yes / No

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