

## **Informed Consent**

**Naturopathic medicine** is the treatment and prevention of diseases and disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Using a variety of treatment modalities, gentle, non-invasive techniques stimulate the body's inherent healing capacity.

### **Traditional Chinese Medicine (TCM)**

TCM includes acupuncture, as well as botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of small disposable, sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes Moxa (a compressed herb), Cupping Therapy or Guasha is used over the skin at or near specific points on the body in order to stimulate the body's energy. Botanical formulas may be given in the form of pills, tinctures, herbal extract powders or decoctions (strong teas) to be taken internally or used externally as a wash, poultice, salve or fomentation.

### **Bowen Therapy**

Bowen is a soft tissue relaxation technique that enhances the body's innate ability to restore and heal itself. The Bowen technique relieves muscle tension and restores normal lymphatic flow without deep muscle work. The treatment is long lasting and the effects profound.

### **Diet and Nutrition**

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

### **Botanical Medicine**

Botanical Medicine is a plant-based medicine using herbal teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. These compounds are also used to boost the body's immune system and prevent disease.

### **Homeopathic Medicine**

Homeopathy, developed in the 1700's, is based on the principle of "like cures like". A remedy is selected, which in its crude form would produce in a healthy individual the same symptoms found in a sick person suffering from the specific disease. Minute amounts of natural substances (plant, animal, mineral) are used to stimulate the body's innate ability to heal. Homeopathy is a powerful tool and effects healing on a physical and emotional level.

### **Physical Medicine**

This includes the use of various hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation, therapeutic ultrasound and heating lamps for treating musculoskeletal and neurological problems. Hydrotherapy refers to the use of hot and cold-water applications to improve circulation and stimulate the immune system.

As Naturopathic Medicine is a holistic approach to health, lifestyle is considered relevant to most health problems. Your naturopathic doctor will help you identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment. Your naturopathic doctor will take a thorough case history; do a full physical examination, BIA Analysis and urine analysis. If required, the physical may include specific examinations such as gynecological, breast, rectal, prostate or genital exams.

## Declaration and Consent to Treatment

Even the gentlest therapies have their complications. Certain conditions such as pregnancy, lactation, those on multiple medications or who have certain diseases such as diabetes, heart, liver or kidney disease, or are very young need to proceed with caution in treatment. It is very important that you inform your naturopath immediately of:

- any disease process that you are suffering from
- if you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or if you are breast-feeding

There are some potential 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 Venipuncture, Acupuncture or Cupping
- Fainting or puncturing of an organ with Acupuncture needles, accidental burning of the skin from the use of Moxa or Cupping
- Muscle strains, sprains or disc injuries from spinal manipulation
- The potential for stroke in neck manipulation  
(Tests will be done to screen for this possibility. Clinical research has shown that stroke-like occurrences are rare, occurring approximately 1 in 1.5 million manipulations).

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 unless so directed by myself when law requires it. I understand that I may look at my medical record at anytime and can request a copy or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my naturopathic doctor will answer any questions that I have to the best of her/his ability. I understand that results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise their judgment during the course of procedures which they feel are in my best interest, based on what is known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below):

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I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.



## PEDIATRIC INTAKE FORM

Today's Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Child's Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Male  Female  Grade Level: \_\_\_\_\_

Referred by: \_\_\_\_\_

Name and relation of individual who is filling out this form:  
\_\_\_\_\_

How did you hear about us? Friends  Family  Presentation  Website   
Newspaper  Other: \_\_\_\_\_

## Contacts (in order of preference)

Name and relation to child: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

Phone: (cell or other) \_\_\_\_\_

Address: \_\_\_\_\_

Name and relation to child: \_\_\_\_\_

Phone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

Phone: (cell or other) \_\_\_\_\_

Address: \_\_\_\_\_

Whom does the child live with? \_\_\_\_\_

## Child's Other Health Care Providers

Provider's name: \_\_\_\_\_

Designation: \_\_\_\_\_

Address (if available): \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Provider's name: \_\_\_\_\_

Designation: \_\_\_\_\_

Address (if available): \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

## Health Concerns

Please list the child's health concerns in order of importance.

1. Primary health concern: \_\_\_\_\_

At what age did this condition/illness begin: \_\_\_\_\_

What do you think might have caused this condition? \_\_\_\_\_

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What other (possibly unrelated) events occurred around the time the condition began? \_\_\_\_\_

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What, if any, medications or supplements have been used to treat this condition and what was their effectiveness? \_\_\_\_\_

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Other health concerns:

2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

## Prenatal Health and History

What was the health of the parents at the time of conception?

Mother:       Poor     Fair     Good     Excellent     Unknown

Father:       Poor     Fair     Good     Excellent     Unknown

What was the health of the mother during pregnancy?

Poor     Fair     Good     Excellent     Unknown

What was the emotional state of the mother during pregnancy?

Poor     Fair     Good     Excellent     Unknown

How was the mother's diet during pregnancy?

Poor     Fair     Good     Excellent     Unknown

Did the mother receive medical care during pregnancy?     Yes     No     Unknown

What was the mother's age at the time of the child's birth? \_\_\_\_\_

How many previous pregnancies and births did the mother have? \_\_\_\_\_

What was the mother's occupation during pregnancy? \_\_\_\_\_

Did the mother experience any of the following during pregnancy?

Bleeding                       High blood pressure                       Nausea                       Vomiting

Diabetes                       Thyroid problems                       Physical or emotional trauma

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: \_\_\_\_\_  
 Other: \_\_\_\_\_

Were any of the following interventions used during pregnancy?

- Ultrasound  Amniocentesis  Chorionic Villi Sampling  Triple Screen  
 Maternal Serum Screening  Other: \_\_\_\_\_

## Birth History

- Term length:  Pre-term (37 weeks or less): \_\_\_\_\_ weeks  
 Full-term (38-42 weeks): \_\_\_\_\_ weeks  
 Post-term (more than 42 weeks): \_\_\_\_\_ weeks

Location of birth:  Hospital  Home  Birthing Center  Other: \_\_\_\_\_

Type of birth:  Vaginal  C-section

Types of Intervention:

- Induced labour  Use of forceps  Epidural/Anesthesia  Episiotomy  
 Other: \_\_\_\_\_

Were there any complications during delivery (e.g., breech delivery)? \_\_\_\_\_  
\_\_\_\_\_

Length of labour : \_\_\_\_\_ Weight of infant at birth: \_\_\_\_\_  
APGAR score (0 to 10): 1minute \_\_\_\_\_ 2 minutes \_\_\_\_\_ 5 minutes: \_\_\_\_\_

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

- Jaundice  Rashes  Seizures  Birth injuries: \_\_\_\_\_  
 Infections: \_\_\_\_\_  
 Difficulties with feeding: \_\_\_\_\_  
 Birth defects: \_\_\_\_\_  
 Other: \_\_\_\_\_

## Dietary History

How was the infant fed?

- Breast fed  Formula (milk/soy/other): \_\_\_\_\_  
 Other: \_\_\_\_\_

How long was the infant fed this way?  
\_\_\_\_\_  
\_\_\_\_\_

Did the infant have any reactions to what they were being fed?  
\_\_\_\_\_  
\_\_\_\_\_

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What foods were introduced before 6 months? (Please list the approximate month that each food was introduced, as well as any reactions that may have occurred).

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What foods were introduced between 6 and 12 months? Were there any reactions to these foods?

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Did the child ever experience Colic?  Yes  No  
If yes, how severe was the colic?  Mild  Moderate  Severe

Please list any food allergies or intolerances that the child has: \_\_\_\_\_

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Does the child have any dietary restrictions (vegetarian/vegan, religious, etc.)?

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Describe the child's usual diet on a typical day:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages (include total quantity): \_\_\_\_\_

Please describe the child's eating habits (e.g., good appetite, picky eater, etc.):

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## Medical History

Has the child ever experienced any of the following illnesses?

- |  |                                     |
|--|-------------------------------------|
| <input type="checkbox"/> Rubella         | <input type="checkbox"/> Mumps      |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Whooping Cough  | <input type="checkbox"/> Asthma     |
| <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Polio      |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Other:     |

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Has the child ever experienced any of the following conditions?

- Diaper Rash    Cradle Cap    Diarrhea    Constipation    High fever  
 Heat or cold intolerance    Trouble with bedwetting    Frequent colds  
 Ear infections

If they have ear infections, how many and how often? \_\_\_\_\_

Has the child received any of the following vaccinations?

- DPT    MMR    HIB    Polio    TB    Flu  
 Smallpox    Pneumovaccine    Chickenpox  
 Other: \_\_\_\_\_

Did the child have any adverse reactions to, or chronic illness, following vaccination? \_\_\_\_\_

Has the child ever been hospitalized?  Yes    No

If yes, for what reason? \_\_\_\_\_

How long was the child in the hospital or under care? \_\_\_\_\_

Has the child ever had any significant physical or emotional traumas? \_\_\_\_\_

Please list any medications and/ or supplements the child is currently taking: \_\_\_\_\_

Does the child have any known drug allergies?  Yes    No

If yes, please list drug allergies: \_\_\_\_\_

## Health and Development

How was the child's health in the first year?

- Poor    Fair    Good    Excellent    Unknown

How is the child's health now?  Poor    Fair    Good    Excellent    Unknown

At what age did the child first:

Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_

At what age did the child begin teething? \_\_\_\_\_

Were there any difficulties associated with teething? \_\_\_\_\_

## Sleep Patterns

What time does the child usually go to bed? \_\_\_\_\_

What time does the child usually wake in the morning? \_\_\_\_\_

Does the child nap during the day?  Yes  No

If yes, what time(s) do they nap? \_\_\_\_\_

Does the child have nightmares?  Yes  No

If yes, how often do they have nightmares? \_\_\_\_\_

Does the child have any problems associated with sleeping?  yes  no

If yes, what kind of trouble do they have (e.g., trouble falling asleep, trouble waking up, etc.)? \_\_\_\_\_

## Social Patterns

Is the child in:  school  daycare  home care  other: \_\_\_\_\_

How would you describe the child's behavior at school? \_\_\_\_\_

\_\_\_\_\_

How would you describe the child's behavior at home? \_\_\_\_\_

\_\_\_\_\_

What are the child's interests and favorite activities? \_\_\_\_\_

\_\_\_\_\_

What, if any, recreational activities are the child involved in? \_\_\_\_\_

\_\_\_\_\_

How would you describe the child's temperament/personality? \_\_\_\_\_

\_\_\_\_\_

Is there anything that you would want to change? \_\_\_\_\_

Does the child exercise regularly?  Yes  No

How much and how often do they exercise? \_\_\_\_\_

\_\_\_\_\_

How much television does the child watch? \_\_\_\_\_ hrs a day/week.

How often does the child read (not for school), or How often does someone read to the child?

Daily  Several times a week  Weekly  Less than weekly

## Family History

Please indicate if a close relative (parent, grandparent, sibling) has had any of the following:

Condition	Relative	Condition	Relative
<input type="checkbox"/> Allergies		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Anemia		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Arthritis		<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Eczema	
<input type="checkbox"/> Birth Defects		<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Bleeding Disorder		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Cancer		<input type="checkbox"/> Psoriasis	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Depression	
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Tuberculosis	
<input type="checkbox"/> Juvenile Arthritis		<input type="checkbox"/> Mental Illness	

I don't know the family medical history

Next to each individual listed below, please put an "L" for living or "D" for deceased, as well as present age or age at the time of death. Please indicate if the family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis.

Relationship	L/D	Age	Diseases Suffered/ Cause of Death
Mother			
Father			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Sister(s)			
Brother(s)			
Maternal Aunts			
Maternal Uncles			
Paternal Aunts			
Paternal Uncles			

Do either of the parents of the child have a chronic illness?  Yes  No

If yes, please describe: \_\_\_\_\_  
 \_\_\_\_\_

## Environment

Are there any pets in the home?  Yes  No

If yes, what type and how many? \_\_\_\_\_

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Does anyone in the child's household smoke? Yes No

How is the child's home heated? \_\_\_\_\_

Do you know of any toxins or other hazards that the child is regularly exposed to? yes  
no

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

How would you describe the emotional climate of the child's home? \_\_\_\_\_

\_\_\_\_\_

Does the child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)? \_\_\_\_\_

\_\_\_\_\_

Is there anything that you feel is important that has not been covered? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **Diet Diary:**

On the following page, you will find a Diet Diary. Please list, in the spaces provided, every food item that the child puts into their mouth (excluding gum, but inclusive of EVERY OTHER food item) for at least a 7 day period. Please take note of any physical symptom or sensitivities that they may experience during this exercise and note them in the 'notes' section provided.

Diet Diary


Breakfast

Lunch

Dinner

Snacks

Notes