

Consent to naturopathic diagnoses and treatment

Patient Name _____ File #: _____

Attending N.D. _____ License #: _____ Assistant _____

I, the undersigned, do hereby acknowledge that I have the right to be informed of any recommended diagnostic and/or treatment procedure(s) and have the right to discuss this, to my satisfaction and understanding. I have the right to request related information with the naturopathic doctor named above and/or with his office or clinical assistant(s). I further acknowledge and confirm that, prior to any diagnostic and/or treatment procedures, I have the right to be informed of, and understand the diagnostic and treatment procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I also understand that I may change the status of the voluntary informed consent at any time.

As a result, I, _____ (Parent or Guardian's Name), voluntarily give my informed consent for Naturopathic diagnostic and treatment procedure(s) for _____ (child).

_____	_____
Parent or Guardian Signature	Date Signed
_____	_____
Witness Signature*	Witness Relation to Patient
Address _____	_____
Town/City _____	Phone no
Province _____	_____
Postal Code _____	Attending N.D. / Assistant

***Witness signature is advised but not necessary** License # _____

I, _____, also agree to pay the full cost of any scheduled appointment that my child may miss, unless I give 24 hours notice.

_____	_____
Parent or Guardian Signature	Date Signed

CHANGE STATUS OF INFORMED CONSENT (fill only if withdrawing your consent to treat)

I do hereby voluntarily withhold and/or withdraw my informed consent for the Naturopathic diagnostic and treatment procedure(s) as specified above.

_____	_____
Parent or Guardian Representative Signature	Date Signed
_____	_____
Witness Signature*	Witness Relation to Patient
Address _____	_____
Town/City _____	Phone no
Province _____	_____
Postal Code _____	Attending N.D. / Assistant

***Witness signature is advised but not necessary** License # _____

General Information

The information that you provide is very important in the assessment of your child's case. It is vital that you fill it out as accurately as possible. Thank you in advance.

Child's Name: _____ Date (mm/dd/yr): _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Sex: _____ Age: _____ Date of birth: _____ Birthplace: _____

How did you hear about us? _____

Primary Contact Person

Name: _____

Relation to child: _____

Emergency contact #:(_____) _____

Phone – Home: (_____) _____

Phone – Work: (_____) _____

Phone – Mobile (_____) _____

E-mail: _____

Other: _____

School or Daycare

School/Daycare Name: _____

Address _____

Phone (_____) _____

Other: _____

Contact information of medical doctor

Name _____

Address: _____

Phone: (_____) _____

Fax: (_____) _____

Secondary Contact Person:

Name: _____

Relation to child: _____

Emergency contact #:(_____) _____

Phone – Home: (_____) _____

Phone – Work: (_____) _____

Phone – Mobile (_____) _____

E-mail: _____

Other: _____

Contact information of Specialist

Name _____

Address: _____

Phone: (_____) _____

Fax: (_____) _____

Other Health Care Providers: (list name, address, contact # and type of service i.e. dentist)

Medical History – General:

How would you describe your child's general health? (circle one) excellent good fair poor

What are your child's main health concerns? (list in order of importance, from most important to least)

Importance	First noticed	Health concern
(Most)1		
2		
3		
4		
5		
6		
(Least)7		

Illnesses in the Past:

Yes / No	Illness/Condition	At age	How long	Hospitalization / Complication
Y / N	Cold & Flu			
Y / N	Fever (greater than 105F)			
Y / N	Cough			
Y / N	Strep Throat			
Y / N	Impetigo			
Y / N	Ear infections			
Y / N	Eczema			
Y / N	Mononucleosis			
Y / N	Jaundice			
Y / N	Measles			
Y / N	Mumps			
Y / N	Rubella			
Y / N	Whooping Cough			
Y / N	Chicken Pox			
Y / N	Scarlet Fever			
Y / N	Rheumatic Fever			
Y / N	Polio			
Y / N	Diabetes			
Y / N	Asthma			
Y / N	Warts			
Other:				

List Allergies or Food Sensitivities

Allergy/Food	First noticed	Describe Severity

List all the child's current medications:

Medication	Prescribed by & when	Dose	Prescribed for

List all the child's current supplements:

Medication	Prescribed by & when	Dose	Prescribed for

Has your child taken anti-biotics within the last 5 years (circle one)? YES NO

If YES, how many times have they taken anti-biotics in the last 5 years? _____

Indicate Vaccinations Received:

Yes / No	Vaccine	At age	Any Side Effects
Y / N	Measles, Mumps, Rubella (MMR)		
Y / N	Deptheria, Pertussis, Tetanus (DPT)		
Y / N	Haemophilus Influenza B (Hib)		
Y / N	Chicken Pox (Varicella Zoster)		
Y / N	Rabies		
Y / N	Hepatitis A		
Y / N	Hepatitis B		
Y / N	Tetanus		
Y / N	Polio		
Y / N	Flu		
Y / N	Other:		

Did any problems or illnesses arise with your child soon after any vaccination? Yes / No If Yes, which ones? _____

Prenatal History

Grade the health of the mother during pregnancy (circle): Excellent Good Fair Poor

Was the mother exposed to any of the following during pregnancy? (circle all that apply): alcohol / tobacco / prescription drugs / recreational drugs / radiation / chemotherapy / excessive sun / infectious disease / trauma / stress / Other: _____

List all supplements & prescription drugs taken by the mother during pregnancy & breast feeding (i.e. folate, iron, thalidomide): _____

Were there any complications during pregnancy? (circle all that apply): nausea or vomiting / hemorrhaging / thyroid problems / high blood pressure / Other: _____

Birth History

Circle all that apply: Vaginal / Cesarean Section / Forceps / Suction / Epidural or drugs / Vacuum Extract

Was your child early or late? _____ and by how many weeks? _____

Length of labour: _____ hours. Weight at birth? _____ # of births (i.e. twin): _____

Was the birth traumatic on the mother, the baby or both? _____ Doula or Midwife used? _____

Where was the birth? (circle) home / hospital / birthing center List any complications during birth: _____

Did your child suffer any of the following? (circle all that apply) jaundice / deformities / rashes / breathing problems / colic / other: _____

Growth & Development of Child

Give the age of when your child first began to do the following: crawl _____, sit up _____, walk _____, teethe _____, speak (mama, dada) _____.

In their first year, your child's health was (circle one): Excellent Good Fair Poor

Your child sleeps _____ hours per day _____ hours per night

Quality of sleep (circle): easily aroused hard to wake nightmares lie on stomach lie on back

Eating History

Fussy eater? Yes / No Feeding (circle): breast fed bottle fed formula fed

If formula fed, began at age _____. Age solids were introduced _____

Length of breast / bottle feeding: _____

Most common foods eaten (circle): home made (from scratch) home made (package) eat out

Feeding complications: _____

What foods were introduced before 6 months: _____

List the solid foods introduced: _____

Does your child have dietary restrictions (religious, vegetarian... etc): _____

List your child's food cravings: _____

List your child's food aversions: _____

Typical daily diet for your child

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks / Beverages: _____

Social History

Please describe how your child interacts with other children, parents, and other caregivers: _____

Please describe your child's behaviour and performance at school: _____

Is your child physically active? Yes / No How much/often: _____

How many hours do they do the following per day? Watch T.V. _____, use computer _____, spend outside _____, read (outside of school) _____. Schooling (circle): daycare preschool school

List extracurricular activities your child is involved in or favorite activities: _____

Age of home: _____ yrs Any recent renovations: Yes / No Upkeep of Home (circle): good bad
Check all that apply to your child's exposure and/or in your home :

Lead Paint: ___ Asbestos: ___ Carpet: ___ Mildew: ___ Pets: ___ Smokers: _____

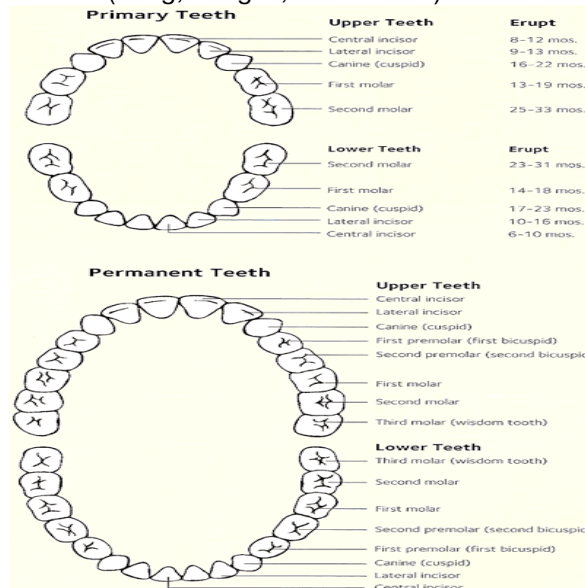
How is the home heated: _____

Home Location (check): Airport: ___ Industry: ___ Suburb: ___ City: ___ Highway: ___ Hydro lines: ___

Describe any known toxins or hazards the child is exposed to at home, daycare, hobbies outside environment etc.: _____

Describe the emotional climate of the child's home: _____

Teeth map: Primary teeth map is for children while the Permanent teeth map is for adults. Use a “/” over the teeth that have had dental work (filling, bridges, crowns etc.) Use an “X” over root canal teeth.



Review of Systems

Please circle "N" if your child never had, "Y" if your child has now and "P" if your child had the condition.

N / Y / P Eczema / Rashes
 N / Y / P Sleeping Problems
 N / Y / P Bedwetting
 N / Y / P Ear Infections
 N / Y / P Breathing Problems

N / Y / P Heart Murmur
 N / Y / P Hearing Problems
 N / Y / P Vision Problems
 N / Y / P Speech Problems
 N / Y / P Cries a lot

N / Y / P Difficult to Please
 N / Y / P Lack of Energy
 N / Y / P Hyperactive
 N / Y / P Tantrums
 N / Y / P Convulsions

N / Y / P Learning Problems
 N / Y / P Problem Child
 N / Y / P Nervous Child
 N / Y / P Teeth Problems
 N / Y / P Colic

N / Y / P Constipation
 N / Y / P Digestive Upsets

Bowel movements per day: _____

Colour: _____

Other: _____

Children between the ages of 6 and 12 should complete the following questions as best as they can on their own. Parent can explain words, but should not influence them in any way.

Most days I feel (check the ones that apply):

- ___ Nervous
- ___ Unhappy
- ___ Discontent
- ___ Need to sleep a lot
- ___ Lazy
- ___ Irritable / cranky
- ___ I'm a slow learner
- ___ I'm accident prone
- ___ Need to sleep a lot
- ___ Lazy

Circle **YES** or **NO** to the following:

- Yes / No Scared of a lot of things
- Yes / No Have very little confidence
- Yes / No Feel you are different
- Yes / No Like to be alone
- Yes / No Like to be with friends

- Yes / No Like to be with family
- Yes / No Get angry easy
- Yes / No Have sleep problems
- Yes / No Bite your nails
- Yes / No Grind your teeth

- Yes / No Wet the bed
- Yes / No Have a hard time concentrating
- Yes / No Your eyes bothered by light
- Yes / No Get along with your family
- Yes / No Do you miss school a lot because you are sick.

On a scale of 1-10 (best happy ever is a 10 and 1 is very sad)....
 How happy are you with your life? _____

If you could change something about your life what would it be? _____

end of section for children ages 6 to 12

Family Medical History

Please place an "X" in the boxes that are relevant to blood relative of the child.

Condition	Mom	Dad	Sister	Brother	Grandma	Grandpa	Aunt	Uncle	Others
Heart attack / disease Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
High blood pressure Severity:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis / Stroke Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Asthma Severity:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Lung disease / T.B. Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Liver disease / Cirrhosis Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Gall bladder disease Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Hypoglycemia / Diabetes Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Kidney disease Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Thyroid disorders / Obesity Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Digestive Problems Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Food Allergies Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Arthritis / Gout Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Eczema / Psoriasis Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Skin Allergies / Hives Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cancer Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Epilepsy / Nervous breakdown Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Syphillis / Gonorrhea Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Miscarriages Number:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Type:	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Is there anything else that you feel I should know about your child?: _____
