healthflow naturopathic
medically trained, naturally focused

#120M, 2204 2nd Street SW, Calgary
403.313.4354 ♦ info@healthflow.ca

Consent to naturopathic diagnoses and treatment

Patient Name_____ File #: _____

Attending N.D._____ License #: _____

I, the undersigned, 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 their 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 understand that the above naturopathic doctor may use different forms of communication(s) with myself outside of face-to-face consultations. These may include email and/or telephone communication. These communications are kept private and confidential. I understand that recommendations, handouts and other treatment outlines may be provided via email. Healthflow Family Wellness Centre operates as an Integrative care center, as such, sharing client files amongst therapists does occur in the event of internal referrals. Privacy, protection and distribution of information within the clinic are done in adherence of the CNDA guidelines. I also confirm that I have the ability to accept or reject this service of my own free will and choice, and that I am not an agent or sub-contracted agent of any municipal, county, provincial, federal, media, insurance, competitor or any regulatory organization, attempting to gather information without so stating.
I also understand that I may at any time withdraw my informed consent by providing such in writing.

As a result, I do hereby voluntarily give my informed consent for Naturopathic diagnostic and treatment

procedure(s) for_____ (child).

_____ _____
Patient or Lawful Representative Signature Date Signed

We strives to provide a safe and respectful environment for all patients, therapists and administrative staff. As part of our policies and procedures we adhere to a **strict no abuse standard**. Abuse of any staff member or therapist can be grounds for dismissal from the clinic and prohibition from returning to the clinic. In order to maintain efficacy of treatment, compliancy to recommendations is necessary for effective results. Naturopathic doctors may refer alternative treatments either internally at the clinic or outside of the clinic if a need presents itself. We understand emergencies happen; in the event that you cannot attend your appointment and need to reschedule, we ask that at least 24-hours notice be given. If an appointment is missed or less than 24 hours notice is given, the clinic reserves the right to charge up to the full cost of the appointment.

I have read and understand the above policies.

_____ _____
Patient or Lawful Representative Signature Date Signed

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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? _____

Online social media groups you belong to? (parenting, vegans, breastfeeding-facebook, or etc.)

_____

Primary Contact Person

Name: _____

Relation to child: _____

Emergency contact #:(_____)_____

Phone – Home: (_____)_____

Phone – Work: (_____)_____

Phone – Mobile (_____)_____

E-mail: _____

Other: _____

Secondary 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: (_____)_____

Contact information of Specialist

Name _____

Address: _____

_____

Phone: (_____)_____

Fax: (_____)_____

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

_____

_____

_____

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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		
(Least)6		

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

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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

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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 their 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:_____

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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: _____

_____

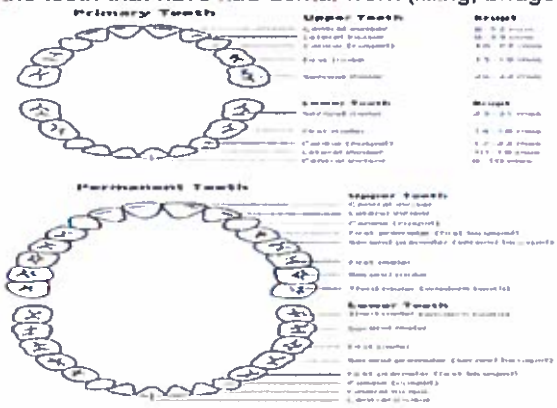
Age of home: _____ yrs Any recent renovations: Yes / No Upkeep of Home (circle): good bad
Check all that apply to your child's exposure and/or in your home :
Lead Paint: ___ Asbestos: ___ Carpet: ___ Mildew: ____ Pets: _____ Smokers: _____
How is the home heated: _____
Home Location (check): Airport: ___ 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 canalled teeth.



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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 <u>should not</u> 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

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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:									
High blood pressure Severity:									
Arteriosclerosis / Stroke Type:									
Asthma Severity:									
Lung disease / T.B. Type:									
Liver disease / Cirrhosis Type:									
Gall bladder disease Type:									
Hypoglycemia / Diabetes Type:									
Kidney disease Type:									
Thyroid disorders / Obesity Type:									
Digestive Problems Type:									
Food Allergies Type:									
Arthritis / Gout Type:									
Eczema / Psoriasis Type:									
Skin Allergies / Hives Type:									
Cancer Type:									
Epilepsy / Nervous breakdown Type:									
Syphillis / Gonorrhea Type:									
Other Type:									

Is there anything else that you feel I should know about your child? (*use reverse side of sheet*)