

IMPORTANT INFORMATION FOR NEW PATIENTS

Congratulations for putting your health first and investigating Naturopathic Medicine and its benefits to your health care program. Naturopathic Doctors are trained like primary health care providers: we use similar physical exams and laboratory tests and recognize the same signs and symptoms. The main difference between a Naturopathic Doctor and your conventional family doctor is the philosophy of care and the treatments are different. Naturopathic Doctors strive to treat the whole person and find the underlying cause of the condition.

TREATMENTS INCLUDE:

- Diet and Nutritional supplementation
- Herbal medicine- the use of plants in tea, tincture or other extraction.
- Homeopathy-the use of dilute plant, mineral or animal substances.
- Hydrotherapy- the use of water treatments to affect circulation and detoxification.
- Traditional Chinese medicine and Acupuncture.

In making your appointment you have implied that you are ready to make some changes in your life to experience better health. Taking the time to fill out this health questionnaire fully will help us to understand your goals and expectations. Together, we will formulate a health care plan that will work for you. Please bring any medications or supplements that you are currently taking with you to your initial appointment.

All of the information that you share with us is kept confidential. Your Naturopathic Doctor is the only one that will review these forms unless you request that we consult on your case with another practitioner.

FEE SCHEDULE- includes GST

Adult initial visit (1.25 hours)- \$155
Child initial visit (1.25 hours) - \$130
Adult 2nd visit (45 minutes) - \$100
Child 2nd visit (45 minutes) - \$90
Adult regular visit (30 minutes) - \$75
Child regular visit (30 minutes) - \$65
Home visit - \$100
Brief return visit - \$37.50
IM Visit- \$13.50
Phone consult (per 10 minutes)- \$37.50

Naturopathic treatment is not covered by OHIP; however naturopathic visit fees are covered by most extended health insurance plans. Payment at the time of service is expected and a receipt will be issued that complies with insurance companies requirements for re-imbusement. Gordon Street Chiropractic Clinic accepts cash, debit, Visa and Mastercard.

CANCELLATION POLICY

If you need to cancel an appointment please give us at least 24 hours notice. A last minute cancellation prevents us from booking other clients who are waiting for a suitable time to come in. Appointments that are cancelled without notice will be charged a \$65 fee (exceptions will of course be made in unavoidable circumstances).

WHAT TO DO WHEN YOU ARRIVE

When you arrive at the clinic please check in at the front desk.

Your first appointment will last approximately an hour and fifteen minutes. We will talk about your chief concerns as well as your lifestyle and any other issues that may arise in the visit. At the end of the appointment we will usually have a treatment plan that you are comfortable with and that is specific to your individual needs. Your treatment plan will be written out for you to take home after your

appointment. We generally see patients one to three weeks after the initial visit to gather any additional information that we didn't discuss in the initial visit and to perform a general physical exam. The second visit is approximately 45 minutes in length. Return visits are 30 minutes long and will be used to monitor your progress.

DISPENSARY

We maintain a small dispensary in our clinic that can supply you with some of the supplements that you may be prescribed. We only carry supplements where quality or formulation is an issue or items that may be very difficult to find elsewhere. All of the supplements, herbs and homeopathics in the dispensary are professional products that are available by recommendation by one of our practitioners only. You are never required to get supplements from us- it is always your choice.

PEDIATRIC VISITS

Parents are asked to accompany children on their appointments for parental input. Pediatric visits usually take 1-1.25 hours as common growth and developmental issues are also discussed in addition to the child's chief concern.

HOW TO FIND US

Gordon Street Chiropractic Clinic is in the South end of Guelph, on Gordon Street between Arkell Drive and Clair Road. For directions and a map please visit www.kristavetternd.ca

We look forward to meeting with you,

Dr. Krista Vetter

Pediatric Naturopathic Intake Form

Name: _____	Age: _____	Date of birth: _____	Sex: _____
Height: _____	Weight: _____	Grade level: _____	
Address: _____			
City: _____	Postal Code: _____		
Phone numbers: (H) _____	(W) _____		
Parent/Legal guardian: _____			
Email: _____			
Who referred you to us? _____			

**Naturopathic and preventative health care are greatly facilitated when the practitioner has a complete picture of the client physically, mentally, and emotionally. Therefore, please take the time to thoroughly complete this health history questionnaire.

Emergency Contact

Name and relation to child: _____

Address: _____

Phone: (home) _____ (work) _____

Who does the child currently live with? _____

Other Health Care Providers

Provider#1 name: _____

Designation (e.g., pediatrician, family physician, etc.): _____

Address: _____ Phone: _____

Provider#2 name: _____

Designation: _____

Address: _____ Phone: _____

What was the reason for your child's last visit to a health care provider? When was the last visit? _____

Health Concerns

1. Primary health concern: _____

At what age did this condition/illness begin? _____

Has this condition occurred before? _____

Does anything make the condition better or worse? _____

Prior treatments if any and outcomes of the treatments _____

Other health concerns:

2. _____

3. _____

4. _____

5. _____

Medical History

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

Excellent Good Fair Poor

Has your 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"/> Diphtheria | <input type="checkbox"/> Small pox |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Polio | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Mono | <input type="checkbox"/> Rubeola | <input type="checkbox"/> Other: _____ |

Does the child have any allergies to drugs, foods, environment, animals or other?

Please list any previous hospitalizations or surgeries? _____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Please indicate the immunizations your child has had and when:

Immunization	Date		Date
DPT (Diphtheria, Pertussis, Tetanus)	_____	Polio	_____
MMR (Measles, Mumps, Rubella)	_____	TB	_____
Haemophilus influenza B	_____	Flu	_____
Smallpox	_____	Chickenpox	_____
Pneumovaccine	_____	Hepatitis A	_____
Hepatitis B	_____		

Did your child have any reactions or complications with the above indicated vaccines?

Family History

Relation	Living (Age)	Any health concerns	Died (age)	Cause of Death
Mother				
Father				
Brother(s)				
Sister(s)				
Maternal grandmother				
Maternal grandfather				
Paternal grandmother				
Paternal grandfather				

Have any blood related family members ever suffered from:

- | | | |
|-----------------------------------------|--------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Genetic disorders |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sickle cells |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid condition | <input type="checkbox"/> Venereal disease |

Other: _____

Prenatal Health and History

How was the health of the parents at conception?

Mother:	Excellent	Good	Fair	Poor	Unknown
Father:	Excellent	Good	Fair	Poor	Unknown

What was the mother's age at the child's birth? _____

How was the mother's health during the pregnancy?

Excellent	Good	Fair	Poor	Unknown
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How was the mother's diet during the pregnancy?

Excellent	Good	Fair	Poor	Unknown
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What was the mother's level and type of exercise during pregnancy?

Did the mother experience any of the following during the pregnancy?

Bleeding	Nausea	Vomiting
High blood pressure	Diabetes	Thyroid problems
Physical trauma	Emotional trauma	

Other:

Did the mother use any of the following during the pregnancy?

Tobacco	Alcohol	Recreational drugs:
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Prescription

medications: _____

Over-the-counter

medications: _____

Supplements: _____

Other: _____

Was the mother exposed to any of the following during the pregnancy?

Diseases:

Toxins:

Other: _____

What was the mother's mental status during the pregnancy?

Were any of the following interventions used during pregnancy?

Ultrasound Amniocentesis Chorionic villi sampling Triple Screen
Maternal serum screening other: _____

Birth History:

Number of pregnancies: _____ Number of miscarriages: _____

Term length with this child: Full Premature: _____ wks

Late: _____ wks

Length of labour: _____ Weight at birth: _____ Height at birth: _____

Head Circumference: _____

Apgar score: 1 Minute _____ 2 Minutes _____ 5 Minutes _____

Any complications during the delivery? _____

Location of birth: Hospital Home Birthing Center Other: _____

Was the birth: Vaginal C-section Induced Forceps

Anesthesia/ Epidural used Episiotomy

Mother's emotional status at the time of birth? _____

Mother's emotional status post-partum? _____

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

Jaundice Rashes Seizures
Respiratory distress Infections Colic Anemia

Birth injuries/defects: _____

Other: _____

In general, how was your child's health in the first year?

Poor Fair Good Excellent Unknown

Diet

Breast fed. How long?

Formula (type): _____

Other: _____

Did your infant experience any difficulties with the formula or breast milk? _____

When was solid food introduced?

What foods were first introduced? Please indicate the age that the foods were introduced and if there were any reactions to the foods.

Describe a typical day's diet for your child? (Approximate quantities)

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

Please describe your child's eating habits (ie. picky eater, large appetite etc.).

Review of Systems

Please indicate any of the following conditions your child now experiences or has in the past:

- | | | |
|---------------------------------------------|------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Asthma or Allergies | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Colds/Flues | <input type="checkbox"/> Strep throat |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Visual problems | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Recurring Fevers |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Back/neck Pains | <input type="checkbox"/> Dental Cavities |
| <input type="checkbox"/> Temper Tantrums | <input type="checkbox"/> Constipation/Diarrhea | <input type="checkbox"/> Growing Pains |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Broken Bones |
| <input type="checkbox"/> Hernias | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Undescended testes |

Bowel Movement frequency _____

Bowel Movement appearance _____

Has your child ever had any significant physical or emotional traumas? _____

Development

Please indicate at what age your child began the following:

Teething _____
Crawling _____
Talking _____

Sitting _____
Walking _____
Potty training _____

Were there problems associated with any of the above mentioned stages?

Sleep

What time does your child usually go to bed? _____

What time does your child usually wake in the morning? _____

Does your child nap during the day? Yes No What time(s): _____

Does your child have nightmares? Yes No How often? _____

Does your child have any problems associated with sleeping (e.g., trouble falling asleep, trouble waking up, etc.)? _____

Social

Is your child in: school daycare home care other? _____

How would you describe your child's temperament?

Please circle 'y' for yes, or 'n' for no. Does your child:

Cry (frequency?)	y	n	Have temper tantrums	y	n
Plays well with others	y	n	Have fantasy friends	y	n
Watch TV (frequency)	y	n	Aggressive	y	n
Shares	y	n	Independent	y	n

How would you describe your child's behavior at home?

How would you describe your child's behavior and performance at school/daycare?

What are your child's interests?

What are your child's fears?

What are the child's favorite activities?

How much physical fitness does your child get?

What extracurricular activities/sports is the child involved in? (If any) How frequently does the child perform these activities?

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

Daily Several times a week Weekly Less than weekly

Is the child exposed to:
Smokers? _____

Alcohol or drug abusers? _____

Physical or verbal abuse? _____

Unsafe neighborhood? _____

Toxins (aluminum, copper..) _____

Environment

Are there any pets in the home? Yes No what type and how many? _____

How is the child's home heated? _____

How would you rate the stress level of the child's home? (0-10) _____

Is there anything that you feel is important that you would like to add? _____

NATUROPATHIC CONSENT TO TREATMENT FORM

Naturopathic Medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches are used. Diet and Nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy and lifestyle counseling are the mainstays of naturopathic medicine.

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 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.

Homeopathy is a form of medicine based on the Law of Similars- that is the use of tiny extremely diluted doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal or mineral origins are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool and affects healing on a physical and emotional level.

Asian Medicine includes acupuncture, as well as the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Botanical formulas may be given in the form of pills, tinctures or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

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. I will try to help you to identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment.

I will take a thorough case history, do a screening physical examination including breast examination if indicated.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform me immediately of any disease process that you are suffering from or if you are taking any

medications. If you are pregnant, suspect you are pregnant or you are breast-feeding please inform me as well.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Temporary aggravation of pre-existing symptoms
- Allergic reactions to herbs or supplements
- Bruising from acupuncture or intramuscular injection

A record will be kept of health services provided to you. This record will be kept confidential and will not be released to others unless you give your consent or the law requires it. You may look at your medical record at any time and can request a copy of it by paying the appropriate fee for copying charges.

I _____ understand that my naturopathic doctor will answer any questions to the best of her ability. I understand that results are not guaranteed. I do not expect my naturopath to be able to anticipate and explain all risks and complications. I will rely on my naturopathic doctor to exercise judgement during the course of the procedure which they feel at that time is in my best interests based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list any exceptions below)

I understand this consent form to cover the entire course of my 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.

Patient Name: (please print) _____

Signature of Patient or Guardian: _____

Date: _____