BURNABY HEIGHTS Integrative HEALTHCARE

Clear Form

Help

PEDIATRIC HEALTH INTAKE

Dear Patient,

Thank you for choosing me as your naturopathic physician for naturopathic medical care. I realize that this is a fairly lengthy questionnaire that you are required to fill out for your child. You deserve to know why it is important. Not only does it provide me with vital information about your child's medical history and concerns, but also it gives me a sense of your family, habits, and your child's personality. I feel this is essential in treatment so we can work together to reach optimal health for your child. So, please answer the questions to the best of your ability. During our appointment, we shall talk together, discussing your child's health concerns and reviewing the questionnaire; combined with a physical examination and laboratory tests, this information will help me provide you with the best possible personal naturopathic medical care.

The information in this questionnaire will be kept confidential. Thank you for your cooperation.

Bibliographic Data

Child's Name _____ Date of Birth _____

Place of Birth _____ Age _____ Sex _____

Parent/Guardian _____ Race/Ethnic Origin _____

Address _____ Phone Number _____

_____ Alternate Phone Number _____

Care Card Number _____ Referred by Whom _____

Email Consent: New legislation requires that we obtain consent prior to sending emails to our patients. I consent to receiving emails from Burnaby Heights Integrative Health Clinic and/or its staff. Yes ☐ No ☐

Email Address:_____

Contacts

1. Contact _____ Relation to Child _____

Address _____ Phone Number _____

2. Contact _____ Relation to Child _____

Address _____ Phone Number _____

Other Healthcare Providers

1. Name _____ 2. Name _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Present Health Concerns (in order of importance, duration of complaint, past treatment)

1. _____
2. _____
3. _____
4. _____

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Is the child currently taking any medications or supplements? _____

If so, please specify _____

Prenatal Health

Health of parents at conception:

Mother	❑ Poor	❑ Fair	❑ Good	❑ Excellent	❑ Unknown
Father	❑ Poor	❑ Fair	❑ Good	❑ Excellent	❑ Unknown
Health of mother during pregnancy:	❑ Poor	❑ Fair	❑ Good	❑ Excellent	❑ Unknown
Diet of mother during pregnancy:	❑ Poor	❑ Fair	❑ Good	❑ Excellent	❑ Unknown

Age of Mother at child's birth: _____

Did the mother seek prenatal care: _____

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

❑ Bleeding	❑ High Blood Pressure	❑ Nausea
❑ Diabetes	❑ Thyroid Problems	❑ Vomiting
❑ Other _____	❑ Physical Trauma	❑ Emotional Trauma

Did the mother use any of the following during pregnancy?

❑ Supplements (e.g., vitamins)	❑ Alcohol	❑ Recreational Drugs
❑ Prescription medications	❑ Tobacco	❑ Other_____

Birth History

Term length: _____weeks Length of labour: _____hours Weight of baby at birth: _____

Any complications? _____ No. of pregnancies? _____

Birth: ❑ Vaginal ❑ C-section ❑ Induced ❑ Forceps ❑ Anesthesia

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

❑ Jaundice	❑ Seizures	❑ Birth defects
❑ Rashes	❑ Birth injuries	❑ Other _____

Childhood History

Accidents or Injuries _____

Serious or Chronic Illnesses _____

Hospitalizations _____

Operations _____

Immunizations _____

Illnesses in the Family

Check in **Child** column if any one of the following has happened to your child. Check the **Blood Relative** column if any of the following have happened to a blood relative and state the relationship (parent, sibling, etc.):

Child	Blood Relative		Child	Blood Relative	
____	_____	Diabetes (sugar)	____	_____	Asthma
____	_____	High blood pressure	____	_____	Allergies
____	_____	Stroke	____	_____	Skin problems
____	_____	Heart disease	____	_____	Anemia
____	_____	Cancer (specify type)	____	_____	Stomach problems
____	_____	Psychiatric problems	____	_____	Kidney problems
Child	**Blood Relative**		**Child**	**Blood Relative**	
____	_____	Obesity	____	_____	Thyroid problems
____	_____	Arthritis (specify type)	____	_____	Bladder problems
____	_____	Cystic fibrosis	____	_____	Liver problems
____	_____	ADD/ADHD	____	_____	High cholesterol

☐ _____ Other ☐ _____ Genetic/inherited disease

Diet

☐ Breastfed (if yes, for how long)_____ ☐ Formula (Specify soy, milk, other)_____

What foods, if any were given prior to 6 months?

4-8 weeks _____

8-12 weeks _____

12-16 weeks _____

16-20 weeks _____

20-24 weeks _____

6 to 12 months _____

Did you child ever experience colic? _____ If yes, how severe and for how long?_____

Describe your child's typical day's diet.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Development

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Did your child have teething difficulties? _____

Describe your child's sleep pattern (e.g., bed times, wake times, any trouble falling asleep, naps, nightmares, dreams).

_____

Describe your child's behaviour and performance at school. _____

Describe your child's personality. _____

Has there been any change in your child's personality? _____

Environment

Is/Was your child in daycare? _____

What are your child's favourite activities? _____

What are your child's favourite toys? _____

Does your child exercise regularly, how often? _____

How much television does your child watch, hours per day/per week? _____

Does your child have any siblings? _____

If so, what birth order is your child (e.g., eldest)? _____

Does your child read books outside of school? Daily _____ Weekly _____ Monthly _____

Does your child have any extracurricular activities outside of school? _____

Does anyone in the child's household smoke? _____

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

Do you have any pets? _____

Is there anything else that you would like to add? _____

Does your child have any sensitivities to light, heat, cold, dark, or odors? _____

GENERAL (Please check if any of the following symptoms are currently a problem or are a recurring problem, if in the past, indicate with a P)

Current Weight: _____

□Poor appetite
□Fevers
□Sweat Easily
□Localized weakness
□Bleed or bruise easily
□Sudden energy drop (time of day?)
□Poor sleep
□Chills
□Tremors
□Poor balance
□Weight loss
□Strong thirst (hot or cold drinks)
□Fatigue
□Night sweats
□Cravings
□Change in appetite
□Weight gain
□Peculiar tastes or smells

SKIN AND HAIR

□Rashes
□Itching
□Dandruff
□Change in hair or skin texture
□Ulcerations
□Eczema
□Loss of hair
□Any other hair or skin problems _____
□Hives
□Pimples
□Recent moles

GASTROINTESTINAL

□Nausea
□Vomiting
□Constipation
□Diarrhea
□Abdominal pain or cramps
□Indigestions
□Belching
□Gas
□Bad breath
□Chronic laxative use
□Black stools
□Blood in stools
□Rectal pain
□Any other stomach problems_____

MUSCULOSKELETAL

□Neck pain
□Back pain
□Shoulder pain
□Joint nodules
□Muscle pain
□Muscle weakness
□Hand/Wrist pain
□Any other joint or bone problems _____
□Knee pain
□Foot/Ankle pain
□Swelling of joints

RESPIRATORY

□Cough
□Bronchitis
□Difficulty breathing lying down
□Coughing blood
□Pneumonia
□Production of phlegm (colour?)
□Pain with deep breath
□Asthma
□Any other lung problems _____

HEAD/EYES, EARS, NOSE, AND THROAT

□Dizziness
□Glasses
□Poor vision
□Cataracts
□Ringing in ears
□Sinus problems
□Grinding teeth
□Teeth problems
□Any other head or neck problems _____
□Concussions
□Eye strain
□Night blindness
□Blurry vision
□Poor healing
□Nosebleeds
□Facial pain
□Jaw clicks
□Migraines
□Eye pain
□Colour blindness
□Earaches
□Spots in front of eyes
□Recurrent sore throats
□Sores on lips or tongue
□Headaches (where/when)

CARDIOVASCULAR

□High blood pressure
□Low blood pressure
□Fainting
□Irregular heart beat
□Swelling of hands
□Swelling of feet
□Cold hands or feet
□Phlebitis
□Difficulty breathing
□Blood clots
□Chest pain
□Dizziness
□Any other heart or blood vessel problems _____

GENITO-URINARY

□Pain on urination
□Inability to hold urine
□Kidney stones
□Increased frequency in the day
□Increased frequency in the night
□Frequent infections: (bladder/kidney
□Bedwetting
□Any other genito-urinary problems _____

NEUROPSYCHOLOGICAL

□Seizures
□Dizziness
□Loss of balance
□Areas of numbness
□Lack of coordination
□Blood in stools
□Concussion
□Depression
□Poor memory
□Quick temper/irritable
□Anxiety
□Easily susceptible to stress
□Has your child ever been treated for emotional problems?
□Has your child ever considered or attempted suicide?
□Any other neurological or psychological problems _____

COMMENTS

Please indicate any other problems you would like to discuss.

_____
_____
_____

INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic physicians 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 may be used throughout the course of treatment. Treatment modalities may include: diet and nutritional supplements, vitamin-mineral injections and intravenous treatments, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, physical medicine and lifestyle counselling.

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

Botanical medicine is plant based medicine that involves the use of herbal teas, tinctures, capsules and other forms of herbal preparations that may assist in recovery from injury and disease.

Homeopathy is a form of medicine that uses minute doses of the very thing that causes symptoms in healthy people. These tiny doses of plant, animal, or mineral origins may be used to stimulate the body's ability to heal itself. Homeopathy can be a powerful tool that effects healing on a physical and emotional level.

Traditional Chinese Medicine and Acupuncture. Eastern herbs and dietary changes may be recommended to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tincture or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medicine theory.

Physical medicine refers to the use of hands-on techniques such as massage therapy as well as various types of electrical stimulation and therapeutic ultrasound for the purposed of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and to stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, your naturopathic physician will perform a thorough case history; conduct a physical examination, and when indicated, take saliva, blood and/or urine samples. Even the safest therapies may cause complications in certain physiological conditions (e.g., pregnancy, breastfeeding, very young children, or those taking multiple medications or with multiple medical conditions). Some therapies must be used in caution; therefore, it is important that you inform us of any medical conditions or change in medical conditions you have as well as any medications or supplements that you are taking. If you are pregnant or if you are breast–feeding, please advise your naturopathic physician immediately.

There may be some slight health risks associated with naturopathic medicine. These include but are not limited to:

Aggravation or pre-existing symptoms
Allergic reactions to supplements, herbs or prescription medication
Pain, bruising or injury from injections, blood draws or acupuncture
Fainting or puncturing of an organ with acupuncture needles

Please initial beside each statement below.

___I understand that a record will be kept of the health services provided to me. This health record will be kept confidential and will not be disclosed or released to others without my consent, unless required by law. I understand that I may look at my medical records at any time and can request a copy of them by paying the appropriate fees.

___I understand that the naturopathic physician will answer any questions that I have to the best of his or her abilities. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions here).

___I understand that charges are to be paid at the times of the visit unless specific arrangements have been made prior to my scheduled appointment. Payment for all dispensary items is due at the time of the visit.

___I understand that missed appointments or late cancellations (less than 24 hour notice) will be subject to a $25 fee.

___I understand that it is my responsibility to comply with the recommendations of the naturopathic physician in terms of treatment schedule and maintaining regular follow up appointments.

__ I have read and understand this document and accept the risks involved with receiving naturopathic treatment.

__ Prescription refills without a Naturopathic Office Visit will be charged $20.00 and Medical Letters will be charged $20.00. These can be claimed on your extended health care plan and may be covered depending on your coverage.

As a patient, you are responsible for the total charges incurred for each visit. We accept cash, debit, visa, or mastercard. If you have extended health coverage for naturopathic physicians, you are responsible for billing your own insurance company. We will provide you with the necessary documentation to do this. If you are on premium assistance with MSP, then you will receive $23 reimbursement for 10 visits per calendar year.

I have read and understand the above-stated policies and information. I understand that I am free to withdraw from treatment and to discontinue further participation in these procedures at any times.

Patient name (please print) _____

Signature of Patient/Guardian: _____ Date: _____

BURNABY HEIGHTS
Integrative
HEALTHCARE

For Patients with Extended Health Benefits
Insurance Providers include: Great-West Life, Sun Life, Standard Life, Johnson Inc., Industrial Alliance, Chamber of Commerce, Maximum Benefit, Manulife, Desjardins, and Blue Cross

Benefit Assignment Form

Insurance Company**:** _____

Patient Name: _____ Date of Birth: _____

Policy Number: _____

Member ID Number: _____

If you are not the insured member, then please provide insured member name and date of birth.

Insured Member Name: _____ Date of Birth: _____

I hereby assign benefits payable for the eligible claims to the **Burnaby Heights Integrative HealthCare, Inc (the Provider)** responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Credit Card: Visa/Mastercard: _____ Exp:_____

Date: _____

Signature: _____ Print Name: _____

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