STONETREE
NATUROPATHIC CLINIC

Welcome to StoneTree, and to the first steps on your way to feeling better! Thank you for choosing us as a part of your health care team.

Your Forms and Health History
Your new patient intake forms are attached to this letter. They may be more extensive then what you're used to – that's because naturopathic doctors are trying to look at you as a whole person in an effort to get to the root of what is causing your health issues. The more information we have to do this job, the better, and as a result, we ask a lot of questions!

Your First Appointment
Feel free to bring any other information you feel is relevant to your first appointment. If you like, you should also feel comfortable bringing a friend or family member with you, too. You can find directions to the clinic on our website at www.stonetreeclinic.com.

How You Found Us
If you'd care to share how you found your way to our clinic, we'd love to know.

☐ I was referred by a health professional

Who? ____________________________________.

Do we have your permission to discuss your case with this professional?
☐ YES ☐ NO

☐ I was referred by a friend or family member

We are so grateful to the people who refer to us. Please help us thank them by letting us know who sent you here:

____

☐ I read an article. Where? ____

☐ I saw an advertisement. Where? ____

☐ Other (internet, etc) ____

We look so forward to seeing you at your first visit! **If you have any questions, don't hesitate to call us at (705)444-5331.**

Yours in good health,

The StoneTree Team

27 Third St, Collingwood ON L9Y 1K4 (705)444-5331

Child Intake

Child's Name ______________________________ Date of Birth _______________ Sex M F

Who is filling out this form? Name ____________________ Relationship ________________

Contacts (in order of preference)

1. Name ____________________________________ Phone (H) ________________________

   Address _________________________________ (W) ________________________

   ____

Relationship to Child ____

2. Name ____________________________________ Phone (H) ________________________

   Address _________________________________ (W) ________________________

   ____

Relationship to Child ____

Whom does the child live with? ____

Other health care providers

1. ______________________ 2. ______________________ 3. ______________________

   ______________________ ______________________ ______________________

Phone #__________________ Phone #__________________ Phone #__________________

What are your child's health concerns, in order of importance:

1. ____

2. ____

3. ____

4. ____

Child's Medical History
Please indicate any serious conditions, illness or injuries, and any hospitalizations, along with approximate dates:
____
____
____
____

Which of the following diseases has your child had?

Rubella (German measles)	Roseola	Impetigo
Measles	Scarlet Fever	Mononucleosis
Chicken pox	Strep throat	Ear Infections
Whooping cough	Mumps	

Does your child have any allergies (medicines, environmental, etc.)?
____
____

Please list all CURRENT medication (Prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).
____
____
____
____

Please list all PAST prescription medications.
____
____
____
____

How many times has your child been treated with ANTIBIOTICS? ________________________

Which of the following immunizations has your child had?

DPP(diphtheria, pertussis, tetanus)	Haemophius influenza	Hepatitis B
Tetanus booster: when? _____	"Flu"	Hepatitis A
MMR(measles, mumps, rubella)	Polio	Chicken Pox
Other ________________________		

Please indicate if any of the above have caused an adverse reaction:
____
____

Has your child had any screening test (i.e. blood, hearing, vision)? Yes No
If yes please list:
____
____

Child's Diet

How was your infant fed?

Breast-fed: how long? _________ Formula: Milk Soy Other

Other: ________________________

Where foods introduce before 6 months? Yes No

If yes please list:

____

____

What foods were introduced between 6-12 months?

____

____

____

Did your child ever experience colic? Yes No

Was it? Mild Moderate Severe

Does your child have any food allergies or intolerances? Yes No

If yes please list:

____

____

Does your child have any dietary restrictions (i.e. religious, vegetarian/vegan)? Yes No

If yes please list:

____

____

Describe a typical day's diet for your child

Breakfast ____________________________________

Lunch ____________________________________

Dinner ____________________________________

Snacks _________________________

Beverages:

Type? ___________________________

How many? _____________________

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first:

Sit up _________ Crawl _________ Walk _________ Talk _________

Describe your child's sleep pattern:

____

Describe your child's temperament:

____

Describe your child's behaviour and performance at school:

____

____

Prenatal Health

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

How was the mother's diet during pregnancy ?

Poor Fair Good Excellent Unknown

What was the mother's age at the time of this child's birth? ______________________

Did the mother receive prenatal medical care? Yes No Unknown

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

Bleeding High Blood Pressure Nausea Vomiting

Diabetes Thyroid Problems Physical Trauma Emotional trauma

Other:____

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

Recreational drugs: Type? ____

Prescription Medications: List? ____

Over-the-counter Medications: List? ____

Supplements: List?____

Tobacco Alcohol Other: _______________________________________

Birth History

Term Length: Full Premature: _________wks. Late: _________wks.

Length of labour: ___________________ Child's weight at birth: ________________

Was the birth: Vaginal C-section Induced Forceps Anesthesia used

Where they're any complications? Yes No

If yes explain?

____

____

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

Jaundice Rashes Seizures

Birth injuries: _______________________ Birth defects:____________________________

Other:______________________________

Family History

Do you know the family medical history? Yes No

Indicate if a close relatives (i.e. parent, sibling) has had any of the following:

Symptoms	Who & Relationship	Symptoms	Who & Relationship
Allergies		Birth defects	
Asthma		Juvenile arthritis	
Diabetes		Other	
Kidney disease			

Do either of the parents have a chronic illness? Yes No
If yes please describe.

____
____

Child's Environment

Is the child in? School Daycare Home care Other

What are the child's favourite activities?

____
____

Does the child exercise regularly? Yes No
How much? ______________________________
How often? ______________________________

How much television doe your child watch? ____________________ hrs. per day/week

How often does your child read, or is read to (not for school)?
Daily Several times a week Weekly Less than weekly Never

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

Are there any animals in the home? Yes No
What kind? ____

How is the child's home heated? ____

Do you know of any toxins or hazards the child is regularly exposed to (home, school, hobbies)? Please describe:

____
____

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

____
____

WITH YOUR PERMISSION….

It is really important to the regulated health professionals at StoneTree Clinic that you understand what you are getting into. Informed consent is not just about signing a piece of paper, it is about really understanding and having the ability to ask questions and get clarity. If you have any questions at any time during your care at StoneTree Clinic, we are committed to answering them.

Here is what you can expect from the StoneTree Clinic team:

We believe in the healing power of nature. That means we are always trying to support your body to do what it should be doing to be healthy. The tools we use to do this are largely natural remedies – diet and nutritional supplementation, herbal medicine, acupuncture, physical manipulations and life style counseling.

We want to get to the root of the problem. That means we want to figure out WHY you are having the symptoms. As a result we sometimes do different assessments than what you might be used to, or look at your current lab tests in a different way. Lab tests ordered by your ND are NOT covered by OHIP. Any charges for lab tests will be discussed with you BEFORE they are ordered.

We like to look at our patients as “whole” people and treat them individually. Not all people with headaches have headaches for the same reason. As a result, we might ask you questions that have seemingly nothing to do with your headaches. Also, you might get a different treatment plan than your friend Betty who came in for the same problem. The reason, you are both different people and the CAUSE of your headaches might be different.

We are REALLY committed to the idea of “Doctor as Teacher” and prevention as the best form of healthcare. As a result you are going to be given lots of information. We do weekly blog-posts and monthly newsletters. We like to communicate with our patients via email with info and links to help you on your journey to wellness.

Want to reach us by email? No problem. We use email a lot to check in, clarify treatment plans and give further information as needed. Here is what we can’t do via email - assess and treat you for a new complaint. That, we have to do in person.

We work as part of a TEAM. There are Naturopathic Doctors, Medical Doctors and Registered Nurses on the StoneTree Clinic team. All of these individuals work together to deliver your care safely and effectively. Don’t worry – you will have one doctor who is primarily responsible for your care, but that doctor, and you, has access to the whole team when managing your case. The team meets weekly to ensure best care. We cover each others holiday to ensure there is always someone around who can care for you when you need it. When you become a patient of StoneTree Clinic you are a patient of the whole team. Want to know who is presently on the team and their credentials? Let us know and we will give you a list.

Although this should go without saying, the StoneTree Clinic team is absolutely committed to keeping your health information completely confidential.

We believe you should be “driving your own healthcare bus”, the StoneTree Clinic team are your navigators. We will never instruct you to refrain from seeking the advice or treatment from another regulated health care provider. We want to be a valued and trusted part of your health care team.

DECLARATION AND CONSENT TO TREAT

I understand that:

I may be assessed and treated in a way different than what is usually offered by a MD

If I am pregnant or lactating I will make sure the StoneTree Clinic team know about it.

I accept the inherent risks of treatment at StoneTree Clinic. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting due to stress or needle fears.
- Puncturing of an organ with acupuncture needles
- Accidental burning of skin from the use of moxa.
- Muscle strains and sprains, disc injuries from spinal manipulation

I agree to be a patient of the entire StoneTree Clinic team of licensed and regulated Health Professionals – Including ND's, MD's and RN's. **Initial:** ___________

I am at liberty to seek or continue medical care from a medical doctor or other care providers licensed to practice in Ontario.

I understand that results are NOT guaranteed. **Initial:** _________

I understand care at StoneTree Clinic is not covered by OHIP. I agree to pay my full account at the time of each visit. **Initial:** _________

I understand that advice given via email will be only for clarification or information.

I understand that a 24-hour cancellation policy is in effect. Full fees are applied without 24-hour notice. **Initial:** _________

I will be given a full and complete verbal explanation of the present and future treatments and/or services that I will receive.

I am not only free to, but am enthusiastically encouraged, to ask as many questions as I need to feel confident about any assessment and treatment I am to receive at StoneTree Clinic.

I can withdraw my consent at any time.

I understand that StoneTree Clinic adheres to the Personal Health Information Protection Act 2004. The Clinic's Health Information Custodian is Tara Gignac ND.

Name of Patient/Representative: ____

Signature of Patient/Representative: ________________________ Date:___________________

Witness:____ Date:___________________