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 Street Collingwood ON L9Y 1K4
(705) 444-5331 feelbetter@stonetreeclinic.com

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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 _____ Snacks _____

Lunch _____ Beverages:

Dinner _____ 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?

_____

_____

DECLARATION AND CONSENT TO TREAT

This is to acknowledge that I (or Parent/Legal Guardian) have been informed and understand that:

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. A number of different approaches are used: Diet and nutritional supplements, botanical medicine, homeopathy, Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counseling.

A StoneTree Clinic naturopathic doctor will take a thorough case history, do a screening physical exam and if your case requires, do more specific physical examinations including breast exams, gynecological exams and genital exams. Certain laboratory assessments may also be required on a case specific basis.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those on multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform your naturopathic doctor of any disease process that you are suffering from or if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise your naturopathic doctor immediately.

There is some slight health risks to treatment by Naturopathic Medicine. 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 or 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

As a patient of StoneTree Clinic, I am at liberty to seek or continue medical care from a medical doctor or other care providers licensed to practice in Ontario. No employee, agent, board member, student, instructor or anyone else under the direction or control of StoneTree Clinic has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

The Treatment and therapies rendered or recommended at StoneTree Naturopathic Clinic may be different that those usually offered by a medical doctor or other licensed health care providers.

As a patient of StoneTree Clinic I understand that results are not guaranteed.

I agree to pay my full account at the time of each visit or treatment, including fee for services, cost of supplements and remedies, cost of laboratory tests and other fees unless otherwise discussed. Payment can be made in cash, personal cheque, Debit Card, Visa or Mastercard.

I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during intake of my case.

I understand that a 24-hour cancellation policy is in effect. To avoid a visit charge I will notify the office 24-hours before a scheduled appointment. _____(intial)

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

OVER……

Privacy of your personal information is an important part of our practice, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information. For more detailed information ask the Privacy Information Officer for a copy of our privacy policy.

In this office Tara Gignac, ND acts as the Privacy Information Officer.

This consent form is intended to cover the entire course of treatments in this office. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Dated this _____ day of _____

Patient's Printed Name _____

Patient's Signature _____

Parent/Legal Guardian _____