Bayview Chiropractic Health Centre
www.drmingaynd.com
(416) 481-7901
Dr. Elizabeth Mingay, ND

PLEASE COMPLETE AND BRING THIS FORM **WITH YOU** TO YOUR CHILD'S FIRST APPOINTMENT

Who is filling out this form (name & relation):
____

Referred by: ____

Pediatric Naturopathic Intake Form

Please take the time to fill out the forms below and bring them with you to your child's initial naturopathic appointment. Please try to be as accurate as possible. All information provided on these forms will be kept confidential.

Name: ____ Date: ____________

DOB: _________________ Age: _____ Gender: M / F School Grade: ____

Family Home Address: ______________________________Apt #: ________

City: _______________ Province: ____________ Postal Code: _____________

Phone: Home: __________________

May we leave messages relating to visits? Y / N Which number? __________

Mother's Name: ______________________Occupation(s): _______________

Phone: Work: ________________________ Cell: _______________________

Father's Name: ______________________Occupation(s): _______________

Phone: Work: ________________________ Cell: _______________________

Siblings: Y / N If yes, list ages: _____________________________________

Parents' marital status: ____

Pediatrician name, phone #, and address: ______________________________

How did you find out about this clinic? ______________________________

Current Health Concerns

Reasons for visit:

1. ____
2. ____
3. ____

Has your child consulted a medical doctor / naturopathic doctor /

acupuncturist / nutritionist / counsellor for these concerns before?

(please circle)

Has your child had any blood work done? If yes, please list: ______________

List names and doses of <u>current</u> medications and/or supplements (vitamins, homeopathics, herbs, other) that your child is currently taking:

Please list any known allergies your child has to food, drugs, environmental, animals:

Medical History

How would you describe your child's general state of health (please circle)?

Excellent Good Fair Poor

Please indicate any serious illnesses, hospitalizations, surgeries, or injuries your child has had, along with approximate dates:

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

☐n☐m☐a☐s rubella (german measles)
☐n☐m☐a☐s roseola
☐n☐m☐a☐s impetigo
☐n☐m☐a☐s eczema
☐n☐m☐a☐s asthma
☐n☐m☐a☐s measles
☐n☐m☐a☐s chicken pox
☐n☐m☐a☐s mumps
☐n☐m☐a☐s scarlet fever
☐n☐m☐a☐s mononucleosis
☐n☐m☐a☐s whooping cough
☐n☐m☐a☐s ear infections
☐n☐m☐a☐s strep throat
☐n☐m☐a☐s colic

Please list any prescription medications your child has been on in the past:

____

____

____

How many times has your child been on antibiotics? ___________________

Date of most recent antibiotic prescription? __________________________

Please indicate what immunizations you have had:
□ DPT (diphtheria, petussis, tetanus)
□ Hepatitis A
□ Hepatitis B
□ MMR (measles, Mumps, rubella)
□ Haemophilus influenza B
□ "Flu"
□ Tetanus booster; when?___________
□ Small pox
□ Polio

Other:____

Please list any vaccination adverse reactions: _________________________

____

Please put an **'N'** for any conditions that your child experiences **NOW** and put a **'P'** for any condition your child has had in the **PAST**. Leave blank if neither apply.

____ Chronic Colds ___ Chronic Sniffles ___ Sinus Problems
___ Coughing/Wheezing ___ Allergies ___ Digestive Problems
____ Stomach aches ___ Diaper Rash ___ Constipation
___ Diarrhea ___ Skin Problems___ Warts ___ Cradle Cap
___ Psoriasis ___ Excessively sweaty as a baby/child ___ Jaundice
___ Anemia ___ Nightmares ___ Bed--wetting ___ Picky eater
___ Tantrums ___ Disobedient ___ Poor teeth ___ Bad foot odor
___ Fears/phobias ___ Hyperactivity ___ Early Puberty
___ Growing pains ___ Seizures ___ Recurring fevers ___ Headache

What screening tests has your child had (hearing, vision, speech, learning)?
____

____

____

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

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

Did the mother have other children already? ____________________________

How was the mother's diet during pregnancy?

☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

Did the mother receive prenatal medical care? Y / N / Unknown

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

☐Bleeding ☐High blood pressure ☐Nausea ☐Vomiting
☐Diabetes ☐Thyroid problems ☐Physical or emotional trauma

Other: ____

____

____

Full-term / premature (please circle) How late? _________________________
Vaginal birth? Y / N
C-section? Y / N
Other____
Difficult labour? Y____ / N

Length of labour________________________Weight at birth___________

Family Health History

Please indicate below if any member(s) of your family has had any of the following health problems:

Health Problem	Relationship to Patient (can be self)	Age of Onset	Duration of Illness	Deceased? (Y / N) and Cause of Death
Alcoholism / drug addiction				
Allergies				
Arthritis				
Asthma				
Autoimmune disease (e.g. RA, Lupus)				
Cancer				
Depression / other mental illness				
Diabetes				
Eczema				
Epilepsy				
Heart problems				
High blood pressure				
Osteoporosis				
Stroke				
Thyroid issues				
Juvenile arthritis				
Other				

Breastfed? Y, for how long____________________________________ / N

Formula? Y, what type____ / N
When was your child put on solid food? ________________
At what age did he/she sit up? ____________________ Crawl? ____________
Walk? _________________ Talk? ________________
At what age did he/she develop teeth? __________

Present – Dietary Information

How many meals does your child consume / day? ______________________
What foods does he/she crave? ______________________________________
Any food aversions? ____
Generally, how is his/her appetite? ___________________________________
____

Please list and identify any foods that your child is sensitive (S) or allergic (A) to and what symptoms he/she experiences:

____
____
____
____

Does your family and/or child maintain any specific dietary regimes (vegetarian, vegan, religious, other)?
____

Please describe your child's typical daily diet:
Breakfast: ____
Snack: ____
Lunch: ____
Snack: ____
Dinner: ____
Other (pop, candy, caffeinated beverages, etc.): __________________________
Water consumed: ____

Do you cook most of your own meals for the family? Y / N
If no, where do you get the majority of your meals? ________________

____
How many times a week does your child eat out at a restaurant? ___________
Do you consider your child's diet healthy? Y / N

What about your child's diet would you like to see improve? ____________

___

Does your child sit down to consume the majority of his/her meals? Y / N

Sleep

What time does your child go to bed? :
What time does your child wake up? :
Does your child do any activities in his/her bedroom other than sleep? Y / N
Does your child have a television in his/her bedroom? Y / N
Does your child share a bedroom with any siblings? Y / N
Does your child have frequent nightmares / dreams (please circle)?

General

Has your child witnessed or experienced any major stressors?

___

___

___

How would you describe your child's temperament? ___________________

___

How would you describe your child's performance in school? ___________

___

Do either of the child's parents' have a chronic illness? Y / N
If yes, please describe: ____

Is the child in school / daycare / homecare (please circle)
Other____

What are your child's favourite activities/hobbies? ____________________

___

Does your child play well with other children? ________________________

___

How often does your child exercise (hours/week)? ____________________

How much television does your child watch (hours/day)? _______________

How often does your child read? And/or does someone read for your child?

____

Does anyone in the household smoke? Y / N

Are there any animals in the home? Y / N

Do you know of any toxins the child is regularly exposed to, either in the home, school or elsewhere? Please describe:

____

____

Please list any other concerns you may have__________________________

____

Informed Consent

Naturopathic medicine is the treatment of illness through the use of natural and non-invasive measures that stimulate the body to heal itself from within. Your ND will take you through a thorough intake, a complete physical exam, and provide you with appropriate and effective treatment plans by the conclusion of the second visit.

It is crucial that you provide your ND with a detailed and accurate medical history, as well as a complete list of any pharmaceutical medications and/or supplements that you are currently taking. Advising your ND of any allergies to medications and/or foods is also very important.

Your signature must be obtained prior to beginning treatment, acknowledging the statements below:

- You have read the above information and that you understand that you are ultimately responsible for your own health.
- Diagnosis, treatment and/or referral to other health care professionals are based upon the assessment of conditions revealed through personal history, interview, physical assessment and laboratory testing.
- You have been informed of, and understand the diagnostic and therapeutic procedures with respect to expected benefits, potential risks and side effects, the likely consequences of not having/following the procedure(s) and what alternative course(s) of action are available.
- You are accepting or rejecting this care of your own free will and choice.
- You accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered (by the end of each visit).
- If you have any questions regarding your treatment program, you will call to clarify these issues.

Patient name (please print): ____

Signature of Guardian: ____________________________ Date: __________

Patient Consent Form For Collection Use and Disclosure of Personal Information

Privacy of your personal information is an important part of our policy, 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 be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy ensures that:

- only necessary information is collected about you
- our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy
- we only share your information with your consent
- storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

We understand the importance of protecting your personal information. To help you understand how we are doing so, we have outlined below how our clinic will use and disclose your information. This clinic will collect, use and disclose information about you for the following purposes:

- to assess your health concerns
- to provide health care
- to advise you of treatment options
- to establish and maintain contact with you
- to remind you of upcoming appointments
- to communicate with other treating health-care providers
- to allow us to efficiently follow-up for treatment, care and billing
- to complete claims for insurance purposes
- to comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners Act
- to invoice for goods and services
- to process credit card payments
- to collect unpaid accounts

• to assist this clinic to comply with all regulatory requirements
• to comply generally with the law
• to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing the consent section of this Patient Consent Form, you have agreed that you give your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information. I agree that Dr. Elizabeth Mingay, ND can collect, use and disclose personal information about___________________________(patient name) as set out above in the information about the clinic's privacy policies.

Guardian signature____

Date__________Signature of witness_______________________________

Naturopathic Fee Schedule

Adult Consultations:

Initial Visit (60-75 mins)	$195
Acupuncture Visit (40 mins)	$110
Follow-up Visit (30 mins)	$80

Pediatric/Adolescent Consultations (under 18 years):

Initial Visit (60-75 mins)	$175
Follow-up Visit (30 mins)	$80

IV Therapy, Injections, Other:

IV Drip	$140
High Dose Vitamin C IV Drip	$180
B12 Injection	$30 + hst
Telephone consultations	$75
Seasonal Allergy Testing	$100

Cosmetic Acupuncture

* Initial Visit (90 mins)	$195
Cosmetic Follow-up (90 mins)	$140
Maintenance Follow-up (60 mins)	$100

* Initial visits include a 45-minute medical intake and a 45-minute introductory cosmetic acupuncture treatment.
For best results, we recommend 12 sessions.

- Fees are to be paid at the end of each visit
- All fees are subject to HST (13%)
- Botanical, homeopathic, and/or supplement prescriptions are not included in the above fee

Naturopathic appointments are not covered by OHIP, however they are covered in many extended health care plans. We recommend that you keep your receipt(s) and consult your insurer.

Please sign and date below, indicating you will abide by and understand all of the information above:

Signature:______________________________ Date:_________________