

NEW PATIENT INTAKE FORM – CHILD (AGE 0-12)

Please print this form, complete as much as possible, and bring with you on the day of your first appointment to our clinic. We look forward to meeting you.

Child's Name		Date of Birth	Age	Gender
Today's Date	Primary Phone (circle: home / cell / work)		Alternate Phone (circle: home / cell / work)	
How would you prefer to receive appointment reminders? <input type="radio"/> Text <input type="radio"/> Voicemail <input type="radio"/> Email				
Mailing Address				
City		Province	Postal Code	
Email Address				
Parent/Guardian Name			Relationship to Child	
Emergency Contact Name / Relationship			Emergency Contact Phone	
Are you currently receiving healthcare at another location/s? Please name other healthcare providers and their role in your medical care:				
How did you hear about us?				

1. Why did you choose to come to Restoration Health Clinic? What do you know about our approach?
2. What **three** expectations do you have for your first visit to our clinic?
3. What is your present level of commitment to make lifestyle changes, if necessary, to treat your child's condition? (Rate from 0-10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10
4. What do you believe are the biggest factors affecting your child's health?

Primary Concerns List in order of priority. Describe your concerns below if necessary.

Concern Example: Headaches	Onset Example: January 2013
1	
2	
3	
4	
5	

Infant History

Birthplace:

Birth Weight:

Birth Length:

1. Were there any of the following illnesses or problems during pregnancy?

- Rubella
 High blood pressure
 Excessive weight gain
 Accident/injury
 Bleeding
 Gestational diabetes
 Pre-eclampsia
 Eclampsia
 Any other problems during the pregnancy? (Please describe)

2. At delivery was your baby:

- Breech
 Cesarean section
 VBAC
 Resuscitated
 Any other problems with birth or the first days of life? (please describe)

3. Did your baby deliver early? (If so, by how many weeks?)

4. Any problems with the baby's health? (Please describe)

5. Breastfed? (List duration) Formula fed? (List duration) Type of formula:

Any feeding problems? (please describe)

Accident History

Has your child had:
 Broken bones?
 Severe burns?
 Poisoning episodes?
 Cuts needing stitches?
 Frequent injuries or accident prone?

Your Child's Medical History

Head Please check <input checked="" type="checkbox"/> all that apply. <input type="radio"/> Current = C and/or <input type="radio"/> Past = P		
C P <input type="radio"/> <input type="radio"/> Headaches	C P <input type="radio"/> <input type="radio"/> Migraines	C P <input type="radio"/> <input type="radio"/> Head injury

Ear/Nose/Mouth/Throat/Neck Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Impaired hearing</p> <p><input type="radio"/> <input type="radio"/> Sensitivity to noise</p> <p><input type="radio"/> <input type="radio"/> Frequent ear infections</p> <p><input type="radio"/> <input type="radio"/> Nose bleeds</p> <p><input type="radio"/> <input type="radio"/> Stiffness</p> <p><input type="radio"/> <input type="radio"/> Loss of smell</p> <p><input type="radio"/> <input type="radio"/> Hayfever</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Frequent colds or flus</p> <p><input type="radio"/> <input type="radio"/> Teeth/gum problems</p> <p><input type="radio"/> <input type="radio"/> Copious saliva</p> <p><input type="radio"/> <input type="radio"/> Mouth ulcers</p> <p><input type="radio"/> <input type="radio"/> Teeth grinding</p> <p><input type="radio"/> <input type="radio"/> Hoarse voice</p> <p><input type="radio"/> <input type="radio"/> Loss of voice</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Dental cavities or infections</p> <p><input type="radio"/> <input type="radio"/> Cold sores</p> <p><input type="radio"/> <input type="radio"/> Mercury (silver) amalgam fillings</p> <p><input type="radio"/> <input type="radio"/> Root canals</p> <p><input type="radio"/> <input type="radio"/> Regular dental cleanings</p> <p><input type="radio"/> <input type="radio"/> Swollen nodes/glands</p>
---	--	--

Eyes Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Glasses or contacts</p> <p><input type="radio"/> <input type="radio"/> Colour blind</p> <p><input type="radio"/> <input type="radio"/> Recent change in vision</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Blurred vision</p> <p><input type="radio"/> <input type="radio"/> Eye pain/strain</p> <p><input type="radio"/> <input type="radio"/> Sensitivity to light</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Eyes watery or dry</p> <p><input type="radio"/> <input type="radio"/> Bloodshot eyes</p> <p><input type="radio"/> <input type="radio"/> Puffy eyes</p>
---	--	---

Respiratory Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Cough</p> <p><input type="radio"/> <input type="radio"/> Mucous/phlegm</p> <p><input type="radio"/> <input type="radio"/> Wheezing</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Difficulty breathing</p> <p><input type="radio"/> <input type="radio"/> Asthma</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Bronchitis</p> <p><input type="radio"/> <input type="radio"/> Pneumonia</p>
---	---	--

Cardiovascular + Blood Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Heart disease</p> <p><input type="radio"/> <input type="radio"/> Rheumatic Fever</p> <p><input type="radio"/> <input type="radio"/> Arrythmia</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Valve prolapse</p> <p><input type="radio"/> <input type="radio"/> Easy bleeding or bruising</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Cold hands/feet</p> <p><input type="radio"/> <input type="radio"/> Anemia</p>
--	--	--

Gastrointestinal Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Constipation</p> <p><input type="radio"/> <input type="radio"/> Diarrhea</p> <p><input type="radio"/> <input type="radio"/> Change in thirst</p> <p><input type="radio"/> <input type="radio"/> Change in appetite</p> <p><input type="radio"/> <input type="radio"/> Abdominal cramping or pain</p> <p><input type="radio"/> <input type="radio"/> Burping</p> <p><input type="radio"/> <input type="radio"/> Flatulence</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Nausea</p> <p><input type="radio"/> <input type="radio"/> Vomiting</p> <p><input type="radio"/> <input type="radio"/> Black or dark tarry stools</p> <p><input type="radio"/> <input type="radio"/> Blood or mucous in stool</p> <p><input type="radio"/> <input type="radio"/> Undigested food in stool</p> <p><input type="radio"/> <input type="radio"/> Jaundice (yellow skin)</p> <p><input type="radio"/> <input type="radio"/> Gallbladder disease</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Irritable Bowel Syndrome</p> <p><input type="radio"/> <input type="radio"/> Crohn's</p> <p><input type="radio"/> <input type="radio"/> Ulcerative Colitis</p> <p><input type="radio"/> <input type="radio"/> Gastritis or Peptic Ulcer</p> <p><input type="radio"/> <input type="radio"/> GERD</p> <p><input type="radio"/> <input type="radio"/> Celiac Disease</p>
--	--	---

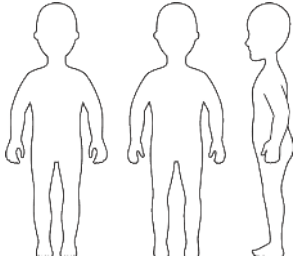
Genital + Urinary Systems Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Increased frequency of urination</p> <p><input type="radio"/> <input type="radio"/> Pain on urination</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Inability to hold urine</p> <p><input type="radio"/> <input type="radio"/> Blood in urine</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Urinary Tract Infections</p> <p><input type="radio"/> <input type="radio"/> Yeast Infections</p>
--	--	---

Inflammatory/Autoimmune Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Autoimmune Disease</p> <p><input type="radio"/> <input type="radio"/> Rheumatoid Arthritis</p> <p><input type="radio"/> <input type="radio"/> Severe Infectious Disease</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Poor Immune Function/ Frequent Infections</p> <p><input type="radio"/> <input type="radio"/> Food Allergies</p> <p><input type="radio"/> <input type="radio"/> Environmental Allergies</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Multiple Chemical Sensitivities</p> <p><input type="radio"/> <input type="radio"/> Latex Allergy</p> <p><input type="radio"/> <input type="radio"/> Lupus SLE</p>
--	---	--

Musculoskeletal Pain Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Joint pain or stiffness</p> <p><input type="radio"/> <input type="radio"/> Broken bones</p> <p><input type="radio"/> <input type="radio"/> Muscle weakness</p> <p><input type="radio"/> <input type="radio"/> Muscle cramping or spasms</p>	<p>Please mark areas of current pain:</p> 
--	--

Skin Diseases Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Rashes</p> <p><input type="radio"/> <input type="radio"/> Eczema</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Hives</p> <p><input type="radio"/> <input type="radio"/> Psoriasis</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Acne</p> <p><input type="radio"/> <input type="radio"/> New or changing mole</p>
---	---	---

Mood + Emotional Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Depression</p> <p><input type="radio"/> <input type="radio"/> Anxiety or nervousness</p> <p><input type="radio"/> <input type="radio"/> Difficulty concentrating</p> <p><input type="radio"/> <input type="radio"/> Poor memory</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Tension</p> <p><input type="radio"/> <input type="radio"/> Easily stressed</p> <p><input type="radio"/> <input type="radio"/> Lack of pleasure or motivation</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Mood swings</p> <p><input type="radio"/> <input type="radio"/> Considered suicide</p> <p><input type="radio"/> <input type="radio"/> Bipolar Disorder</p> <p><input type="radio"/> <input type="radio"/> Schizophrenia</p>
--	---	---

Neurologic Please check ✓ all that apply. Current = **C** and/or Past = **P**

<p>C P</p> <p><input type="radio"/> <input type="radio"/> Loss of balance</p> <p><input type="radio"/> <input type="radio"/> ADD/ADHD</p> <p><input type="radio"/> <input type="radio"/> Mild Cognitive Impairment</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Sensory Integrative Disorder</p> <p><input type="radio"/> <input type="radio"/> Multiple Sclerosis</p>	<p>C P</p> <p><input type="radio"/> <input type="radio"/> Autism</p> <p><input type="radio"/> <input type="radio"/> Seizures</p>
---	---	---

Behaviour Please check ✓ all that apply. Current = **C** and/or Past = **P**

<input type="radio"/> <input type="radio"/> Unusual play <input type="radio"/> <input type="radio"/> Doesn't do for self <input type="radio"/> <input type="radio"/> Very cautious <input type="radio"/> <input type="radio"/> Hides knowledge/skill <input type="radio"/> <input type="radio"/> Lost in thought/unreachable <input type="radio"/> <input type="radio"/> Poor focus, attention <input type="radio"/> <input type="radio"/> Sits for a long time, staring <input type="radio"/> <input type="radio"/> Poor sharing <input type="radio"/> <input type="radio"/> Rejects help <input type="radio"/> <input type="radio"/> Curious/gets into things <input type="radio"/> <input type="radio"/> Destructive	<input type="radio"/> <input type="radio"/> Hyperactive <input type="radio"/> <input type="radio"/> Constant movement <input type="radio"/> <input type="radio"/> Melt downs <input type="radio"/> <input type="radio"/> Tantrums <input type="radio"/> <input type="radio"/> Self mutilation <input type="radio"/> <input type="radio"/> Runs away <input type="radio"/> <input type="radio"/> Jumps when pleased <input type="radio"/> <input type="radio"/> Flaps arms <input type="radio"/> <input type="radio"/> Head banging <input type="radio"/> <input type="radio"/> Falls, gets hurt running, climbing	<input type="radio"/> <input type="radio"/> Does opposite of asked <input type="radio"/> <input type="radio"/> Teases others, bullies <input type="radio"/> <input type="radio"/> Shrieks <input type="radio"/> <input type="radio"/> Toe walking <input type="radio"/> <input type="radio"/> Arches back with crying or bright lights <input type="radio"/> <input type="radio"/> Licking <input type="radio"/> <input type="radio"/> Rhythmic rocking <input type="radio"/> <input type="radio"/> Bites fingers, nails <input type="radio"/> <input type="radio"/> Chews on things
---	--	--

Cancer Please describe.

Developmental History

Please indicate the approximate age in months for the following milestones: (example: walking 14 months or check the box for never)

Sitting up _____ months <input type="radio"/> Never	Crawl _____ months <input type="radio"/> Never
Pulled to stand _____ months <input type="radio"/> Never	Potty trained _____ months <input type="radio"/> Never
Walked alone _____ months <input type="radio"/> Never	Dry at night _____ months <input type="radio"/> Never
First words _____ months <input type="radio"/> Never	Spoke clearly _____ months <input type="radio"/> Never
Lost language _____ months <input type="radio"/> Never	Lost eye contact _____ months <input type="radio"/> Never

Family Medical History

List any diseases for each family member. Please include family member's age and cause of death if no longer alive.

Mother	Maternal Grandmother	Maternal Grandfather
Father	Paternal Grandmother	Paternal Grandfather
Siblings		

Vaccinations

If relevant, attach a copy of your child's vaccination record.

1. Is your child up to date with vaccinations? Yes No
2. Do you feel vaccinations have had an impact on your child's health? Yes No

Stress/Coping

1. Has your child experienced any major life changes that may have impacted his/her health? Yes No
2. Has your child ever experienced any major losses? Yes No
3. Has your child ever seen a counsellor? Yes No
4. Does your child have a favourite toy or object? Yes No
5. Has your child ever experienced a significant trauma? Yes No

Sleep/Rest

1. Average number of hours your child sleeps per night _____
2. Does your child have trouble falling asleep? Yes No
3. Does your child feel rested upon awakening? Yes No
4. Does your child snore? Yes No
5. Who are the main people who care for your child?

Surgeries & Hospitalizations Include when, where and injuries.

Diet & Lifestyle

1. What does your child typically eat in one day?

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

2. What are the least healthful foods in your child's diet?
3. Does your child drink: Water Juice Pop Milk (note if dairy alternative) :
5. Do you have any questions or concerns about your child's diet?

Medications & Supplements:

Medication (Over the counter / prescription)	Dosage & Frequency
Supplements (Including brand name)	Dosage & Frequency

Allergic reaction/intolerances to Medications Example: penicillin causes hives

Allergic reaction/intolerances (Foods, Environment) Example: cow's milk causes bloating

Have you or your child had any prior experiences with natural medicine? If yes, please describe:



AUTHORIZATION AND CONSENT

Dear Patient,

Thank you for your interest in retaining Restoration Health Clinic Inc. ("Restoration") to provide you or your child with naturopathic care and guidance to support and improve your or your child's health and well being.

Prior to Restoration agreeing to accept you or your child as a patient and provide you or your child with its naturopathic services, Restoration requires that you review and agree to the terms and conditions contained in this letter agreement.

Throughout this letter agreement the terms "you", "I", "me" and "my" shall refer to you the undersigned individual or your child (as applicable), specified at the end of this letter agreement.

I wish to retain Restoration to provide me or my child with naturopathic care, treatment and guidance to support and improve my or my child's health and well being (the "Treatment"). I understand and agree that prior to Restoration providing me the Treatment, Restoration requires, and is relying on, my consent and the following representations, warranties and covenants:

1. I understand and acknowledge that Restoration employs naturopathic doctors ("ND") to provide the Treatment and does **not** employ traditional medical doctors to provide the Treatment. For the purposes of providing the Treatment, I consent to one or more of Restoration's NDs or staff to carry out the following tasks:
 - (a) take a thorough case history and conduct a screening physical examination; which may include a breast exam, gynaecological, rectal, prostate, and blood and urine samples as required; and
 - (b) recording your personal medical information and sharing your personal medical information with Restoration Staff and other medical professionals solely in connection with your Treatment and subject to strict confidentiality guidelines implemented by Restoration.
2. I understand and acknowledge that Restoration employs the use of Botanical Medicine, Traditional Chinese Medicine, Acupuncture, Bony manipulations, Massage, Hydrotherapy, Nutrition, Lifestyle Counseling, Psychological counseling, Homeopathy, Intramuscular injections, intravenous injections, Pharmaceutical prescriptions, or Vaccinations in providing the Treatment.
3. I represent and warrant that all medical information provided by me to Restoration during my initial health assessment is true and correct. I will advise Restoration as soon as possible of any errors in the medical information I provided to Restoration or any changes to my current health status including any disease or ailments that I may be suffering from, any medication or over the counter drugs that I am consuming and whether I am pregnant, suspect I may be pregnant or am breast-feeding.
4. I hereby acknowledge and agree that Restoration has not made any warranties or representations of any kind to me regarding results that may be achieved from the Treatment. I understand that any results or outcomes arising from the Treatment are individual and may vary from person to person. I understand that the results of the Treatment are not guaranteed and do not expect the ND's will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the Treatment provided to me by Restoration.
5. I hereby acknowledge and agree that the Treatment may lead to certain unforeseen complications, including but not limited to: aggravation of pre-existing symptoms; allergic reactions to pharmaceuticals, supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations. I also acknowledge that I have the right to accept or reject this medical care of my own free will and choice.
6. I recognize that specific foods, botanicals and medications may create allergic and possible serious reactions, in particular, products containing nuts. I further acknowledge that these allergies may cause me serious bodily harm. I represent and warrant that I have provided to Restoration during my initial health and assessment a list of all items which, to the best of my knowledge, I am allergic or sensitive to.

7. I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. Notwithstanding, I understand that the Staff and ND's at Restoration are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats or harm to any individual and/or serious threat of suicide involved with my case. I understand that I may look at my medical records at anytime and can request a copy of it by paying the appropriate fees. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.
8. In consideration for Restoration agreeing to provide me with the Treatment, I hereby irrevocably and unconditionally release and forever discharge Restoration, its directors, officers, employees, agents and contractors and Restoration's successors, assigns, heirs and legal representatives (all such persons and entities being called the "Released Parties") of and from all manner of actions, causes of action, suits, demands, debts, accounts, covenants, contracts, damages and all other claims whatsoever, which the undersigned or its successors or assigns ever had, now has or may in the future have against any of the Released Parties for or by reason of any cause, matter or thing related to or arising from the Treatment provided to me including (but not limited to) any bodily harm or injury sustained by me or any other person. I further acknowledge and agree that the Released Parties will in no way be responsible for any bodily harm or injury suffered by me as a result of the Treatment.
9. I further agree and acknowledge that Restoration has the right to cease providing the Treatment to me at any time effective immediately, without any compensation to me whatsoever. This letter agreement will cover the entire course of my Treatment and I am free to withdraw my consent and to discontinue participation Treatment at any time.
10. Please note we require 48 hours notice for all cancelled appointments or the full visit fee will be charged.

We thank you for the opportunity of being able to work with you on improving your health, and wellbeing.

Yours truly,

RESTORATION HEALTH CLINIC INC.

I hereby certify that the representations and warranties contained in this letter agreement are true and correct and I hereby agree to the foregoing covenants and terms and conditions.

I hereby consent to _____ [enter name of ND] on behalf of Restoration and Restoration Health Clinic Inc. to provide me or my child with the Treatment described above.

Dated the ____ day of _____, 201____.

Print Name of Patient (if patient is a minor, print name guardian and relationship of guardian to patient):	
Signature of Patient (or signature of guardian if applicable):	
Address of Patient (and address of guardian if applicable):	
Telephone Number:	Email Address: