**Pediatric Naturopathic Intake Form**

Prior to your visit, please complete the following form with as much detail as possible so that I can better understand the health needs of your child.

| PATIENT INFORMATION | | |
|---|---|---|
| Name: _____ _____ _____<br>First Middle Last | | |
| Age: | DOB: _____ /_____/_____<br>MM DD YY | Sex: |

| CONTACT INFORMATION | | |
|---|---|---|
| Home Address: | | |
| City: | | Postal Code: |
| Home Phone: | Cell Phone: | Work Phone: |
| May we leave messages at the above phone numbers? If so, please circle which ones.<br>Note that no confidential information is left on voicemails.<br>Home Cell Work | | |
| Email address: | | |
| Preferred Method of Contact: | | |

| EMERGENCY CONTACT INFORMATION |
|---|
| Primary Contact: |
| Relationship: |
| Phone Number(s) for emergency contact: |

| OTHER HEALTHCARE PROVIDERS | | |
|---|---|---|
| Medical Doctor: | Location: | Date of Last Visit: |
| Specialist: | Location: | Date of Last Visit: |
| Specialist: | Location: | Date of Last Visit: |

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| CLINIC INFORMATION | |
|---|---|
| How did you hear about Patricia Arcuri, ND?<br><br>Has your child seen a Naturopathic Doctor before? | |
| HEALTH CONCERNS | |
| What are your child's most important health concerns? Please list in order of importance to you. | |
| 1.<br><br>2.<br><br>3.<br><br>4. | 5.<br><br>6.<br><br>7.<br><br>8. |
| Please list any diagnoses your child has received (presently or in the past), who diagnosed the condition and any relevant dates. | |
| MEDICATIONS AND SUPPLEMENTS | |
| Please list any prescription medications, over-the-counter medications, as well as any vitamins or supplements your child is taking. If possible, please include dosages and frequency. | |
| 1.<br><br>2.<br><br>3.<br><br>4. | 5.<br><br>6.<br><br>7.<br><br>8. |
| Can your child swallow pills and/or capsules? | |
| ALLERGIES (Please list below) | |
| | |
| GOALS OF TREATMENT | |
| What are the top 3 goals that you hope to accomplish through naturopathic treatment?<br><br>1.<br><br>2.<br><br>3. | |

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| IMMUNIZATIONS (please check all that apply) | |
|---|---|
| MMR | Rotavirus |
| DPT | Pneumococcal |
| Chickenpox (Var) | Meningococcal |
| Smallpox | Hepatitis A |
| H. Influenza (Hib) | Hepatitis B |
| Flu Shot | Other: |
| Did your child have any adverse reactions to any of the above immunizations?<br>If so, please specify: | |

| GENERAL INFORMATION | |
|---|---|
| Your child's current weight: | Your child's current height: |

| MEDICAL HISTORY | | | |
|---|---|---|---|
| **Condition** | **Y/N** | **Has your child ever had any of the following?** | **If so, please list dates and results** |
| Chicken pox | | Electroencephalogram (EEG) | |
| Measles | | Sleep study | |
| Mumps | | Psychological evaluation | |
| Rubella | | Hearing tests | |
| Scarlett Fever | | Speech/Language Evaluation | |
| Pneumonia | | Vision tests | |
| Tonsillitis | | Injuries, surgeries or hospitalizations (please specify) | |
| Ear infections | | | |
| Strep throat | | | |
| Other | | | |

| FAMILY HISTORY | | |
|---|---|---|
| **Condition** | **Y/N** | **Family Member** |
| Anemia | | |
| Asthma | | |
| Autoimmune | | |
| Cancer | | |
| Diabetes | | |
| Eczema | | |
| Epilepsy | | |
| Heart Disease | | |
| High blood pressure | | |
| Kidney disease | | |
| Stroke | | |
| Other | | |
| Family History Unknown | | |

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| DIET & HEALTH HABITS | | | |
|---|---|---|---|
| Please describe your child's typical daily diet, including water and other beverages. | | | |
| **Breakfast:** | **Lunch:** | **Dinner:** | **Snacks:** |
| | | | |

| PRENATAL HISTORY |
|---|
| Previous pregnancies by birth mother, miscarriages or complications? Yes No |

| MOTHER'S HEALTH DURING PREGNACY (please check all that apply) | | |
|---|---|---|
| Bleeding | Nausea | Physical/emotional trauma |
| Illness | Hypertension | Cigarettes, alcohol or drug consumption |
| Medications | Diabetes | Other: |

| BIRTH HISTORY | |
|---|---|
| Child's weight at birth:<br>Mother's age at birth:<br>Length of Labour:<br><br>Complications during birth: | <br>__ Full term<br>__ Premature<br>__ Late<br>__ Vaginal delivery<br>__ C-section |

| **Did your child have any of the following problems shortly after birth?** | | |
|---|---|---|
| Rashes | Birth defects | Other: |
| Jaundice | Seizures | |
| Colic | Fever | |
| Birth Injuries | Blue baby | |

Was your baby breast-fed?
If yes, breast-fed for how long?

Was your baby formula fed?
If yes, type of formula (ie. milk, soy):

At what age did your child begin eating solids?
Which foods?

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____ First tooth _____

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**Informed Consent**

Please note that this form must be signed prior to your first appointment.

Naturopathic medicine promotes wellness and aims to prevent disease by addressing the root cause of illness. Dr. Patricia Arcuri, ND will take a detailed case history and perform any relevant physical examinations. It is very important that you inform Dr. Patricia Arcuri, ND of any medical concerns, medication and/or supplements that you may be taking, as well as if you are pregnant, suspect you are pregnant or if you are breastfeeding. As a patient, you will receive information about your diagnosis and/or treatment, any alternative options available, the material effects/costs, expected benefits, risks, side effects and in each case, the consequences of not having the diagnosis and/or treatment acted upon. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine. Possible health risks of naturopathic medical treatment include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, fainting or injury from acupuncture
- The staff are trained to handle emergencies should the need arise.

I understand:

- An electronic medical record will be kept of the health services provided to me. This record will be kept in strict confidentiality and will not be released to others unless law requires it or I give my written consent.
- Dr. Patricia Arcuri, ND will have to report me in the following instances: when I am in imminent danger of harming myself or others, when there is reasonable suspicion that I am neglecting and/or emotionally, physically or sexually abusing a minor, and if I engage in sexual relations with any of my healthcare providers.
- I may access my medical records at any time and can request a copy by paying the required fee.
- Dr. Patricia Arcuri, ND does not guarantee treatment results. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and potential complications.

I recognize that this consent form covers the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I have read this statement and agree to work within its guidelines, including the limits of confidentiality.

Patient Name: (Please print):_____

Signature of Guardian:_____

Date:_____

ND Signature: _____

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**PATIENT CONSENT FOR COLLECTION,**
**USE AND DISCLOSURE OF PERSONAL INFORMATION**

**Privacy and protecting your personal information in an important part and consideration of my practice as a naturopathic doctor. This privacy policy outlines what I do to ensure that:**

- Only necessary information is collected about you;
- I only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols (this includes cloud-based electronic medical records that are housed within Canada and are compliant with such legislation and privacy protocols);
- Privacy protocols comply with privacy legislation and standards of naturopathic doctor's regulatory body

**We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:**

- To assess your health concerns, provide health care and advise you of treatment options;
- To establish and maintain contact with you;
- To remind you of upcoming appointments;
- To efficiently follow-up with you for treatment;
- To complete claims for insurance purposes;
- To invoice for goods and services;
- To process credit card payments;
- To collect unpaid accounts and follow up on billing, as required;
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others;
- To be used for educational and research purposes (this includes case summaries and reports, photographs, lab results and other pertinent medical information). Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances.

**Patient Consent**

I, _____ have reviewed the above information that explains how Dr. Patricia Arcuri, ND, will use my personal information and the steps that are taken to protect my information. I agree that Dr. Patricia Arcuri, ND, can collect, use and disclose personal information about my case as set out above regarding privacy policies.

**Patient Name:**_____

**Signature of Guardian**:_____

**Date:** _____

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**Naturopathic Payment & Policy Agreement**

Please read the following agreement, as it explains the policies regarding cancellations and your financial obligations while under the care of Dr. Patricia Arcuri, Naturopathic Doctor.

**Payment Agreement:**

- Payment is always due at the time of service.
- Naturopathic visits are not covered by OHIP.
- We accept the following forms of payment: cash, debit card, Visa, Mastercard
- We do not offer direct billing to insurance companies. However, we will gladly provide you with a receipt to submit to your insurance company to request reimbursement.
- Naturopathic visits are exempt from HST.
- Laboratory testing and supplements are not included in the fees below.
    - Prices vary and are subject to HST.

| Visit Type | Length | Fee |
|---|---|---|
| Adult Initial Visit | 60 minutes | $165 |
| | | |
| Pediatric Initial Visit<br>(12 or under) | 60 minutes | $140 |
| | | |
| Follow Up Visits | 60 minutes | $125 |
| | 45 minutes | $100 |
| | 30 minutes | $75 |
| | 15 minutes | $45 |
| | | |
| Acupuncture Treatment | 30 minutes | $75 |

**Policies:**

- **Cancellation Policy:** If you need to reschedule or cancel an appointment, we require a minimum of 24hr notice prior to the appointment date. Patients with less than 24hr notice, or no shows, will be charged half of their original appointment fee. For the first offence only, the missed appointment fee is waived.
- **On-Time Policy:** Your time is valuable to us and we take pride in seeing you on time. Should you arrive late, you will be seen for the remaining time allocated to your scheduled appointment; however, you will be billed for the full amount of time that you were originally scheduled.
- **Extended appointments (when required):** Dr. Arcuri, ND believes in taking the time to cover all of your concerns without rushing you. She will do her best to keep to the original appointment length; however, issues may arise that require additional time. We bill for the time spent with the doctor if the appointment extends beyond the time allotted.
- **Email Reply & Phone Consults:** Email and phone communications involving treatment clarifications will not be billed; however if additional research and access to your patient file are required, then we will request that you schedule a phone consult or in-person visit. Any phone calls that address new concerns need to be scheduled and will be billed at the same rate as appointments. Phone consults can only be scheduled if at least one in-person visit has occurred.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above.

Print Name:_____ Date:_____

Signature:_____

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