

MacDonald Naturopathic Medical Clinic
Dr. Crista MacDonald-Werby, BHSc., ND – Doctor of Naturopathic Medicine
29 Wellington Street North, Woodstock, Ontario N4S 6P4
Tel: (519) 539-7000

Dear

Thank you for booking an appointment at the MacDonald Naturopathic Medical Clinic for your child! As discussed, we have included a detailed health intake questionnaire and consent forms. Please bring the completed questionnaire and forms to your appointment, as well as a copy of any lab or blood work that has been performed within the past year (your medical doctor/specialist can supply you with a copy of your lab results if you ask him/her).

Your appointment information is as follows:

Date:

Time:

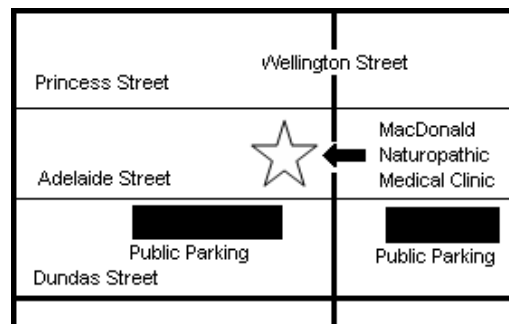
The MacDonald Naturopathic Medical Clinic is located at 29 Wellington Street North. There is plenty of free parking in the public parking lots along Adelaide Street.

Your initial appointment will be 1 ¼ hrs in length and will consist of a thorough health intake and a physical exam. Follow-up visits are generally 30 minutes in length. The cost of the initial appointment is \$160. The second appointment and all follow-up appointments are \$77. Payment is made on receipt of treatment. ***We accept cash, cheque and debit.*** Naturopathic medical services are covered by most extended health insurance plans. Direct submission is available to some benefit providers. Please check with us for more information.

If you have any questions please feel free to contact us at (519) 539-7000. We look forward to working with you and your child in achieving his/her health goals!

Wishing you good health,

Dr. Crista MacDonald-Werby, ND



MacDonald Naturopathic Medical Clinic
Dr. Crista MacDonald-Werby, BHSc., ND – Doctor of Naturopathic Medicine
 29 Wellington Street North, Woodstock, Ontario N4S 6P4
 Tel: (519) 539-7000

PEDIATRIC INTAKE FORM (INFANT TO AGE 7)

Child's Name: _____
 Address: _____ City: _____
 Province: _____ Postal Code: _____ Phone: _____
 Email: _____ Date of Birth: _____

Parent/Guardian Contacts:

Name	Relation	Home Phone	Work Phone

Food or Drug Allergies: _____
 Environmental Allergies: _____

Emergency Contact: _____ Phone: _____ Relation: _____
 Name of Medical Doctor: _____ Phone: _____

How did you hear about us?
 Newspaper Website Friends Family Other: _____

This is a confidential record of your child's medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize us to do so.

Health Concerns

What are your child's main health concerns in order of importance to you?

Vitamins and Supplements

Is your child taking any vitamin/mineral/herbal supplements? Y N
 If yes, please list the supplement(s) and the dosage:

Supplement/Vitamin	Reason for taking	Dosage

Prescription Drugs

List all prescription drugs that your child is currently taking. Indicate present dose and how long she/he has been on each medication.

Prescription Drug	Dosage	When did she/he begin the medication?

What over-the-counter medications does your child take? _____

How many times has your child taken antibiotics? _____

Medical History

List any major surgery or injury and when it happened:

List any major illnesses or diseases that your child has/had:

Vaccinations (please check)

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Flu Shot |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella) | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Other _____ |

Did your child experience a reaction to any of these vaccinations?

Present and Past Health Symptoms

Please check “√” if your child is currently experiencing the following symptom or write ‘P’ beside the box if she/he has experienced the symptom in the past.

General

- Change in appetite
- Weight gain
- Weight loss
- Cancer
- Diabetes
- Poor sleep
- Nightmares
- Sleep walking
- Fatigue

- Allergies
- Chills and fevers
- Night sweats
- Heavy perspiration
- Cravings
- Strong thirst

Eyes Ears Nose Throat

- Ear aches
- Ear infections
- Ringing in ears

- Sinus infections
- Enlarged glands
- Recurrent sore throat
- Nasal obstruction
- Runny nose
- Post nasal drip
- Nosebleeds
- Headaches
- Loss of taste/smell
- Eye pain

- Eye strain
- Dizziness
- Impaired vision
- Facial pain/tics
- Mercury fillings
- Sores in mouth

Skin and Hair

- Rash
- Itching
- Eczema
- Acne
- Cold sores
- Warts
- Hair loss
- Excess hair
- Dandruff
- Change in mole(s)
- Dryness
- Hives
- Boils
- Bruising/bleeding

Cardiovascular

- Irregular heartbeat
- Heart problems
- Fainting
- Cold hands or feet
- Blue skin

Respiratory

- Difficulty breathing
- Chronic cough
- Asthma
- Shortness of breath
- Throat phlegm
- Wheezing

Muscle, Bone & Joints

- Muscle pain
- Muscle weakness
- Arthritis
- Other pain

Gastrointestinal

- Abdominal pain
- Nausea
- Vomiting
- Bloating

- Burping
- Bad breath
- Jaundice
- Constipation
- Diarrhea
- Incomplete bowel movements
- Chronic laxative use
- Rectal pain
- Blood in stool
- Colic
- Excess gas
- Intestinal worms
- Number of bowel movements per day or week? _____

Infections

- Rubella (German measles)
- Measles
- Mumps
- Chicken pox
- Scarlet fever
- Mononucleosis
- Rheumatic fever
- Whooping cough
- Hepatitis
- Tuberculosis
- HIV/AIDS

Neurological

- Loss of balance
- Poor memory
- Dizziness
- Lack of coordination
- Seizures/Epilepsy
- Concussion
- Loss of sensation
- Muscle weakness

Kidney and Bladder

- Frequent urination
- Urgency to urinate
- Pain on urination
- Wetting the bed
- Incontinence

- Kidney stones
- Bladder infection
- Blood in urine

Female Health

- Vaginal discharge
- Vaginal pain

Male Health

- Testicular swelling
- Undescended testicles
- Testicular pain

Emotional

- Irritability
- Anxiety
- Nervousness
- Depression
- Anger
- Aggressive
- Hyperactive
- Inattentive
- Unusual fears
- Other _____

Please rate your child's level of stress from 1 (low stress) to 10 (high stress):

1 2 3 4 5 6 7 8 9 10

Who does your child live with?

What does your child enjoy doing in her/his spare time (hobbies, activities, etc)?

Family History

Please indicate if the child's family member suffered from any diseases such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies or arthritis.

Relationship	Diseases Suffered/Cause of Death
Father	
Mother	
Brother(s)	
Sister(s)	
Paternal Grandfather	
Paternal Grandmother	
Maternal Grandfather	
Maternal Grandmother	
Uncles	
Aunts	

Chemical, Heavy Metal and Toxin Exposure

Please circle the chemicals, toxins and/or heavy metals that your child has been exposed to:

Second Hand Smoke	Cleaning Products	Mercury
Pesticides	Asbestos	Aluminum
Herbicides	Radiation	Lead

Birth History

Birth Mother:

Age of mother at conception: _____

Was there any difficulty conceiving? Yes No

Health of the birth mother at the time of conception: excellent good fair poor

Was the mother on any medications, supplements or other therapies at the time of conception? Yes No

If yes, please list: _____

Birth Father:

Age of father at conception: _____

Was there any difficulty conceiving? Yes No

Health of the birth father at the time of conception: excellent good fair poor

Was the father on any medications, supplements or other therapies at the time of conception? Yes No

If yes, please list: _____

Pregnancy:

Health of the birth mother during the pregnancy: excellent good fair poor

During the pregnancy did the birth mother experience any of the following (please circle)?
Vaginal bleeding Thyroid problems Diabetes Nausea
Physical/emotional trauma High blood pressure Other _____

Was the birth mother on any medications, herbs, vitamins or therapies during the pregnancy (please list)?

Was the birth mother exposed to toxic chemicals, smoke, alcohol or recreational drugs during the pregnancy? Yes No

Were there any complications during the pregnancy?

Labor and Delivery:

Was the birth: Vaginal Cesarean Induced Premature Full term Past term

Were there any complications during the delivery?

Neonatal:

Weight of the child at birth: _____ Height of the child at birth: _____

Please list any abnormalities, treatments or surgeries your child received following the birth:

Was your child breastfed? Yes No If yes, until what age: _____

If no, what formula was the child fed? _____

Did your child have any problems feeding during the first few weeks? Yes No

Developmental Milestones:

At what age did your child (please answer all those that apply):

Lift head	_____	Rollover	_____	Sit up	_____
Hold objects	_____	Crawl	_____	Walk	_____
First words	_____	Dress alone	_____	Toilet train	_____

How would you rate your child's mental, physical and emotional progress (please circle)?

Below average Average Above average

Food Introduction:

At what age was the following food introduced?

Fruit	Vegetables	Wheat
Meat	Milk	Eggs

Diet:

How many cups/bottles/glasses does your child drink on average per day?

Milk		Soft Drinks (regular)		Fruit Juice	
Water		Soft Drinks (diet)		Other: _____	

Diet: Non-Vegetarian Vegetarian Vegan For how long? _____

Does your child consume (circle):

Aspartame Colours/dyes MSG Trans-fats/Hydrogenated oils BBQ-ed foods

Known Food Allergies/Food Sensitivities: _____

Please describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

General:

Is there anything else that I should know about your child?

SIGNATURE

I attest that the information provided is true and accurate to the best of my knowledge.

Guardian's Signature: _____ Date: _____

Thank you for taking the time to fill out this questionnaire. It will allow us to assess your child's past and current state of health and it will help us to better understand your and your child's health goals.

MacDonald Naturopathic Medical Clinic
Dr. Crista MacDonald-Werby, BHSc., ND – Doctor of Naturopathic Medicine
29 Wellington Street North, Woodstock, Ontario N4S 6P4
Tel: (519) 539-7000

Health Consent Form

NOTE TO PATIENT: We want your *informed consent*. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have a question about any of this, please ask.

CONSENT TO EXAMINATION AND TREATMENT

I would like to take this opportunity to welcome you to the MacDonald Naturopathic Medical Clinic. Naturopathic Medicine is a distinct primary health care system that blends modern scientific knowledge with traditional and natural forms of medicine.

At the MacDonald Naturopathic Medical Clinic, treatment approaches can include any combination of: Clinical nutrition, Botanical (herbal) medicine, Acupuncture, Asian Medicine, Homeopathic medicine, Physical therapeutics, Hydrotherapy, and Life-style counseling.

In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your cooperation in signing this statement of informed consent. In so doing you understand that:

1. I, Crista MacDonald-Werby, ND, am a Naturopathic Doctor, and not a conventional medical doctor. Naturopathic Medicine is the art and science of disease diagnosis, treatment and prevention using non-invasive natural therapies tailored to each patient and their individual health concerns.
2. The methods I use may have a proven clinical foundation and/or a proven scientific foundation, yet may not be accepted by standard (allopathic) medicine.
3. I am required by my licensing board to perform a physical examination on each new patient. A physical examination will allow me to better understand your unique state of health.
4. Referral to other health professionals will be made as necessary. You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider while under care at the MacDonald Naturopathic Medical Clinic.
5. While changes in dietary habits are not an absolute prerequisite for treatment, you understand that failure to follow sound nutritional, exercise, and lifestyle programs could undermine the expected results.
6. You are accepting or rejecting this care of your own free will.
7. All fees for services and supplements are to be paid at the time of the appointment by the patient or the guardian. **There is a fee for completing insurance forms, letter writing and telephone consultations of greater than 10 minutes. Notice of 24 hours (in person or by telephone – NO emails please) is required for appointment cancellation, otherwise you will be charged an administrative fee of \$50.00.**

CONSENT FOR THE COST OF OUR SERVICES

Initial appointment (1 1/4 hours) \$ 160
Follow-up appointment (30 minutes) \$ 77
Quick appointments (15 minutes) \$ 45
Home visits (30 minutes) Appointment cost + \$20 travel
Health products (if needed) are in addition to the cost of the visit (prices vary).
Laboratory test fees (if needed) are in addition to the cost of the visit (prices vary).

I, _____ have read and understood the above statements regarding *Consent to Examination and Treatment* and *Consent for the Cost of our Services*.

SIGNATURE _____ DATE: _____
(Patient or guardian)

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with naturopathic services, the MacDonald Naturopathic Medical Clinic will collect some personal information about me (e.g., home telephone number, address, past and present health history, etc.).

The MacDonald Naturopathic Medical Clinic’s Privacy Policy is several pages long. A copy of the Privacy Policy is always available at the clinic’s reception desk. Do not hesitate to discuss our policies with the clinic owner, Crista MacDonald-Werby, ND.

I have reviewed the MacDonald Naturopathic Medical Clinic’s Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask questions about the Privacy Policy and they have been answered to my satisfaction.

I understand that **only if I check off** the following boxes will I receive the following:

- I would like to receive notice when it is time to review whether I need another appointment.
- I would like to receive newsletters and other informational mailings or emails from the MacDonald Naturopathic Medical Clinic.
- I would like to receive notice of promotions and/or seminars or workshops offered by the MacDonald Naturopathic Medical Clinic

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments. I agree to the MacDonald Naturopathic Medical Clinic collecting, using and disclosing personal information about me as set out above and in the MacDonald Naturopathic Medical Clinic’s Privacy Policy.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

NATUROPATHIC DOCTOR: _____