Pinewood
NATUROPATHIC MEDICAL CLINIC

PATIENT INFORMATION AND CONSENT FORM

I, the undersigned, voluntarily consent to the procedures and treatment provided to me at Pinewood Naturopathic Medical Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments and that the risks will be explained to me in a manner that I can understand prior to any treatment. With this knowledge, I understand and acknowledge that I may ask questions regarding my treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Pinewood Naturopathic Medical Clinic or any of its practitioners or personnel regarding cure or improvement of my condition.

I hereby consent to the collection, use and/or disclosure of my personal information for purposes related to the delivery of patient care and other related uses at Pinewood Naturopathic Medical Clinic. I understand that a record will be kept of the health services provided to me. I further understand that my personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Pinewood Naturopathic Medical Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased.

_____
Patient's Name

_____ _____
Patient's Signature Date

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Patient Information Form

Please complete the following information in full. Thank you.

Dr. Miss Mr. Mrs. Ms

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____
Suite/Apt./Unit No: _____
City: _____ Province: _____
Postal Code: _____

Gender: Male Female Date of Birth: _____
Month / Day / Year

Work Phone: _____ Extension: _____
Home Phone: _____ Mobile Phone: _____
Fax Number: _____ Other Phone: _____
E-mail: _____
Preferred contact method: _____
May we leave a message? _____

Family Doctor: _____
Phone Number: _____

How did you hear about the clinic: _____

<u>Emergency Contact</u>
Name: _____ Phone Number: _____
Relationship: _____

Please list Allergies (drug, food, etc):

_____
_____
_____
_____
_____

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Electronic Mail Authorization

I, _____, whose e-mail address is _____ request and authorize you, _____, Pinewood Naturopathic and its staff, to communicate with me and other authorized healthcare providers involved in my care about any aspect of my health and medical care by means of electronic mail. By giving this authorization I demonstrate an understanding of the following issues related to the use of electronic mail:

· I understand electronic mail is not appropriate for communication about all health issues, particularly those of an urgent nature and Pinewood Naturopathic and Dr. Rebecca Hauser can make no guarantee of response within a certain time frame.

· I understand that electronic mail is not encrypted and therefore not as confidential as mail or telephone communication.

· I understand that it is possible for a third party, including an employer, to intercept or read electronic mail without knowledge of either the sender or recipient of the mail. Because of the ease and informality with which electronic mail can be used and because electronic mail may be easily rebroadcast to multiple addresses, the potential loss of confidentiality associated with its use may be of greater consequence than that suffered with written or telephone communication.

· Since Pinewood Naturopathic and Dr. Hauser do not operate or control any service on the internet, I understand they cannot and do not guarantee that use of this means of communication will be free from technological difficulties including, but not limited too, loss of messages.

· I understand that information communicated by means of electronic mail will be incorporated and retained within the Pinewood Naturopathic medical records. As a result, that information, including, but not limited to my electronic mail address, may be disseminated as part of an authorized release of a copy of the medical record.

My signature below denotes that I accept the risk of loss of privacy of confidential medical information associated with communication by electronic mail and nonetheless, agree to its use. I also agree that Pinewood Naturopathic, Dr. Hauser and any staff, shall not be liable for any type of damage or liability arising from or associated with loss of confidentiality due to communication by electronic mail.

This authorization for communication by means of electronic mail is valid until I notify you in writing I no longer authorize the use of electronic mail to communicate information concerning my medical care. Pinewood Naturopathic and Dr. Hauser also retain the right to terminate electronic mail as a means of communication at any time if such becomes, in the healthcare provider's judgement, burdensome or inappropriate.

_____ _____

Signature of patient, guardian, authorized representative Date

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Edmonton AB T6E 6N1
T: 587 984 9660
F: 587 773 5602
W: www.pinewoodnaturopathic.com

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Pediatric Intake Form

Name :_____

Date:_____

Patient Full Name: _____ Date of Birth: _____
Gender: M or F Age: _____
Current Height/Length: _____ Current Weight: _____

Contact Information

Name of Primary Caregiver: _____
Address: _____
Phone Number: Home _____ Work: _____
Relationship to Patient: _____
Email address: _____ [ ] yes, please send appointment reminders by email.
Name of Family Physician or Pediatrician: _____
Contact Information: _____

Please list your present health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Please list any current and previous medications (over the counter and prescription) and supplements (including vitamins, homeopathic and herbal remedies):

_____
_____
_____

Immunization History

VACCINE	DATE	ADVERSE REACTIONS (i.e. - fever, nausea, vomiting, seizures, behavior changes)
DPT		
MMR		
Meningitis		
Hep-A		
Hep-B		
Flu Vaccine		

Chicken Pox		
Polio		
Other		

Childhood Illnesses

	DATE(S)	COMMENTS
Chicken Pox		
Ear Infections		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Rubella		
Scarlet Fever		
Strep Throat		
Whooping Cough		
Other		

Allergies (include medications, animals, foods, seasonal, pollens etc.)

Patient's Medical History (please check all that apply):

CONDITION	YES	COMMENTS
Asthma		
Cough/Wheeze		
Frequent Infections		
Earache		
Exposure to Cigarette Smoke		
Colic		
Constipation		
Diarrhea		
Vomiting		
Heart Murmur		
Anemia		

Acne		
Eczema		
Cradle Cap		
Jaundice		
Thrush		
Warts		
Epilepsy/Seizures		
High Fever		
Bed Wetting		
Fatigue		
Insomnia		
Dizzy Spells		
Headaches		
Hyperactivity		
Moodiness		
Learning Difficulties		
Depression		
Other		

Surgeries and Hospitalizations (include dates and details): _____

_____

_____

Prenatal/Natal History

**if assisted fertility methods were used, or if your child was adopted please provide as much information as is known.*

Mother or Gestational Surrogate's Age During Pregnancy: _____
Number of Children: _____
Total number of pregnancies (including any that were not full term): _____
Partner's Age During Pregnancy: _____

Mother's Health During Pregnancy (check all that apply):

CONDITION	YES	COMMENTS
Alcohol Consumption		
Bleeding		
Cravings		
Depression		
Diabetes		
Exercise		

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High Blood Pressure		
Illness		
Nausea		
Over the Counter Medication		
Prescription Medication		
Physical/Emotional Trauma		
Recreational Drugs		
Supplements		
Smoking		
Stress		
Travel		
Thyroid Condition		
Toxemia		
Weight Gain (how much)		
X-Rays		
Other		

Were there any fertility issues surrounding the patient's conception? Y or N
If yes, describe: _____

_____

Briefly describe Mother's diet during pregnancy and prenatal care received (include mediations and supplements): _____

_____

Briefly describe Partner's health during the pregnancy: _____

_____

Did Mother work during the pregnancy? Y or N
If yes, specify occupation and when she stopped working: _____

Briefly describe the pregnancy and birth (include emotional climate of pregnancy as well as length of labour and any complications):

_____

_____

Circle all that apply: hospital birth home birth vaginal delivery
c-section OB/Gyn midwife doula epidural antibiotics forceps vacuum induction

Did Mother experience Post-Partum Depression? Y or N
Details: _____

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How many weeks was the pregnancy? _____

Natal History

Birth Weight; _____ Birth Length: _____ Head Circumference: _____
APGAR Score: _____ Birth Defects: Y or N If yes, specify _____

Dietary Information

Was the patient breast-fed? Y or N
If yes, how long? _____
If no, describe alternative: _____
Type of Formula: _____
Age Solid Foods Introduced: _____
What foods were introduced before 6 months? _____
_____
What foods were introduced between 6-12 months? _____
_____
Are there any Food Allergies or Intolerances? Y or N
If yes, describe: _____
Describe patient's appetite: _____

24 Hour Diet Diary:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

Describe any dietary restrictions (vegetarian, vegan, religious etc.)? _____

Developmental History

Describe patient's health in their first year: _____
_____
_____

At what age did the patient first:
Sit-up: _____ Crawl: _____ Talk: _____
Potty Training: _____ Walk: _____

Describe patient's dental history including teething, dental visits and cavities:
_____
_____

Describe the patient's typical schedule, including sleep habits: _____

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Social History

Parents: Married:_____ Separated:_____ Divorced: _____
Patient lives with: _____
Other's living in the home: _____
Parent's (mom or dad) Occupation: _____ F/T or P/T
Parent's (mom or dad) Occupation: _____ F/T or P/T

Day Care/School
On average how much time does the patient spend at day care/school? _____

Describe the patient's behaviour and performance at school (include teacher comments and relationships with other children): _____

How many hours per day does the patient spend:	HRS
Watching Television	
Reading	
Playing Videogames	
Surfing the Internet	
Playing Outside	
Doing Homework	
Organized Sports/Lessons	

Briefly describe the patient's personality and general disposition: _____

Home Environment

Describe your living environment (ex: house, apartment, new, old)

Is the patient exposed to any of the following (circle all that apply):
cigarette smoke pets mold chemicals (ex: paint)
Describe the emotional climate of your home: _____

Family History

Please provide age and health concerns for the following biological family members. If deceased, please indicate the age of death.
Mother: _____

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Father: _____
Siblings: _____
_____
Maternal Grandparents: _____
_____
Paternal Grandparents: _____
_____

Please indicate if there is a family history of any of the following:

CONDITION	YES	CONDITION	YES
Alcoholism		Epilepsy	
Allergies		Heart Disease	
Anemia		High Blood Pressure	
Asthma		Kidney Disease	
Arthritis		Mental Illness	
Bleeding Disorders		Obesity	
Cancer		Stroke	
Colitis		Thyroid Conditions	
Diabetes		Tuberculosis	
Eczema		Ulcers	

Does the patient have any of the above conditions: Y or N
If yes, describe: _____

Please list any other comments or concerns: _____
_____
_____
_____