INNATE WELLNESS
NATUROPATHIC MEDICAL CENTRE

5 Quebec Ave
{High Park Station}
Toronto, ON M6P2T3
TEL: 416 760 9424
FAX: 416 760 0029
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Personal Information

<table>
<tr><td colspan="2">Today's Date</td><td>Child's Name</td><td>Sex
M F</td><td>Height
Weight</td></tr>
<tr><td>Date of Birth</td><td>Age</td><td colspan="3">Parents/Guardians' Names</td></tr>
<tr><td colspan="2">Address

Email</td><td>Contact Information
[h]
[w]
[c]</td><td colspan="2">In case of emergency notify

Contact number</td></tr>
<tr><td colspan="5">Innate Wellness will email you confirmation of your child's upcoming appointments. If you wish to be contacted by phone, please list the best number to contact you.</td></tr>
<tr><td colspan="5">How did you learn about Innate Wellness?</td></tr>
</table>

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General Health Questionnaire

Please take the time to fill out this questionnaire carefully to help us provide you with a complete evaluation. If you have further questions, concerns, or comments, please bring them to our attention.

Please list your additional Health Care Providers (i.e. Medical Doctor, Chiropractor, Medical Specialist, etc.)

Name Occupation Phone	Name Occupation Phone	Name Occupation Phone

Please describe your child's primary health concern(s) and the dates you first noticed symptoms.

Major Concern (in order of importance):	Since:	Cause:

Please list all prescribed and over-the-counter medications (OTC), vitamins, minerals, herbs, & homeopathic remedies which your child is presently using. Please include the dose, brand, & ingredients.

Medications – Current	Natural Supplements – Current

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Please list all prescribed, OTC medications, vitamins, minerals, herbs, & homeopathic remedies your child has had in the past. Please include the reason for the prescription.

Medications – Past

_____
_____
_____
_____

Natural Supplements – Past

_____
_____
_____
_____

Please check all illnesses or diagnoses your child has had in the past, along with the date.

	Illness	Date		Illness	Date
☐	Alleriges _____	_____	☐	Frequent Colds	_____
☐	Anemia	_____	☐	Measles	_____
☐	Asthma	_____	☐	Mumps	_____
☐	Chicken Pox	_____	☐	Pneumonia	_____
☐	Constipation	_____	☐	Rheumatic Fever	_____
☐	Diarrhea	_____	☐	Rubella	_____
☐	Ear Infection	_____	☐	Sinusitis	_____
☐	Eczema	_____	☐	Tonsillitis	_____
☐	Epiglottitis	_____	☐	Other _____	_____

Please check which immunizations your child has had, along with the date.

		Date			Date
☐	Chicken Pox	_____	☐	Chicken Pox	_____
☐	Diphtheria	_____	☐	Diphtheria	_____
☐	Haemophilis Influenza Type B	_____	☐	Haemophilis Influenza Type B	_____
☐	Hepatitis A	_____	☐	Hepatitis A	_____
☐	Hepatitis B	_____	☐	Hepatitis B	_____
☐	H1N1	_____	☐	H1N1	_____
☐	HPV	_____	☐	HPV	_____
☐	Influenza	_____	☐	Influenza	_____
☐	Measles	_____	☐	Measles	_____

Did your child ever have any reactions to immunizations? If yes, please explain. Yes No

_____
_____
_____

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Please list any hospitalizations, surgeries, or injuries. Include the reason, when it occurred and the outcome.

	Date	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe illnesses in the family and the relationship to your child.

Illness	Relationship	Illness	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pre-Natal History

Were there any concerns with the mother's health during the pregnancy? If yes, please explain. Yes No

_____

_____

Please check any that applied during the pregnancy.

- ☐ Anemia
- ☐ Bleeding/Spotting
- ☐ Vomiting
- ☐ Gestational Diabetes
- ☐ Hypertension/High Blood Pressure
- ☐ Infection _____
- ☐ Nausea
- ☐ Pre-Eclampsia
- ☐ Thyroid Problems
- ☐ Trauma (i.e. emotional/physical)
- ☐ Other

Please provide the following:

Mother's age during this pregnancy _____

Number of previous pregnancies _____

Number of previous miscarriages _____

Number of previous abortions _____

What was the mother's emotional health during the pregnancy? Was there a lot of stress? Were there good support systems?

_____

_____

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Did the mother use the following during pregnancy? If so, please indicate how much.

Tobacco _____ per day/wk/mth Alcohol _____ per day/wk/mth

Caffeine _____ per day/wk/mth Other _____ per day/wk/mth

Were there any medications, supplements, herbs, etc. used during pregnancy? ? If yes, please list. Yes No

Medications Natural Supplements

_____ _____

_____ _____

_____ _____

_____ _____

Were there any exposures to diseases during this pregnancy? If yes, please list. Yes No

_____

_____

Did you travel during this pregnancy? If yes, where did you travel to? Yes No

_____

What is/was your occupation and where is/was it located?

_____

_____

Birth History

Was the labour spontaneous or induced? If induced, for what reason?

_____

Duration of labour? _____ hours Type of Delivery? _____

Were there any complications during delivery? If yes, please explain. Yes No

_____

_____

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Were there any interventions used for labour and delivery? Please check all that apply.

- ☐ Catheter
- ☐ Epidural
- ☐ Episiotomy
- ☐ Forceps
- ☐ Laughing Gas
- ☐ Oxytocin
- ☐ Other Pain Medication
- ☐ Prostaglandin Gel
- ☐ Vacuum Extraction
- ☐ Other _____

What type of delivery did you have and who attended? Please check all that apply.

- ☐ Home Birth
- ☐ Hospital Birth
  which hospital? _____
- ☐ Midwife
- ☐ Doula
- ☐ Physician
- ☐ Other _____

Newborn History

Baby's:
weight at birth _____ length at birth _____ APGAR (if known) _____
1min. _____
5min. _____

Were there any complications after delivery? Please check all the apply

- ☐ Anemia
- ☐ Birth Anomalies
- ☐ Bleeding
- ☐ Colic
- ☐ Feeding Trouble
- ☐ Fever
- ☐ Infections _____
- ☐ Jaundice
- ☐ Rasj
- ☐ Respiratory Distress
- ☐ Seizures
- ☐ Other _____

Milestones:

Smiling _____	Teething _____	Standing _____
Rolling Over _____	Crawling _____	Walking _____
Laughing _____	Talking _____	

Was the child breastfed? If yes, for how long? Yes No _____

Was the child bottle fed? Yes No

If yes, what type of formula and for how long? _____

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When were solid foods introduced? _____

What were the first foods to be introduced and how were they prepared?

_____

_____

Were there any reactions to any foods that were introduced? If yes, please explain. Yes No

_____

_____

Please describe your child's temperament.

_____

_____

Please describe your child's sleeping patterns, including current and past patterns.

_____

_____

What are some of your child's interests?

_____

_____

How is your child doing at daycare or school?

_____

_____

Does your child do any type of exercise/activities? If so, what type and how often?

_____

_____

Does anyone smoke in the house or around your child (i.e. parent, guardian, caregiver)?

_____

Is your child exposed to animals? If yes, please list what type(s). Yes No

_____

_____

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Informed Consent

We would like you to understand the services we provide, the costs involved, and what we do with the personal information we obtain about your child. If you have any questions about this, please ask. This informed consent begins today and is between the Naturopathic Doctor and the person named at the end of this document.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. The following outlines the therapies we may utilize.

- **Individual Diets and Nutritional Supplements** are recommended to address deficiencies, treat disease processes and to promote health.
- **Botanical Medicine** is a plant-based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations for the treatment of illness and disease.
- **Homeopathy** is a form of medicine based on the law of similars – that is the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal or mineral origin are used to stimulate the body's ability to heal itself.
- **Asian Medicine** includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, extracts or decoctions (strong teas) to be taken internally or used externally as a wash.
- **Physical Medicine** refers to the use of hands-on techniques such as soft tissue work and spinal manipulation.
- **Hydrotherapy** refers to the use of hot/cold water applications to improve circulation and stimulate the immune system.
- **Lifestyle Counseling** involves identifying risk factors and making recommendations to help optimize one's physical, mental and emotional environment.

During your initial visits, your N.D. will take a thorough case history, do a screening physical examination, and when indicated, take blood and urine samples.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. It is very important, therefore, that you inform your N.D. immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your N.D. immediately. Health risks associated with Naturopathic Medicine include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process;
- Allergic reactions to supplements, foods or herbs;
- Pain, bruising or injury from intramuscular injections or acupuncture;
- Fainting or puncturing of an organ with acupuncture needles;
- Muscle strains and sprains or disc injuries from spinal manipulation.

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Please check the box (☑) to indicate you have read and understand the following:

Disclaimer of Health Care Related Services

☐ I understand that the Naturopathic Doctor (N.D.) will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I will rely on her to exercise judgment during the course of the procedure which she feels at the time is in my best interests, based upon the facts then known.

☐ I understand that any treatment or advice provided to me by my N.D. is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from a physician, surgeon, or any other licensed health care provider.

☐ I understand that I am at liberty to seek or may continue to seek treatment or advice from a physician, surgeon or any other licensed health care provider and it has not been suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

Confidentiality

☐ I intend this consent form to cover 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 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 without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy, by paying the appropriate fee.

Payments & Appointment Etiquette

☐ I understand the fee schedule as stated below and I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand Innate Wellness' lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and I am ready for my appointment.

☐ I understand that I may purchase any recommended medicines or supplements from the dispensary at Innate Wellness or a pharmacy or retail store of my choice.

Patient Name _____
(please print)

Parent/Guardian Name _____ Signature _____ Date _____
(please print)

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Fee Schedule

New Patient Initial Assessment

Naturopathic First Assessment (60-90min.)	200.00

Your N.D. may suggest further testing as part of the initial assessment

Treatment Plan & Follow-up Appointments

Follow Up Visit (30-45min.)	125.00
Check In Visit (~15min.)	65.00

Supplements and Remedies

Supplements and remedies are available from the office dispensary or from a naturopathic pharmacy of your choice.

Missed Appointment Fee (less than 24 hours business days' notice) **Full price of the appointment**

Prices are subject to change.

We accept Cash, Visa, MasterCard, and Interac Debit.