Newcastle Chiropractic & Health Centre

Dr. Amy Henehan, BA, ND
Naturopathic Doctor

Newcastle Family Chiropractic
10 King Ave. East, Newcastle, ON
L1B 1H6

PEDIATRIC Patient Intake Form

Last Name	First Name	Middle Name	
Date	Date of Birth M/D/Y	Age	Sex
Who is filling out this form: Name:	Relationship:		

Contact Information

Street Address	Town/City	Province	Postal Code
Home Phone Number	Alternative Phone Number	May we leave messages regarding your appointment? Yes/No	
Email address			
Who does the child live with?			

Emergency Contact Information

Name	Relation	Phone Number
Name	Relation	Phone Number

Other Health Care Providers

Name	Specialty/Focus	Contact Info
Name	Specialty/Focus	Contact Info
Name	Specialty/Focus	Contact Info
Date of Last Medical Visit	Date of Last Physical Exam	Date of Last Blood Work
List of Routine Screening Tests Performed by Other Physicians:		

How did you hear about this clinic?		If referred➔ please let us know by whom:
Have you been treated by a Naturopathic Doctor (ND) before?	Name of ND:	Date of Last Visit

Health History

In your opinion what are your child's most important health concerns?

1. _____

2. _____

3. _____

4. _____

5. _____

6.

Current Height	Current Weight	Past Max Weight	Past Min Weight

Vaccination / Immunization Record: Check all that apply

Please note vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule 2004

- ☐ **DPT (Diphtheria, Pertussis, Tetanus)**
- ☐ **MMR (Measles, Mumps, Rubella)**
- ☐ **Hepatitis B**
- ☐ **Polio**
- ☐ **Varivax/Varilrix (Chicken Pox)**
- ☐ **Pneumococcal Conjugate (Meningitis/Pneumonia)**
- ☐ **Meningococcal C Conjugate (Meningitis)**
- ☐ Other: _____
- ☐ Gardasil/Cervarix (HPV Vaccine)
- ☐ Haemophilus Influenza B
- ☐ Hepatitis A
- ☐ BCG (Tuberculosis)
- ☐ Flu Vaccine

Did any of your vaccines cause adverse reactions, if yes: _____

Which of the following childhood illnesses have you had? Check all that apply:

- ☐ Asthma
- ☐ Rheumatic Fever
- ☐ Rubella (German Measles)
- ☐ Polio
- ☐ Scarlet Fever
- ☐ Whopping Cough
- ☐ Mumps
- ☐ Roseola
- ☐ Chicken Pox
- ☐ Measles

List all Diagnosed Medical Conditions:	**Treatments Received:**	**Year of Diagnosis:**

List all Surgeries/Medical Procedures:	**Reason:**	**Date (Year/Month)**

List all Allergies (medications, foods, supplements, environmental, etc.)	**Reaction Type**

List all prescription drugs, over-the-counter medications (pain killers, antacid, etc), **herbs and natural supplements** (vitamins, homeopathics, etc) **that you are taking:**

Medication	Dosage	Start Date

Family History

Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information

Father Age: Related Health History:	**Mother** Age: Related Health History:
Grandmother (Paternal) Age: Related Health History:	**Grandmother (Maternal)** Age: Related Health History:
Grandfather (Paternal) Age: Related Health History:	**Grandfather (Maternal)** Age: Related Health History:

Siblings	**Age**	**M/F**	**Health History**
1.			
2.			
3.			

Diet and Lifestyle

Diet	Breast fed?	If YES, how long?
	Formula fed/Other?	If YES, how long?
	At what age did you introduce solid foods?	Initial foods: Any reactions:
	Did your child experience colic? Yes/No	
	Does your child have any dietary restrictions (religions, vegan/vegetarian)?	
Health and Development	How would you rate your child's health? Poor Fair Good Excellent	
	Has your child met all developmental milestones?	
	How would you describe your child's temperament/mood?	
	How would you describe your child's behaviour at school/daycare?	

Sleep	On average how many hours/night? _____ Does your child have trouble falling asleep? Yes/NO	Do your child wake up during the night? Yes/No How many times? _____
Energy	On a scale 1(lowest)→10(highest), rate your child's energy level:	
Stress	What are sources of stress in your child's life:	
Toxins	Is your child exposed to second hand smoke?	Is your child exposed to toxins? Please specify

Please use this space for any information you feel is important but has not been covered:

INFORMED CONSENT

COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of care rendered by Newcastle Family Chiropractic. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what we are doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, College of Naturopaths Ontario
- How our Clinic Collects, Uses and Discloses Patients' Personal Information
- The clinic will collect, use and disclose information about you 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 by sending newsletters/information mailings and making reminder calls for upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for goods and services, process payments, collect unpaid accounts
- 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

INFORMED CONSENT: Please note that this form must be signed prior to your first appointment

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. Dr. Amy Henehan, ND will take a thorough case history and perform a physical examination. If your case requires, the physical may include more specific examinations such as breast, gynecological, rectal, prostate or genital exams and blood and urine samples may be taken.

It is very important that you inform the Naturopathic Doctor, Dr. Amy Henehan, ND immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, 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.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise us of any allergies
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles

CANCELLING OR RESCHEDULING APPOINTMENTS

We require that you give us at least 24 hours notice when cancelling or rescheduling an appointment. A missed appointment, without proper notice, can result in a full appointment charge to be paid before another appointment is booked.

STATEMENT OF ACKNOWLEDGMENT/CONSENT

As a patient of Dr. Amy Henehan, ND I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices.

I _____(print patient name) have read and understand how Dr. Amy Henehan, ND will use my personal information and the steps which the staff is taking to protect my information. I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

I _____(print patient name) have read and understand the above information. I recognize that this consent form covers the entire course of treatment for my present condition. I understand that treatment results are not guaranteed. I also understand that I am free to withdraw my consent and to discontinue treatment at any time. I give my informed consent to Dr. Amy Henehan, ND to provide naturopathic medical consultation, assessment and treatment to me.

Patient Name (Print): _____

Guardian Signature: _____ Date: _____

ND Signature: _____