

CHILD INTAKE FORM

Our health is influenced by many different factors. Your child's health history is an important part and will provide valuable information for me to understand their current health. Please fill out this form and bring it with your child to the first visit.

GENERAL CONTACT INFORMATION

Childs Name _____
(Last name) (First name)

Birthdate (mm-dd-yy): _____ Gender: _____ Today's Date (mm-dd-yy): _____

Address: _____
Street City Province Postal Code

Parents Contact Information (in order of preference):

Guardian #1: _____ Relationship to child: _____

Phone (H): _____ (C): _____ E-mail: _____

Guardian #2: _____ Relationship to child: _____

Phone (H): _____ (C): _____ E-mail: _____

May we leave you a message about your appointment: Y N Preference: Home Cell Email

With whom does the child live with? _____

Who is filling out the form (Name and Relation)? _____

How did you hear about the clinic? _____

Medical Doctor: _____ Last Visit: _____
Name Telephone (mm/yy)

PERSONAL MEDICAL HISTORY

What are your child's health concerns, in order of importance?

1. _____
2. _____
3. _____

Please indicate any surgeries, health diagnoses and hospitalizations along with approximate dates:

Does your child have any allergies or hypersensitivities to any of the following?

Foods: _____

Medicines/Supplements: _____

Environment: _____

Please list all prescription and over the counter medications, vitamins or supplements, including brands your child is taking:

Are all vaccinations up to date? Yes or No

If no please indicate which immunizations your child has had?

- DPT (Diphtheria, pertussis, tetanus) Haemophilus influenza B Hepatitis B
 Tetanus booster; when? _____ Polio Small Pox
 MMR (Mumps, measles, Rubella) Hepatitis A Other _____

Please indicate any adverse reactions: _____

How many times has your child been treated with antibiotics? _____

Has your child had any of the following?

	Never	Mild	Average	Severe
Rubella (German Measles)				
Measles				
Chicken pox				
Mumps				
Roseola				
Scarlet Fever				
Whooping Cough				
Strep Throat				
Impetigo				
Mononucleosis				
Ear infections				

What screening tests has your child had (blood, hearing, vision, etc.)? When? _____

FAMILY HISTORY

Please indicate if a close relative (Parent or sibling has had any of the following:

Condition	When? (Their age)	Family Member
Allergies/ Hay Fever		
Asthma		
Birth defects		
Diabetes		
Juvenile arthritis		
Kidney Disease		
Other		

PRENATAL HEALTH

What was the health of the parents at conception?

- Mother: Poor Fair Good Excellent Unknown
 Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

- Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy?

- Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care?

- Yes No Unknown

Did the mother experience any of the following during the pregnancy?

- Bleeding High Blood Pressure Nausea Physical or Emotional Trauma
 Diabetes Thyroid Problems Vomiting

Did the mother use any of the following during the pregnancy?

- Tobacco Recreational Drugs OTC Medications
 Alcohol Prescription medications Supplements

BIRTH HEALTH

Term length: Full Premature: _____ weeks Late: _____ weeks

Length of labor: _____ Weight at birth: _____

Was the birth: Vaginal C-section Induced Forceps Anesthesia used

Any complications? _____

Did the child experience any of the following at or shortly after birth?

- Jaundice Rashes Seizures Failure to thrive Respiratory distress
 Colic Hypoxia Surgery Difficulty Feeding Meningitis
 Respiratory distress Other: _____
 Birth defects _____ Birth injuries _____

DIET

How was your infant fed?

- Breastfed. How long? _____ Formula: Milk/ Soy/ Other: _____
 Other: _____

When approximately were foods were introduced and were there any issues?

Did your child ever experience colic? Yes No How Severe? Mild Moderate Severe

Does your child have any food allergies or intolerances? Please list.

Does your child have any dietary restrictions? (religious, vegetarian, vegan, etc.)

HEALTH AND DEVELOPMENT

How was your child's health in the first year?

- Poor Fair Good Excellent Unknown

At what age did your child first:

Sit up: _____ Crawl: _____ Walk: _____ Talk: _____

Describe your child's sleep patterns:

How would you describe your child's temperament?

How would you describe your child's behavior and performance at school?

ENVIRONMENT

Is your child in: School Daycare Homecare Other: _____

What are your child's favorite activities?

Does your child exercise regularly? Yes No How much and how often?

How much television does your child watch? _____ hours a day/week

How often does your child read (not for school), or how often does someone read to your child?

Daily Several times a week Weekly Less than weekly

Does anyone in the child's household smoke? Yes No

Are there animals in the home? Yes No

How do you describe the emotional climate of the child's home?

Is there anything you feel is important that has not been covered?

Thank you for taking the time to complete this form. The information provided will be discussed in further detail during your child's visit. Please bring this form with you to your visit or email.



Informed Consent Form

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. Your Naturopathic Doctor will take a thorough case history and perform a physical examination. Each patient seeking care in this clinic should understand that the practitioner is a Naturopathic Doctor, not a medical doctor.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

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. Treatments used in this clinic include nutrition, botanical medicine, lifestyle counseling, homeopathy, Traditional Chinese medicine (including acupuncture), hydrotherapy, physical medicine, laboratory testing and supplement recommendations.

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. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by your Naturopathic Doctor prior to manipulating the neck.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

I have been informed and I understand that:

- I am free to withdraw my consent and to discontinue treatment at any time.
- My Naturopathic Doctor will explain the exact nature of any treatment provided and will answer any questions I may have.
- The clinic does not guarantee treatment results.
- I agree to pay my account in full at each visit. I am aware that Alberta Health Care does not cover these fees.
- I understand cancellations must be made with 24 hours notice or a missed appointment fee applies.

Patient Name (please print): _____

Signature of Patient or Guardian: _____ Date: _____



PATIENT PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of providing you with quality naturopathic care. Dr. Harmi Kaler understands the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly.

We strive to ensure that:

- Only necessary information is collected about you;
- We only share your information with your written consent;
- Storage, retention, and destruction of your personal information complies with existing privacy legislation and privacy protection protocols of our regulatory body, The College of Naturopathic Doctors of Alberta.

Information is collected, used and disclosed about you for the following purposes:

- To assess your health concerns and advise you of treatment options;
- To establish and maintain contact with you and remind you of upcoming appointments;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up for treatment, care and billing;
- To comply with legal and regulatory requirements;

I have read and understand how Dr. Harmi Kaler will use my personal information and the steps taken to protect my information. I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

Signature of Patient or Guardian: _____ Date: _____

EMAIL CONSENT FORM

Name: _____ E-mail: _____

I hereby acknowledge that I consent to email communications about my care. It is my responsibility to inform Dr. Kaler if my email address changes. I understand that I am exposing myself to certain risks, which include but are not limited to:

- The privacy and security of email communication cannot be guaranteed.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Backup copies of Email may exist even after sender or recipients have deleted their copy.
- Email senders can easily misaddress an Email or be received by unintended recipients
- Email is easier to falsify than handwritten or signed documents.

Dr. Kaler will use reasonable means to protect the security and confidentiality of emails. Due to the risks above, Dr. Kaler cannot guarantee the security and confidentiality of emails and will not be liable for improper disclosure of confidential information that is not caused by Dr. Kaler's intentional misconduct.

Dr. Kaler will try to read and respond to emails. No one shall use Email for medical emergencies or other time-sensitive matters. It is the patient's responsibility to follow up with Dr. Kaler if a response has not been received within a reasonable time period.

Please be advised all Emails to or from Dr. Kaler will be made part of your medical record. It is your responsibility to inform Dr. Kaler of any types of information you do not want sent by Email. Dr. Kaler will not forward Emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

I acknowledge that I have read and fully understood this consent. I understand the risks associated with email communications between Dr. Kaler and myself, and consent to the conditions outlined. In addition, I agree to the instructions for communicating by Email, as well as any other instructions that Dr. Kaler may impose.

Signature of Patient or Guardian: _____ Date: _____



DIRECT BILLING AND CANCELLATION POLICY

If I am unable to make a scheduled appointment I must provide 24 hours advance notice to avoid being charged a missed appointment fee of 100% of my scheduled visit. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements, cost of laboratory tests, administrative fees as well as any other applicable fees.

Anyone who either forgets or consciously chooses to forgo their appointment for whatever reason will be considered a "no-show". They will be charged for their "missed" appointment and all future services will be denied until the account is settled.

In the event that an appointment is cancelled or rescheduled with less than 24 hours' notice you are subject to a late cancellation fee of \$50.

Credit card information provided below will only be used in the event that less than 24 hours' notice was provided for cancellations or changes, no show appointments or if insurance direct billing does not pay Harmony Health Integrative Centre the amount authorized. In the event the credit card does not work, the balance owing must be paid within 5 business days of being advised. Harmony Health Integrative Centre reserves the right to cancel any future appointments until this is done.

Signature of Patient or Guardian: _____ Date: _____

Credit Card information: Visa MasterCard

Patient(s) Name: _____

Name on Card (please print): _____

Credit Card Number: _____

Expiration Date (Month/ Year): _____ CVV: _____

Cardholder's Full signature: _____ Today's Date: _____