Dr. Harmi Kaler
NATUROPATHIC DOCTOR

CHILD INTAKE FORM

Our health is influenced by many different factors and you provide valuable information to understand your current health.

GENERAL CONTACT INFORMATION

Name: _____
(*Last name)* *(First name)*

Birthdate (M/D/Y): _____ Gender: _____ Today's Date: _____

Address: _____
Street *City* *Province* *Postal Code*

Guardian/ 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 Which Number? _____

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* *(M/Y)*

PERSONAL MEDICAL HISTORY

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

1. _____
2. _____
3. _____

Please indicate any serious conditions, illnesses, injuries, and any hospitalizations along with approximate dates:

_____

_____

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

Foods: _____

Medicines/ Supplements: _____

Environment: _____

Other: _____

Please list all medications, vitamins or other supplements your child is currently taking:

_____

_____

_____

Are all vaccinations up to date? Yes □ No □

If no please indicate which immunizations your child has had?

□DPT (Diphtheria, pertussis, tetanus)
□Tetanus booster
□MMRV
□Haemophilus influenza B
□Polio
□Hepatitis A
□Hepatitis B
□Small Pox
□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				
Whopping 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 ☐ Nausea ☐ Emotional Trauma ☐ Thyroid Problems
☐ High Blood Pressure ☐ Physical Trauma ☐ Diabetes ☐ Vomiting

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

☐ Tobacco ☐ Recreational Drugs ☐ Over the counter 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 ☐ Failure to thrive ☐ Hypoxia ☐ Meningitis
☐ Rashes ☐ Respiratory distress ☐ Surgery ☐ Birth defects
☐ Seizures ☐ Colic ☐ Difficulty Feeding ☐ Birth injuries

DIET

How was your infant fed?

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

Approximately at what age were solids 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.

Dr. Harmi Kaler
NATUROPATHIC DOCTOR

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 injections, IV therapy, IV Chelation, Prolotherapy, Ozone therapy, nutrition, botanical medicine, lifestyle counseling, homeopathy, Traditional Chinese medicine (including acupuncture), hydrotherapy, physical medicine, and 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 Intravenous therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa

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: _____

Dr. Harmi Kaler
NATUROPATHIC DOCTOR

PATIENT PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of providing you with quality naturopathic care. Dr. Kaler understands the importance of protecting your personal information. She is 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. 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 Guardian or Patient: _____ Date: _____

EMAIL CONSENT FORM

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.

Please be advised all Emails to or from Dr. Kaler will be made part of your medical record. Dr. Kaler will not forward Emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

Email is not the primary method of contact. It will not be used for medical emergencies or other time-sensitive matters. I realize that no medical advice will be provided over email and that email is **only** to clarify matters already discussed in appointments with Dr. Kaler. All new concerns require me to book a follow-up appointment.

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: _____

Harmony Health
INTEGRATIVE CENTRE

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 that can be either $50 or the full cost of the 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.

Patient(s) Name:_____

Signature of Patient or Guardian: _____ Date: _____

DIRECT BILLING AND CREDIT CARD POLICY

Direct Billing with insurance provides a preauthorization for payment. However, in some cases the amount authorized can change when payment is received or the payment may be sent to the plan member instead. Therefore, it is clinic policy in order to direct bill any insurance company that a valid credit card must be provided and kept on file. The 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, supplement refills or if insurance 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. The credit card must be updated in order to direct bill in the future as well.

Credit Card information: Visa MasterCard

Name on Card (please print): _____

Credit Card Number: _____

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

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