WELCOME to Naturopathic Medicine at Vivo!

What You Can Expect:

1st Appointment: The first appointment is up to 1 hour; this includes a detailed patient intake, a complete health history, a physical exam and initiation of a treatment plan. The initial visit provides the comprehensive information to create appropriate treatment plans.

2nd Appointment: The second appointment is up to 45 minutes; a customized treatment plan is presented (and optimized). Reaching the expected health goal(s) will depend on how well treatment is followed.

Follow up visits: Follow up visits will vary in length (20-45 minutes) and in frequency. They are beneficial to monitor progress and if needed, make modifications to the treatment plan.

What We Would Like:

Please bring in the following on your initial visit:

- Completed **Child Intake** form
- Completed and signed **Informed Consent** form
- All prescription and non-prescription **medications**
- All **natural health product** or supplement information
- Recent (within 6 month period) **lab tests** if possible

Thank-you, I look forward to working with you and your family.

To better health,

Amy de Oliveira BSc, ND

Naturopathic Treatment INFORMED CONSENT

Naturopathic medicine and care is a unique primary health care system that combines standard medical diagnostics and knowledge with traditional, natural and gentle therapies. The goal is to understand the individual, address the underlying cause and improve health and well-being.

I, _____ [guardian's name] understand that the form of medical care is based on naturopathic principles and practices.

I will completely disclose and inform my Naturopathic Doctor of all my child's health concerns and conditions, allergies, medications, supplements and medical interventions.

I understand that my identity and my child's identity will be protected and kept confidential.

I understand that a record will be kept of the health services provided. 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 child's medical records and can request a copy by paying a fee

I understand that the Naturopathic Doctor 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 understand that although naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to:

- Aggravation of pre-existing conditions and symptoms
- Allergic reactions to supplements or botanical prescriptions
- Pain, bruising, fainting or puncturing of an organ with acupuncture needles

I understand that fees and supplements are to be paid for at the time of the consultation period.

I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice

PATIENT CONSENT

- I have read and understand the above-stated policies, information, missed appointment fee
- I intend this consent form to cover the entire course of treatment for the said child
- I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time (written or verbal format).

Patient Name: _____ Date: _____

Guardian Signature: _____

Naturopathic Doctor: _____

PEDIATRIC INTAKE FORM – Naturopathic Medicine

GENERAL PATIENT INFORMATION

Date**:** _____ Grade in school: _____

Childs Name: _____ Age: _____ Birth Date: ___ dd/mm/yy___ Sex: F M

Mother's (or Guardian) Name _____ Father's (Guardian) Name _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell or other phone: _____

May we leave messages relating to your visits? Y / N Which Phone #? _____

How did you find out about naturopathic services at the centre? If referred, please indicate from whom

_____

E-mail Address:_____
Would you like to receive our electronic health newsletter: Yes No

Person to notify in case of emergency: _____

Phone Number: _____ Relationship: _____

Other health care providers;
1. _____ Speciality _____
2. _____ Speciality _____

HEALTH CONCERNS:

What is the main reason that you are here today? _____

What are your child's health concerns or health goals, in order of importance:

1. _____ When did it start _____
2. _____ When did it start _____
3. _____ When did it start _____
4. _____ When did it start _____

How would you describe the child's general state of health? Poor Fair Good Excellent

List any allergies to drugs, plants, foods, animal, other? _____

List any treatments, operations or hospitalizations in the past:

1._____

2._____

MEDICAL HEALTH HISTORY

Current Medications (prescription, over the counter, birth control)

Medication	Dose per day	What purpose	Date when Started

Current Supplements or Herbs

Supplement or Herbs	Dose per day	What purpose	Date when Started

Please indicate which of the following illnesses your child has had:

- ☐ Chicken pox
- ☐ Impetigo
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Rubella
- ☐ Scarlet fever
- ☐ Strep throat
- ☐ Whooping cough

Hearing tests Normal: Yes No Not Tested

Vision Tests Normal: Yes No Not Tested

Any speech impediments: Yes No Past

Learning impediments: Yes No Don't know

Vaccination History: **Yes**, has had; **No**, has not; **Some**, did not finish all shots

MMR:	Yes	No	Some	DPT:	Yes	No	Some
Hep B:	Yes	No	Some	Hib:	Yes	No	Some
Chickenpox:	Yes	No	Some	Polio:	Yes	No	Some

Any reactions to vaccinations? If so, please explain: _____

Date of last antibiotic use _____ Date of last physical exam or screening _____

FAMILY HISTORY

Allergies:	Yes	No	Obesity:	Yes	No
Cancer:	Yes	No	Tuberculosis:	Yes	No
Cardiovascular disease:	Yes	No	Mental Illness:	Yes	No
Diabetes mellitus:	Yes	No	**Any parent with chronic illness**_____		

PREGNANCY & BIRTH HISTORY

Mother's Pregnancy history: Age at conception: _____

Health During Pregnancy

Smoking:	Yes	No	Diabetes:	Yes	No
Coffee:	Yes	No	Nausea/Vomiting:	Yes	No
Recreational drugs:	Yes	No	Emotional Stress:	Yes	No
Preeclampsia:	Yes	No	Length of Labor: _____		
Vaginal birth:	Yes	No	Traumatic birth:	Yes	No

If the birth was difficult, please explain: _____

Was the birth: C-section Vaginal Induced

Child breastfed: Yes No For how long: _____

When was child put on solid food: _____

LIFESTYLE

What are your child's favourite activities? _____

Does the child exercise regularly? Y/N Activity? _____ # days per week _____

How much TV does your child watch? _____

How long is an average night sleep? _____

How would you describe your child's temperament? _____

How would you describe your child's behaviour at school? _____

_____

Any particular household stressors child has witnessed or gone through?

1. _____
2. _____

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

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