

Dear Parent or Guardian,

Investing in your child's health will benefit them now and for a lifetime!

We practice naturopathic medicine and complimentary therapies and we endeavor to help your child achieve health in the most caring and gentle way as well as enable them to develop healthy habits for life.

The Principles of Naturopathic Medicine:

*First, do no harm.*

*Cooperate with the healing power of nature.*

*Address the fundamental cause of disease.*

*Heal the whole person through individualized treatment.*

*Teach the principles of healthy living and prevention.*

This package consists of 2 parts:

- Informed Consent Form (pages 2-3)
- Paediatric Intake Form (pages 4-8)

Please read all of the information provided, complete the **Intake Form** and **Informed Consent Form**, and **bring them with you on your first visit**. The information you provide will play an important role in developing your child's individualized health care plan. Please note: the information provided on these forms and in our interactions are strictly confidential.

**Your child's first visit is 1-1 1/2 hours long and will include:**

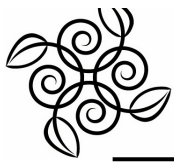
- A thorough health history including review of your intake form
- Review of your current supplements and medications (please bring them with you)
- Review of any laboratory reports, blood tests, etc. (please bring copies of any lab reports conducted in the last 6 months)
- Physical examination, time permitting
- Initial assessment
- Some initial treatment recommendations, if applicable

The second visit typically consists of a physical examination and subsequent treatment recommendations. The frequency and duration of subsequent visits required to monitor your child's progress and to provide treatments will be determined based on the nature of the condition and the type of treatment plan.

We look forward to meeting you!

Sincerely,

Larissa Popov, N.D.



## INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of disease 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. A number of different treatment approaches may be used alone or simultaneously throughout the course of treatment.

**Nutrition:** Dietary modifications and/or supplementation are given in order to address deficiencies, treat disease processes, and to support proper functioning of the body.

**Herbal medicine:** Is a plant-based medicine that involves the use of herbs in the form of teas, tinctures, capsules, tablets, flower essences and topical preparations. Herbs can be used to assist in the recovery from illness or injury and support proper functioning of the body.

**Homeopathy** is a form of medicine based on the *Law of Similars*, or "like cures like. The *Law of Similars* states that a substance that can create symptoms in healthy people, at very minute doses, can be used to treat these same symptoms. These minute doses of plant, animal or mineral origin are powerful medicines that stimulate the body's natural ability to heal itself on the physical, mental, emotional and spiritual level.

**Traditional Chinese Medicine** is a system based on the Taoist philosophy of the balance between *Yin* and *Yang*, opposite poles in nature. Treatment strategies include the use of herbs, acupuncture and dietary modifications to bring the body back into balance. Herbs may be given in the form of tablets, tinctures, and decoctions (strong teas) to be taken internally or used externally. Acupressure or acupuncture may be made administered depending on the comfort level of the child.

**Hydrotherapy** is the therapeutic use of water. Hot and cold applications may be used to promote circulation, reduce inflammation and strengthen the immune system.

**Physical Medicine** includes basic soft-tissue work, orthopedic testing and assessments.

**Lifestyle counselling** involves identifying risk factors and making recommendations that will promote physical, mental, emotional and spiritual well-being.

### **Bodywork:**

**Craniosacral Technique** is a type of gentle bodywork based on osteopathic techniques that involves the subtle release of tissues and joints from restriction while working within the body's natural limitations.

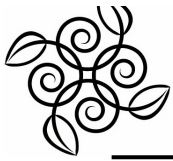
**Bowen Technique** is a type of gentle bodywork which uses soft plucking motions at points along the muscles and tendons which release structures from their "holding patterns" and allow them to relax and rebalance with the rest of the body.

Both techniques elicit a deep relaxation response in the recipient and can be very beneficial for a variety of conditions.

**Laboratory testing:** Your naturopathic doctor may collect urine, hair or other samples for in-office laboratory tests or refer you externally for lab testing as required.

**Health risks** associated with treatment by naturopathic medicine in children include but are not limited to:

- aggravation of pre-existing symptoms during the healing process
- allergic reactions to supplements or herbs
- pain, bruising or injury from acupuncture
- fainting or puncturing of an organ with acupuncture needles



STATEMENT OF ACKNOWLEDGEMENT

I, (print name of parent or guardian) \_\_\_\_\_, acknowledge that as the parent or guardian of

(name of child) \_\_\_\_\_, I have read the information included herein regarding naturopathic care for my child, and I understand that the services provided are based on naturopathic medicine and other complimentary therapies. I also recognize that even the gentlest therapies may cause complications in certain physiological conditions which depends greatly on the individual and the extent of illness. Some therapies must be used with caution with conditions such as diabetes, heart, liver or kidney disease, or those on multiple medications. I therefore confirm that I have informed and will continue to inform the practitioner fully of my child's medical history, family history, medications and/or supplements currently taken (prescription or over-the-counter), or was previously taking. If my child is female, I have advised the practitioner if my child is pregnant or breast-feeding or that there is a possibility that she is pregnant, and I will continue to do so.

\_\_\_\_\_  
Initials I understand that a record will be kept of the health services provided to my child. 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 record at any time and I can request a copy of it by paying the appropriate fee.

\_\_\_\_\_  
Initials I understand that the naturopathic doctor will answer any questions I have to the best of her ability. I understand that I will be informed of the diagnostic and therapeutic procedures and treatment plan for my child before undergoing treatment and I will discuss any requests for related information with the naturopathic doctor. I acknowledge and confirm that I will become informed of the diagnostic and therapeutic procedures and plans with respect to financial costs, expected benefits, potential risks and side effects, the likely consequence of not having or following the treatment plan, and any alternative course(s) of action available to my child. 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. With this knowledge I voluntarily consent to the recommended diagnostic and therapeutic procedures outlined above for my child, except for (please list any exceptions): \_\_\_\_\_

\_\_\_\_\_  
Initials I understand that fees and dispensary purchases are not covered by OHIP and are to be paid in full at the end of the appointment.

\_\_\_\_\_  
Initials I understand that a fee may be charged for any missed appointments or cancellations with less than 24 hours notice.

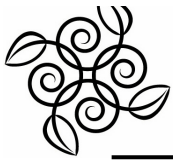
\_\_\_\_\_  
Initials I understand that any treatment or recommendation provided for my child by the naturopathic doctor is *not* mutually exclusive from any other treatment or recommendation that he or she is now receiving or may in the future receive from another licensed health care provider. I am at liberty to seek or continue medical care for my child from a medical doctor or other health care provider licensed to practice in Ontario.

\_\_\_\_\_  
Initials As part of my agreement to treatment with the naturopathic doctor, my child will maintain annual physical exams with the family doctor as well as continue to receive medical treatment and supervision with a conventional medical doctor.

\_\_\_\_\_  
Initials I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment my child receives with the naturopathic doctor. I understand that I am free to withdraw my consent and discontinue my child's treatment at any time.

Name of Parent or Guardian (please print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_



## PAEDIATRIC INTAKE FORM

Name of child: \_\_\_\_\_ Date: \_\_\_\_\_

SEX: M F AGE: \_\_\_\_\_ DOB (year/month/day): \_\_\_\_\_

Name of Parent/Guardian(s): \_\_\_\_\_

Home phone#: \_\_\_\_\_ cell#: \_\_\_\_\_

Address: \_\_\_\_\_ Parent's email: \_\_\_\_\_

Parent's address if different from above: \_\_\_\_\_

Family arrangement: married common-law separated divorced

How did you hear about the clinic? (advertisement, friend ,family) \_\_\_\_\_

### EMERGENCY CONTACT:

Name: \_\_\_\_\_ phone#: \_\_\_\_\_ work#: \_\_\_\_\_

Primary care physician name & contact information: \_\_\_\_\_

ALLERGIES (environmental, drugs, food, chemicals): \_\_\_\_\_

CHIEF CONCERNS in order of importance: \_\_\_\_\_

\_\_\_\_\_

Please list any treatments currently or previously used for this condition and their results:

\_\_\_\_\_

\_\_\_\_\_

PAST MEDICAL HISTORY: For the following, please include date of onset and any complications/adverse effects.

Major health concerns: \_\_\_\_\_

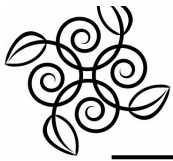
\_\_\_\_\_

Major injuries:

\_\_\_\_\_

Medications currently taken: \_\_\_\_\_

*Continued from page 1,*



VACCINATIONS: Has your child received regular vaccinations according to standard Pediatric schedule? Y N

If no, please explain,

Please indicate which vaccinations your child has had:

DPT (diphtheria, pertussis, tetanus) \_\_\_\_\_ Chicken pox \_\_\_\_\_ Tetanus booster \_\_\_\_\_  
MMR (measles, mumps, rubella) \_\_\_\_\_ Flu shot \_\_\_\_\_ Hib (Haemophilus influenza B ) \_\_\_\_\_  
Polio \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Hepatitis A \_\_\_\_\_ Meningitis \_\_\_\_\_  
Other: \_\_\_\_\_

Any adverse reactions? Yes/No Please explain: \_\_\_\_\_

Supplements (vitamins/minerals/herbs, include how often taken and effects): \_\_\_\_\_

FAMILY MEDICAL HISTORY:

Please state any of the following if they apply: allergies, arthritis, asthma, eating disorder, epilepsy, heart disease, high blood pressure, stroke, cancer, diabetes, depression, substance abuse, mental illness, bleeding problems, multiple sclerosis, obesity, kidney disease, tuberculosis, thyroid problems, other

MATERNAL

PATERNAL

Parents:

Parents:

Aunts/Uncles:

Aunts/Uncles:

Grandparents:

Grandparents:

Sibling 1:

Sibling 1:

Sibling 2:

Sibling 2:



PRENATAL HISTORY

Health of parents at conception:                      Poor                      Good                      Excellent

Health of mother during pregnancy: \_\_\_\_\_

Mother's diet during pregnancy: \_\_\_\_\_

Mother's food cravings during the pregnancy: \_\_\_\_\_

Mother's age at time of child's birth?      \_\_\_\_\_      Were there any fertility issues?                      Yes      No

Please describe: \_\_\_\_\_

Did the mother receive prenatal medical care?    Yes      No

If yes, please describe: ie. Midwife, doula, obstetrician, GP \_\_\_\_\_

Did the mother experience any complications during her pregnancy?    Yes      No

If yes, please describe and include any that apply: e.g. gestational diabetes, high blood pressure, varicose veins, placenta previa, breech position... \_\_\_\_\_

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

tobaccoalcohol                      recreational drugs                      Prescription medications: \_\_\_\_\_

Over the counter medications: \_\_\_\_\_

Supplements: \_\_\_\_\_ Other: \_\_\_\_\_

BIRTH/POST NATAL HISTORY

Child's birth order (ie. Youngest , oldest) \_\_\_\_\_

Number of weeks of pregnancy at birth: \_\_\_\_\_ Length of labour: \_\_\_\_\_

Weight at birth: \_\_\_\_\_ Length at birth: \_\_\_\_\_

Vaginal or caesarean birth: \_\_\_\_\_ Please list any complications: \_\_\_\_\_

Interventions: e.g. forceps, vacuum extraction, external fetal monitor, epidural, pitocin, induction of labour, other

DIET:



Breastfeeding: Yes No Formula: \_\_\_\_\_ Freq. Amt: \_\_\_\_\_ Other foods: \_\_\_\_\_

Food introduction: Yes No First foods? \_\_\_\_\_

Any adverse reactions: \_\_\_\_\_

Time and place of meal consumption: \_\_\_\_\_

Habits, cravings and aversions: \_\_\_\_\_

Concerns: \_\_\_\_\_

ELIMINATION: Stool Frequency: \_\_\_\_\_ Appearance: \_\_\_\_\_ Urinary Frequency: \_\_\_\_\_

Toilet training: Yes No When? \_\_\_\_\_ Concerns: \_\_\_\_\_

SLEEP: Hrs/night: \_\_\_\_\_ Naps frequency: \_\_\_\_\_ Location: \_\_\_\_\_

Habits: \_\_\_\_\_ Concerns: \_\_\_\_\_

BEHAVIOUR/PERSONALITY: Describe child: \_\_\_\_\_

Discipline: (reasons, methods) \_\_\_\_\_

Temper tantrums? Yes No Management: \_\_\_\_\_

Fears: \_\_\_\_\_

Stress level: Low Medium High Emotional climate in child's home: \_\_\_\_\_

Please describe child's interactions with:

Parent(s)/Guardians: \_\_\_\_\_

Other children: \_\_\_\_\_

DAY CARE Yes No Where: \_\_\_\_\_ Freq/Length: \_\_\_\_\_

Concerns: \_\_\_\_\_

GROWTH & DEVELOPMENT: Growth and development are age appropriate Yes No

MILESTONES: Please list age at which the following occurred: (specify if timing was unusual)

Sitting: \_\_\_\_\_ Crawling: \_\_\_\_\_

Rolling over: \_\_\_\_\_ Walking: \_\_\_\_\_

Talking: \_\_\_\_\_ Teeth eruption: \_\_\_\_\_



ACTIVITIES/HOME ENVIRONMENT:

TV (hours/day) \_\_\_\_\_

Games/hobbies: \_\_\_\_\_

Family time (hrs): \_\_\_\_\_

Environmental exposures if known (water quality, pesticides, cleaning products, carpet, paint, etc). \_\_\_\_\_

Safe neighbourhood: Yes      No

DENTAL CARE: Yes      No      Comments: \_\_\_\_\_

REVIEW OF SYSTEMS:

Please circle any that apply currently or in the past and make additions in the space provided if necessary:

**General:**      Fever    Illness    Hospitalization    Injury \_\_\_\_\_

**Head:**      Swelling    Rash    Hair loss \_\_\_\_\_

**Eyes:**      Red    Inflammation    Tears    Lazy eye \_\_\_\_\_

**Ears:**      Inflammation    Discharge    Acuity    Infections \_\_\_\_\_

**Nose:**      Infection    Allergies    Breathing    Mucus    Bleeding    Picking \_\_\_\_\_

**Mouth:**      Cavities    Swelling gums    Cold sores    Rash \_\_\_\_\_

**Skin:**      Rash    Dryness    Moles/birthmarks    Scars \_\_\_\_\_

**Neck/Throat:**    Lymph nodes    Stiffness      Sore throat    Strep \_\_\_\_\_

**Respiration:**    Cough    Wheezing    Asthma    Recurrent infections \_\_\_\_\_

**Cardiovascular:**    Paleness      Heart murmur    Shortness of breath    Palpitations \_\_\_\_\_

**Gastrointestinal:**    Stomach aches    Diarrhea    Constipation    Vomiting \_\_\_\_\_

**Genitourinary:**    Painful urination    Inflammation    Rash \_\_\_\_\_

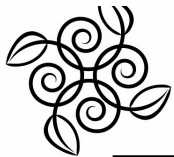
**Musculoskeletal:**    Muscle pain      Stiffness      Loss of strength    Fractures \_\_\_\_\_

**Neurological:**    Seizures      Loss sensation    Tremors      Anxiety      Fatigue

Coordination Problems \_\_\_\_\_

Any other concerns not already covered on this form: \_\_\_\_\_





*Thank you for taking the time to fill out the requested information. It will be very helpful in assessing your child's present health and in creating his/her personalized treatment plan.*