Health Centre Of Milton
Chiropractic & More…

Date _____

Child Intake Form:

Name _____ Age _____ Date of Birth (y/m/d) _____

Address: _____ City_____ Postal Code_____

Contact Phone number (caregiver): _____(H) _____ (W)_____ (other)

With whom does the child live? _____

Caregiver #1 Name _____ Relation to child _____

Caregiver #2 Name _____ Relation to child _____

How did you hear about our clinic? _____

Family Doctor Name _____Phone _____ Last seen? _____

When was your last physical exam? _____ Were blood tests done? **Y/N** Blood Type _____

Child's Current Health Concerns

1) _____ How long? _____
2) _____ How long? _____
3) _____ How long? _____

What kind of conventional treatment have you received? _____

Please circle all of the following complementary healthcare practitioners the child have seen:

Naturopathic Doctor Chiropractor Acupuncturist Massage Therapist Osteopath Other _____

Please list any medications or supplements that the child is taking

1)_____ 2)_____

3)_____ 4)_____

5)_____ 6)_____

Health History:

Please check all that apply and indicate child's age at time of infection and how often these occur:

o Chicken Pox	o Mononucleosis	o Scarlett Fever
o Fifth's Disease	o Mumps	o Tonsilitis
o Frequent colds	o Polio	o Whooping Cough
o Hand, foot, mouth disease	o Pneumonia	o Strept throat
o Measles	o Rubella	o Ear infection
o Other		

Dr. Tanya Lee, B.Sc, N.D
Health Centre of Milton
420 Main St. Unit 102-103
Milton, ON
905.878.8131

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Are there any ailments from which the child feels they have never been well since?

_____

Please list any trauma, injuries, surgeries or accidents your child has sustained:

1)_____ 2)_____

3)_____ 4)_____

Any Allergies or intolerances (foods, medications, preservatives etc….)

1)_____ 2)_____

3)_____ 4)_____

Has your child been treated with antibiotics? **Y or N** If so, how many times? _____

Vaccination History:

Was the child vaccinated? **Y/N** Any adverse reactions (ex: fever)? **Y/N** - Please explain _____

○ DPT (Diptheria, Pertussis, Tetanus)	○ Haemophilus influenza	○ Hepatitis A
○ Tetanus booster: when?	○ Flu: # of times	○ Hepatitis B
○ MMR	○ Polio	○ Rubella
○ HPV	○ Other	

Nutrition:

Does your child have any dietary restrictions? **Y or N**

Breast fed? **Y or N** How long?	Formula Fed? **Y or N** Age introduced	Solids Age introduced

Please list the first solid foods introduced:

1)_____ 2)_____

3)_____ 4)_____

Are there any foods your child craves specifically? _____

Prenatal History:

Was your child naturally conceived? **Y or N**, if no please describe _____

Any of the following complications during the pregnancy?

○ Bleeding	○ Illness	○ High blood pressure	○ Other
○ Diabetes	○ Nausea	○ Thyroid problems	
○ Emotional Trauma	○ Physical Trauma	○ Vomitting	

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Please list all vitamins and/or medication taken during pregnancy

1)_____ 2)_____

3)_____ 4)_____

Any drugs or alcohol taken during pregnancy? **Y or N** Please indicate _____

Birth History

Term length: _____wks Labor: Spontaneous? **Y / N** Induced? **Y / N** Duration of Labour: _____hrs

Type of delivery: __ Vaginal __ C-section __ Hospital __ Home Birth __ Water Birth

Were there any interventions used? __ Epidura l __ Episiotomy __ Forceps __ Suction

Any complications? _____

Was the mother strept B positive? **Y / N** if yes, were antibiotics used during birth? **Y / N**

Birth Weight: _____ Length _____ Apgar Score _____

Health and Development

At what age did your child first

Sit _____ Crawl _____ Walk _____ Talk _____

Home Environment:

How would you describe the overall mood in your home? Very stable / Stable / Stressful / Very Stressful

Do you live close to any of the following? Dump / Airport / Highway / Industry / Power lines

Are there pets in your house hold? **Y / N** Any mold? **Y / N**

Thank you for taking the time to fill out this lengthy questionnaire. It will be a valuable resource in understanding your health.

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Patient Consent Form

Congratulations for making a commitment to your health by coming in for a naturopathic assessment by Tanya Lee, Doctor of Naturopathic Medicine, at the Health Centre of Milton. I hope that you enjoy your experience as we work together to help you achieve your full health potential.

Naturopathic Medicine is a unique and comprehensive approach to improving health and treating illness. As primary health care practitioners, our goal is to provide safe and effective health care to each patient in a compassionate and efficient manner. In order to assess your individual condition, your Naturopathic Doctor will take a thorough case history, perform a screening physical exam, and laboratory tests. Therapeutics include clinical nutrition and supplementation, botanical medicine, acupuncture, and Traditional Chinese Medicine, homeopathy and lifestyle counseling. Further detailed information on the treatments used by Naturopathic Doctors can be provided on request (either through verbal or written explanation provided by the Naturopathic Doctor).

Each Person must sign this document prior to the initial visit.

My signature acknowledges that I have been informed and understand that:

1) I am encouraged to create a comprehensive health care team working towards my best interests and continue to seek medical care from other qualified health practitioners (physician, chiropractor, dentist, etc.) as required.
2) I understand that Naturopathic Doctors are required by their licensing boards to perform a screening physical exam on each new patient. This will be adhered to unless the referring practitioner sends a full report to the N.D.
3) I am aware of the slight health risks concerning some treatments, which may include, but are not limited to; aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, fainting, bruising or injury from acupuncture or venipuncture. I have received a full and complete explanation of the treatment or services that I may receive at this office and hereby authorize consent to treatment.
4) I understand that working with a Naturopathic Doctor involves a team-like approach and while appropriate individualized advice regarding obtaining my treatment goals will be provided, I also commit to being responsible for my own health. If I am having difficulty following a treatment plan, I will contact my ND so that we can make the necessary modifications to ensure that I am able to continue to work towards my health and wellness goals.
5) I am aware that I can purchase the products recommended by my Naturopathic Doctor at the location of my choice. I am under no obligation to purchase products from the Health Centre of Milton. However, if I do purchase products at the clinic, I am aware that they cannot be returned for refund, as they will not be resold. Just as a pharmacy cannot accept returns on pharmaceutical products, we cannot accept returns on nutraceutical products so that we can guarantee that all of our products have been stored in appropriate conditions until they are dispensed.
6) I understand that a record will be kept of health services provided to me. Other health care practitioners of the Health Centre of Milton may have access to my information as needed for my own benefit. Otherwise, this record will be kept confidential and will not be released to anyone outside this office unless so directed by myself or unless it is required by law.
7) I understand that I may look at my medical record at anytime and that copy of my file will be provided to me, for a fee, upon request. I have reviewed the Health Centre of Milton's privacy policy and I understand how it applies to me. I agree to the Health Centre of Milton's collecting, using and disclosing personal information about me as set out in this policy.
8) I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

I, _____, have read, understood and acknowledge the above statements.
(guardian's name printed)

_____ _____
(signature of guardian) (date)

_____ _____
(signature of N.D) (date)

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