Dr. Tanya Lee, ND
Dr. Melissa Bucking, ND   Patient Intake Forms

Name:___________________   Date:____________________

Child Intake Form:

Name ____ Age __________ Date of Birth (y/m/d) _____________

Address: ___________________________________ City_____________________ Postal Code_____________

Contact Phone number (caregiver): ____

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 and location ____ Last seen? _____________

Child's Current Health Concerns

1) ____ How long? ________________
2) ____ How long? ________________
3) ____ How long? ________________

What kind of conventional treatment have you received? ____

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		

Name:___________________ Date:____________________

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** Up to date? **Y/N** Any adverse reactions (ex: fever)? **Y/N**

○ 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 complications during the pregnancy? ____

Name:__________________ Date:___________________

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? __ Epidural __ 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 ________________

Health Centre of Milton
420 Main St. E Unit 102-103
Milton, Ontario L9T 1P7
905.878.8131

Dr. Tanya Lee, H.BSc., N.D #1742
Dr. Melissa Bucking, BSc N.D #3723

Name:_________________ Date:__________________

Patient Consent Form

Congratulations for making a commitment to your health by coming in for a naturopathic assessment at the Health Centre of Milton. We 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 counselling. 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. 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 my treating naturopath’s privacy policy and I understand how it applies to me. I agree to the 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, provicinal 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.
(print name)

____ _________________________________
(signature of patient) (date)

____ _________________________________
(signature of N.D) (date)

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Dr. Melissa Bucking, ND Patient Intake Forms

Name:___________________ Date:____________________

FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

The privacy of your personal information is an important part of your ND's naturopathic practice. Your naturopath and the clinic staff are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.
As your naturopathic doctor, acts as the Privacy Information Officer. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection

Our privacy policy outlines what our Clinic is doing to ensure that:
· only necessary information is collected about you;
· we only share your information with your consent;
· storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
· our privacy protocols comply with privacy legislation and standards of our regulatory body, the The College of Naturopaths of Ontario (2015)

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

Our Clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our Clinic is using and disclosing your information.

This Clinic will collect, use and disclose information about you for the following purposes:
· to advise you of treatment options
· to send you newsletters and other information mailings
· to communicate with other treating health-care providers
· to invoice for goods and services
· to assist this Clinic to comply with all regulatory requirements
· to establish and maintain contact with you
· to remind you of upcoming appointments
· to complete claims for insurance purposes
· to process credit card payments
· to comply generally with the law
· to allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale.
· to allow us to efficiently follow-up for treatment, care and billing
· to comply with legal and regulatory requirements of our regulatory body, the College of Naturopaths of Ontario acting under the authority of the Regulated Health Practitioners Act

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined

Patient Consent

I have reviewed the above information that explains how your Clinic will use my personal information, and the steps your Clinic is taking to protect my information.

I _____________________________ agree that Dr. _____________can collect use and disclose personal information
(print name of patient or power of attorney)
as set out above in the information for ____
(patient name)

____ __________________________ __________________
signature of patient/power of attorney Date Witness

I, ____, hereby agree and consent that Dr.____________________may
(print name of guardian)
communicate and disclose medical information with the following people, through in-house visits, email and phone:

name of person authorized	signature of patient	date
___________________________________	___________________________________	______________________
___________________________________	___________________________________	______________________
___________________________________	___________________________________	______________________

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