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THE NATURAL MEDICINE CLINIC

Please help us provide you with a complete evaluation by taking the time to fill out this intake form carefully. All of your answers will be held completely confidential. If you have any questions, please ask. Thank you.

NAME: **DATE:**

ADDRESS:

CITY: **PROVINCE:** **POSTAL CODE:**

DATE OF BIRTH (DD/MM/YYYY): **AGE:** **SEX:**

EMAIL: **Would you like to be added to our newsletter?**

PHONE HOME: **WORK:** **CELL:**

MAY WE LEAVE MESSAGES RELATING TO YOUR VISIT?

EMERGENCY CONTACT INFO:

NAME / RELATION: **PH#:**

OTHER HEALTH CARE PROVIDERS YOU ARE CURRENTLY SEEING

NAME: **PH#:** **SPECIALTY:**

NAME: **PH#:** **SPECIALTY:**

May we contact your physician(s) about your condition/treatment?

PLEASE LIST / DESCRIBE YOUR MAIN CONCERNS FOR YOUR CHILD (in order of priority):

1

2

3

4

5

Have you been treated by anyone else for these concerns? If so, when, how and did it help?

Please Rate Your Child's General State Health (1 = Poor, 5 = Excellent) ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

Dr. Shawna Clark, ND, BA
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HOW DID YOU HEAR ABOUT OUR CLINIC?

DOES YOUR CHILD HAVE ANY ALLERGIES (MEDICATIONS, SEASONAL, ENVIRONMENTAL, FOOD)?

ALLERGY	REACTION

PLEASE LIST ANY CURRENT MEDICATIONS OR SUPPLEMENTS & DOSE YOUR CHILD IS TAKING:

MEDICATION	DOSE

MEDICAL HISTORY
PLEASE LIST ANY PAST MEDICAL CONCERNS (eg: illnesses, injuries, hospitalizations, surgeries, traumas):

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (Please select if applies)

- ☐ Abortion
- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis
- ☐ Asthma
- ☐ Abuse
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Crohn's
- ☐ Cirrhosis
- ☐ Deafness
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Gallstones
- ☐ Gonorrhea
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Irritable Bowel
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Leukemia
- ☐ Lupus
- ☐ Measles
- ☐ Menstrual disorder
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Parasites
- ☐ Pneumonia
- ☐ Pregnancy
- ☐ Psoriasis
- ☐ Rubella
- ☐ Scarlet Fever
- ☐ Strep Throat
- ☐ Syphilis
- ☐ Thyroid problems
- ☐ Tinnitus
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Ulcers
- ☐ Urinary Tract infection
- ☐ Whooping Cough
- ☐ Yeast Infection
- ☐ Other:

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HOW MANY TIMES HAS YOUR CHILD HAD ANTIBIOTICS?

VACCINATION HISTORY:
PLEASE CHECK THE IMMUNIZATIONS YOUR CHILD HAS RECEIVED (comment on any adverse reactions):

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ TETANUS BOOSTER
- ☐ MMR (measles, mumps, rubella)
- ☐ TETANUS BOOSTER
- ☐ HEMOPHILUS INFLUENZA B
- ☐ FLU
- ☐ POLIO
- ☐ CHICKEN POX
- ☐ HEPATITIS A
- ☐ HEPATITIS B
- ☐ HPV (Gardasil)

DIET / LIFESYLE
DOES YOUR CHILD DO ANY FORM OF PHYSICAL ACTIVITY? ☐ Y ☐ N
WHAT TYPE? HOW OFTEN?
DOES YOUR CHILD FOLLOW A SPECIAL DIET? ☐ Y ☐ N TYPE:

NUTRITIONAL HISTORY
HOW WAS YOUR INFANT FED? ☐ BREAST ☐ FORMULA ☐ BOTH

DID YOUR INFANT EXPERIENCE ANY REACTIONS TO BREAST MILK OR FORMULA? ☐ Y ☐ N

DID YOUR CHILD EXPERIENCE ANY FOOD REACTIONS WHEN THEY WERE INTRODUCED? ☐ Y ☐ N
WHAT?

SLEEP PATTERNS
WHAT TIME DOES YOUR CHILD GO TO BED? WAKE UP?
DOES HE/SHE NAP DURING THE DAY? ☐ Y ☐ N
DOES HE/SHE HAVE ANY PROBLEMS DURING SLEEP (i.e. grinding teeth, sleep walking, bedwetting) ☐ Y ☐ N

PLEASE WRITE A SHORT DESCRIPTION OF YOUR CHILD, INCLUDING STRENGTHS, WEAKNESSES AND MAJOR PERSONALITY TRAITS:

IS THERE ANYTHING ELSE YOU THINK IS IMPORTANT WITH REGARDS TO YOUR CHILD'S HEALTH?

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ADD-ON FOR PATIENTS UNDER 5 YEARS

PRE-NATAL HEALTH AND BIRTH HISTORY:

HOW WAS THE MOTHER'S HEALTH AT CONCEPTION? ☐ Excellent ☐ Fair ☐ Good ☐ Poor ☐ Unknown

HOW WAS THE FATHER'S HEALTH AT CONCEPTION? ☐ Excellent ☐ Fair ☐ Good ☐ Poor ☐ Unknown

HOW WAS THE MOTHER'S HEALTH DURING PREGNANCY? ☐ Excellent ☐ Fair ☐ Good ☐ Poor ☐ Unknown

HOW WAS THE MOTHER'S EMOTIONAL HEALTH DURING? ☐ Excellent ☐ Fair ☐ Good ☐ Poor ☐ Unknown

HOW WAS THE MOTHER'S DIET DURING PREGNANCY? ☐ Excellent ☐ Fair ☐ Good ☐ Poor ☐ Unknown

DID THE MOTHER RECEIVE MEDICAL CARE DURING PREGNANCY? ☐ Y ☐ N

DID THE MOTHER USE ANY OF THE FOLLOWING DURING PREGNANCY?

Alcohol	☐ Y ☐ N	What & How Much?
Cigarettes	☐ Y ☐ N	What & How Much?
Recreational Drugs	☐ Y ☐ N	What & How Much?
Prescription Drugs	☐ Y ☐ N	What & How Much?
Supplements	☐ Y ☐ N	What & How Much?

WERE THERE ANY INTERVENTIONS OR COMPLICATIONS DURING DELIVERY? ☐ Y ☐ N

WAS YOUR BABY ☐ **PRE-TERM** ☐ **FULL-TERM** ☐ **POST-TERM?**
DID YOUR BABY EXPERIENCE ANY OF THE FOLLOWING AT OR SHORTLY AFTER BIRTH?

JAUNDICE	☐ Y ☐ N
BIRTH INJURIES	☐ Y ☐ N
INFECTIONS	☐ Y ☐ N
BIRTH DEFECTS	☐ Y ☐ N

DEVELOPMENT
AT WHAT AGE DID YOUR CHILD FIRST:

SIT UP **CRAWL** **WALK** **TALK** **TEETH**

DID YOU HAVE ANY CONCERNS REGARDING YOUR CHILD'S DEVELOPMENT?

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INFORMED CONSENT TO NATUROPATHIC TREATMENT

Dr. Shawna Clark, ND utilizes the principles and practices of Naturopathic Medicine, case history, other supportive therapies, labs and functional tests to assess and assist the body's own ability to heal and to improve the quality of life and health through natural means. All of the information gathered will be maintained with complete confidentiality and any personal information will not be shared without first gaining my consent, with the exception of professional consult or dialogue with regards to specific patient care.

The slight health risks of some Naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reaction to supplements or herbs; pain, fainting, drowsiness, bruising, bleeding, burns or injury from acpuncture/cupping/massage/bodywork; muscle strains and sprains; disc injuries and stroke from spinal manipulations. As a patient of this clinic, I have read and understand this information, and I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions.

The information provided is complete and inclusive of all past and present health concerns including risk of pregnancy and all medications, over the counter drugs and supplements. I agree to immediately inform the attending Naturopathic Doctor of any adverse effects I may experience, any disease process that develops during treatment, any medications or drugs, over the counter or otherwise, that I use or change, or if I become pregnant, suspect pregnancy or are breast-feeding. Accepting treatment further implies compliance with treatments to the best of my ability and to inform the attending Naturopathic Doctor of any non-compliance, intended or otherwise. I understand that treatment results for each individual are variable and Traditions Clinic and Dr. Shawna Clark, ND do not and cannot predict or guarantee individual treatment results at any time. I also confirm that I have the ability to accept or reject this care of my own free will. I acknowledge that I have a right to purchase remedies and vitamins from a source other than what is available from Dr. Shawna Clark, ND. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating.

ACUPUNCTURE TREATMENTS
Only single use, sterile & disposable needles are used in this clinic.

Apart from general medical information, it is important that you let your practitioner know:

- If you have a history of fainting spells ☐ Y ☐ N
- If you have a pacemaker or any other electrical implants ☐ Y ☐ N
- If you have a bleeding disorder ☐ Y ☐ N
- If you are taking anti-coagulants (blood thinners) ☐ Y ☐ N
- If you are or are planning to become pregnant ☐ Y ☐ N

I acknowledge that the treatments are not covered by OHIP and I accept full responsibility for any fees incurred during care and treatment at the time of my visit. Telephone consultations will be billed to me according to the length of time. Cancellations must be made 48 hours prior to my scheduled appointment time to avoid being charged a cancellation fee. (initial)

Patient Name (please print):

Signature of Patient or Guardian:_____ Date:_____

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Dear Valued Patient,

TRADITIONS CLINIC is an established, reputable and busy inter-disciplinary wellness clinic. We maintain a deep respect and appreciation for our clientele and do our utmost to fulfill your expectations and help you meet your health goals. Our practitioners' time is in high demand and we ask that our valued patients respect all appointment times that have been allotted for you.

Our cancellation policy has evolved to reinforce the mutual respect required between practitioners and patients to provide the high quality service we strive for. In order to keep things running smoothly and efficiently, to allow for equal access to care for all of our patients and to encourage compliance and success, our cancellation policy must be universally applied and deferred to.

TRADITIONS CLINIC requires 48 hours notice for all cancellations. Appointments cancelled or missed within 48 hours of the set appointment will be charged a fee. The fee is set at half the rate of the scheduled time and will be processed 48 hours after that set time. Emergencies are exempt from this policy and patients are given this 48-hour period to explain their absence. We appreciate your understanding and cooperation.

As a patient at TRADITIONS CLINIC, I recognize the above mentioned cancellation policy and authorize an automatic charge and payment for any missed appointments or appointments cancelled within the 48 hour period prior to my scheduled appointment, exempting notification of emergencies within 48 hours after my scheduled appointment.

Name

Signature _____

Date

Credit card # ☐ VISA ☐ MC

Expiry date (MM/YR) security code

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