DR. JULIE CHAN
NATUROPATHIC DOCTOR
REGISTERED ACUPUNCTURIST

# INTAKE FORM FOR CHILDREN AND TEENS

*Please complete the intake form as thoroughly as possible and return it to the clinic reception. Please be advised that some of the questions may be very detailed and that is intended so your Naturopathic Doctor can attend to your needs in the most holistic manner.*

**Patient's Identification**

| | | | | | |
|---|---|---|---|---|---|
| **Last Name** | | **First Name** | **DOB**: _____/_____/_____ DD / MM/ YYYY | **Sex** | **Age** |
| **Address** | | | **City, Province** | **Postal Code** | |
| **Home Phone** | **Work Phone** | **Cell Phone** | **Email address:** | | |
| **Emergency Contact** | | **Emergency Number** | **Would you like to be on our mailing list to receive quarterly health newsletters and updates?** | **Y** | **N** |
| **Doctor's Name:** | | **Doctor's Number** | **Doctor's Address:** | | |
| **Are you under the care of other health practitioners? If yes, please list names and their specialty:** | | | | | |
| **How did you hear about our clinic?** □ **Referred by your doctor** □ **Referred by friend/family (Name)** _____ □ **Internet** □ **Other** | | | | | |

**Parent/Guardian Information #1**

| | | | | |
|---|---|---|---|---|
| **Last Name** | **First Name** | **DOB**: _____/_____/_____ Month Day Year | **Relation to Patient** | |
| **Address** | | **City, Province** | **Postal Code** | |
| **Home Phone** | **Work Phone** | **Cell Phone** | **Email address:** | |

**Parent/Guardian Information #2**

| | | | | |
|---|---|---|---|---|
| **Last Name** | **First Name** | **DOB**: _____/_____/_____ Month Day Year | **Relation to Patient** | |
| **Address** | | **City, Province** | **Postal Code** | |
| **Home Phone** | **Work Phone** | **Cell Phone** | **Email address:** | |

**HealthCare Providers: (Please List)**

| NAME | ADDRESS | PHONE NUMBER |
|---|---|---|
| **1.** | | |
| **2.** | | |

**Health Concerns:**

| Please List Chief Health Concerns (in order of importance) | How long has it been | Past or Current |
|---|---|---|

| | going on for? | Treatments |
|---|---|---|
| **1** | | |
| **2** | | |
| **3** | | |
| **4** | | |
| **5** | | |
| **6** | | |

**Medical History**

| How would you rate your child's current state of health: Excellent Good Fair Poor | |
|---|---|
| List any history of accidents, surgeries, drug/allergic reactions, hospitalizations, major illnesses, and complications in the past | When? |
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| Please list all food, environmental, vaccine and drug allergies: | |
| How many times in one year does your child have a cold, sinusitis, flu, sore throat or lung infection? | |
| How many times has your child been treated with antibiotics in the last 5 years? 0-5 5 to 10 >10 | |
| What is your child's energy level (10 being the highest) 0 1 2 3 4 5 6 7 8 9 10 | |
| What is your child's stress level (10 being the highest) 0 1 2 3 4 5 6 7 8 9 10 | |
| What are your main sources of stress? | |
| How would you describe the emotional climate at home? | |
| Who lives at home with the child? | |
| Does your child have any siblings? Please describe. | |
| What are your child's hobbies? | |

**Has your child had any of the following illnesses?**

□ Chicken Pox □ Measles □ Mumps □ Rubella □ Whooping Cough
□ Scarlet Fever □ Roseola □ Polio □ Meningitis □ Mononucleosis
□ Tuberculosis □ Strep throat □ Frequent Ear Infections □ Rheumatic Fever

**Vaccination History**

**Please list what vaccination your child has had:**

□ DPT □ Hepatitis A □ Hepatitis B □ Influenza (flu) □ Tetanus; booster □ Polio
□ Small Pox □ Chicken pox □ German Measles □ MMR (Measles, Mumps, Rubella)
□ Haemophilus influenza B □ Other? _____
□ Any adverse reactions? □ Yes □ No If yes, describe: _____

**Medications and Supplements** – Please list all medications and supplements child is currently taking.

| Medications | Supplements and Vitamins |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |

**Family History**

**Please indicate if any immediate family members (parents, siblings, grandparents) have had or have the following conditions/**

| | | | | |
|---|---|---|---|---|
| □ Diabetes | □ Heart Disease | □ High Blood Pressure | □ Autoimmune disease | □ Depression |
| □ High Cholesterol | □ Stroke | □ Cancer | □ Alcohol/drug abuse | □ Arthritis |
| □ Seizures | □ Kidney Disease | □ Thyroid Dysfunction | □ Schizophrenia | □ Allergies |
| □ Asthma | □ Other Mental Illness | □ Other: _____ | | |

**Prenatal and Birth History**

**How would you describe the health of the parents at the time of conception?**

| | | | | | |
|---|---|---|---|---|---|
| Mother: | Excellent | Good | Fair | Poor | Unknown |
| Father: | Excellent | Good | Fair | Poor | Unknown |

**How would you describe the health of the mother during the pregnancy?**

Excellent Good Fair Poor Unknown

**At what age did the mother of this child give birth?** _____

**Was this her first pregnancy?** Y N

**Was there any difficulty conceiving this child?** Y N

**What, if any, interventions were used to increase the chance of conception?**

_____

**Please describe any health problems, stress, or complications, and the emotional state of the mother during pregnancy**

_____

**Did the mother use any of the following during pregnancy? If yes, please list amounts and frequency of use**

□ Alcohol _____ □ Tobacco _____

□ Second hand smoke _____ □ Recreational Drugs _____

□ Prescription Drugs _____ □ Over-the-counter Drugs _____

□ Exposure to workplace chemicals (explain)_____

**Mother's weight gain during pregnancy** _____ **Length of pregnancy** _____wks

**Type of birth (circle):** vaginal C-section Length of labour _____hrs

**Interventions (circle):** forceps vacuum epidural episiotomy other

**Were there any complications during or immediately after labour & delivery? If so, please describe**

_____

**Postnatal History**

**Birth weight** _____ **Birth length** _____ **Were there any health concerns at birth? If yes, please describe**

_____

**In the first few weeks after birth, did your child experience any of the following?**

| | | | |
|---|---|---|---|
| □ congenital birth defect | □ fever | □ infection | □ jaundice |
| □ skin conditions | □ colic | □ vomiting | □ restlessness |
| □ feeding difficulties | □ constipation | □ other _____ | |

Age at first: _____ sitting _____ crawling ____ teething ____ walking ____ talking

**Any developmental delays or concerns?** _____

_____

**Diet and lifestyle**

**How was your child fed?** □ Breast fed. How long? _____ □ Formula fed? Brand: _____

**At what age were solid foods introduced into the child's diet?** _____

**What order, if any, did you follow in introducing foods?** _____

**Current Height** _____ **Current Weight** _____ **Any concerns about height or weight?** _____

**Describe a typical diet for one day and amounts:**

| | |
|---|---|
| Breakfast: | Snacks: |
| Lunch: | Beverages: |
| Dinner: | Other: |

**How many times a week do you have these foods?**

___ Fruit/Fruit juices
___ Vegetables
___ Luncheon meat/smoked meat
___ Wheat products (bread, pastas,
___ Bagels, pastries, cakes etc.)
___ Sugar, sweets (candy, cookies etc.)
___ Salty snack foods (eg. Chips)
___ Artificial sweeteners (Splenda etc.)
___ Fast food (McDonald's etc.)
___ Dairy products (milk, cheese etc)
___ Herbal tea
___ Coffee
___ Regular tea
___ Alcohol

**What kind of water do you primarily drink?** ☐ Tap ☐ Well ☐ Bottled ☐ Filtered ☐ Distilled
**Are there any foods which you exclude from your child's diet? For what reason?**

_____

**How much water does your child consume per day?** _____ **Other Beverages?** _____ **# of Bowel Movements/Day** _____

**Is your child regularly exposed to tobacco smoke or other environmental toxins at home?** _____

**Are there pets in the home?** _____

**Lifestyle**

| |
|---|
| Does your child exercise? □ Never □ < 1/wk □ 1-3/wk □ 3-5/wk □ >5/wk |
| How many hours dose your child sleep? Any difficulty staying asleep? □ Yes □ No |
| Any difficulty falling asleep? □ Yes □ No Does your child feel well-rested after waking up? □ Yes □ No |

**Please describe your child's disposition** _____

_____

**If your child is preadolescent or adolescent, please fill out the following questions and have your child fill out the accompanying confidential questionnaire for teens (age 14 -17) that follows the Review of Systems.**

**What information, if any, has your child been given about what changes they can expect during puberty?**

_____

**What information, if any, has your child been given about their sexuality, birth control, or protection from sexually transmitted diseases?** _____

**What information, if any, has your child been given about substances such as tobacco, alcohol, or recreational drugs?**

_____

**Do you have concerns or comments about any of these topics?** _____

For Initial Naturopathic Appointments, parent(s)/guardian(s) may choose the option of attending the appointment without the patient (child/teen). An examination can be performed on the follow-up visit. Please try to bring in any relevant reports such as blood or imaging reports, report cards, or assessment results to the first visit.

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# REVIEW OF SYSTEMS

(Please check with a ✓ for current symptoms or put a "P" for past symptoms)

| NEUROLOGICAL | GASTRO-INTESTINAL TRACT | NOSE & SINUSES | EYES |
|---|---|---|---|
| □ Fatigue | □ Poor appetite | □ Allergies | □ Impaired vision |
| □ Chills | □ Poor thirst | □ Itchy nose | □ Glasses/contacts |
| □ Seizures | □ Bloating | □ Nasal discharge | □ Colour blindness |
| □ Dizziness | □ Burping or gas | □ Loss of smell | □ Far-sighted |
| □ Fainting | □ Heartburn | □ Postnasal drip | □ Near-sighted |
| □ Paralysis | □ Ulcers | □ Nosebleeds | □ Double vision |
| □ Mood swings | □ Bad breath | □ Sinus infections | □ Blind spots |
| □ Quick temper | □ Abdominal pain | □ Nasal congestion | □ Difficulty seeing at night |
| □ Speech problems | □ Constipation | □ Hoarseness | □ Sensitivity to sun |
| □ Insomnia | □ Laxative Use | □ Sinus pain | □ Infections |
| □ Feeling stressed | □ Difficult digestion | □ Snoring | □ Eye pain |
| □ Poor memory | □ Diarrhea | □ Sleep apnea | □ Redness |
| □ Loss of balance | □ Difficulty swallowing | □ Other _____ | □ Discharge |
| □ Headaches | □ Vomiting | | □ Dryness |
| □ Feeling anxious | □ Nausea | RESPIRATORY and IMMUNE SYSTEM | □ Blurring |
| □ Feeling nervous | □ Incomplete bowel movements | □ Prone to getting sick | □ Excessive tearing |
| □ Phobias | □ Hard stools | □ Colds | □ Spots/Floaters |
| □ Neuralgia | □ Loose stools | □ Sore throats | □ Glaucoma |
| □ Numbness/ tingling | □ Hemorrhoids | □ Ear infections | □ Cataracts |
| □ Jerking | □ Mucus in stool | □ Swollen lymph nodes | □ Styes or lumps |
| □ Tremors | □ Green stool | □ Chest pain | □ Eye strain |
| □ Alcohol/drug use | □ Undigested food in stool | □ Chronic cough | □ Eye fatigue |
| □ Learning difficulties | □ Black tarry stool | □ Phlegm | □ Other _____ |
| □ Confusion | □ Blood in stool | □ Wheezing | |
| □ Dementia | □ Pale stool | □ Bronchitis | MOUTH AND THROAT |
| □ Prolonged sadness/ grief | □ Anal itching | □ Pneumonia | □ Swollen/sore lips |
| □ Depression | □ Anal fissures | □ Tuberculosis | □ Swollen/sore tongue |
| □ Irritability | □ Rectal pain | □ Asthma | □ Swollen/sore gums |
| □ Mental illness | □ Rectal bleeding | □ Emphysema | □ Bad breath |
| □ Panic attacks | □ Liver disease | □ Pleurisy | □ Mouth Sores/Cankers |
| □ Hyperactivity | □Gallbladder disease | □ Coughing blood | □ Gum bleeding |
| □ Poor focus | □ Gall stones | □ Pain breathing | □ Cold Sores |
| □ Aggression | □ Jaundice | □ Smoking | □ Dentures |
| □ Autism | □ Fatty Liver | □Shortness of breath (SOB) | □ Cavities |
| □ Schizophrenia | □ Other _____ | □ Chronic Fatigue Syndrome | □ Mercury Fillings |
| □ Had Concussion | | □ Frequent antibiotic use | □ Sensitive Teeth |
| □ Poor Self Esteem | | □ Chronic infections | □ Grinding teeth |
| □ Other _____ | | □ Steroidal use | □ Other _____ |
| | | □ Other _____ | |

CARDIO-VASCULAR
□ High cholesterol
□ High blood pressure
□ Low blood pressure
□ Rapid heart rate
□ Slow heart rate
□ Arrhythmia
□ Palpitations
□ Murmurs
□ Angina
□ Chest pain
□ Poor circulation
□ Blood clots
□ Deep leg pain
□ Varicose veins
□ Heart valve problems
□ History of stroke
□ History of heart attack
□ Hardening of arteries
□ Rheumatic fever
□ Cold extremities
□ Swelling of limbs
□ Easy bruising
□ Other_____

ENDOCRINE
□ Hypothyroid
□ Hyperthyroid
□ Thyroid issue
□ Goiter
□ Excessive sweating
□ Heat intolerance
□ Cold intolerance
□ Excessive thirst
□ Excessive hunger
□ Diabetes I
□ Diabetes II
□ Hypoglycemia
□ Weight issues
□ Hormone therapy
□ Other _____

MUSCLE AND JOINT
□ Neck pain
□ Back pain
□ Joint pain
□ Joint swelling
□ Joint stiffness
□ Muscle weakness
□ Muscle pain
□ Shoulder pain
□ Knee pain
□ Foot/ankle pain
□ Hip pain
□ Elbow Pain
□ Hand/wrist pain
□ Sacral Pain
□ Herniated Disc
□ Arthritis
□ Curvature of the spine
□ Sciatica
□ Fractures
□ Osteoporosis
□ Loss of height
□ Bursitis
□ Fibromyalgia
□ Other _____

SKIN AND HAIR
□ Eczema
□ Hives
□ Rash
□ Acne
□ Lumps/Bumps
□ Colour Change
□ Scarring
□ Dry skin
□ Itching
□ Skin cancer
□ Nail changes
□ Warts
□ Herpes
□ Change in moles
□ Psoriasis
□ Strong body odour
□ Easy perspiration
□ Dandruff
□ Hair Loss
□ Other _____

EARS
□ Ringing in ears
□ Trouble hearing
□ Ear discharge
□ Ear pain
□ Tubes in ears
□ Ear infections
□ Wax build-up
□ Itching
□ Other _____

GENITO-URINARY TRACT
□ Blood in urine
□ Incontinence
□ Kidney / urinary Infections
□ Urgency
□ Frequent urination
□ Night urination
□ Bad odour urine
□ Painful urination
□ Flank pain
□ Bedwetting
□ Kidney stones
□ Other _____

MALE REPRODUCTIVE
□ Hernia
□ Low libido
□ Prostate problems
□ Sores or lumps
□ STDs
□ Sexually active
□ Testicular pain
□ Testicular masses
□ Erectile dysfunction
□ Herpes
□ Premature ejaculation
□ Undescended testicles
□ Low sperm
□ Discharges
□ Other _____

FEMALE REPRODUCTIVE
□ Heavy menses
□ Light menses
□ Clots
□ Painful periods
□ Irregular periods
□ Vaginal discharge
□ Abnormal PAP
□ Bleeding between periods
□ Vaginal itching
□ Vaginal sores
□ Use of tampons
□ Odour to discharge
□ Painful intercourse
□ Low libido
□Yeast infections
□ Endometriosis
□ Uterine fibroids
□ Hysterectomy
□ Ovarian cysts
□ Sexually active
□ Menopausal
□ Hotflashes
□ Difficulty conceiving
□ Infertility
□ Diagnosed with STD
□ History of ovarian, uterine or cervical cancer
□ Other _____

BREAST HEALTH
□ Sore breasts
□ Lumps
□ Breast Pain
□ Nipple discharge
□ Fibrocystic breasts
□ Skin puckering
□ History of breast cancer
□ Other _____

**ADDITIONAL CONCERNS:**

_____

_____

DR. JULIE CHAN
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REGISTERED ACUPUNCTURIST

# Informed Consent to Naturopathic/Acupuncture Therapies (Minor)

This is to acknowledge that I have been informed and I understand that:

1. Any treatment or advice provided to me as a patient of Dr. Julie Sook-Man Chan, Naturopathic Doctor and Registered Acupuncturist, is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another health care provider. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario;

2. I have not been recommended to refrain from seeking or following the advice of another licensed health care provider

3. No employee, agent, or anyone else under the direction of Naturopathic Doctor and Registered Acupuncturist, Dr. Julie Sook-Man Chan is suggesting or recommending to me to refrain from seeking or following the advice of another health care provider.

4. The treatment and therapies rendered or recommended by Naturopathic Doctor and Registered Acupuncturist, Dr. Julie Sook-Man Chan may be different than those usually offered by a medical doctor or other health care provider.

5. There are some risks, however rare, to Naturopathic Medicine. These include but are not limited to:

   • aggravation of pre-existing symptoms,
   • reaction to supplements or herbs,
   • bruising from an acupuncture needle

6. Naturopathic Doctors use a variety of therapeutic approaches, either alone, or in combination. These include Traditional Chinese Medicine and Acupuncture, Nutritional and lifestyle counseling, nutritional supplementation, Botanical Medicine, Homeopathic Medicine, Vitamin Injections, Intravenous and Parenteral Therapy.

**Service Fee List**

| Service | Fee as of August 1, 2016 |
|---|---|
| Initial Consultation (120 minutes) | $225.00 |
| Initial Consultation (90 minutes) | $195.00 |
| Follow-up Visits (60 minutes) | $145.00 |
| Follow-up Visits (45 minutes) | $115.00 |
| Follow-up Visits (30 minutes) | $80.00 |
| Email or Telephone Consultation | Same as visits |
| Acupuncture (Acupuncture or Naturopathic visit) | $70.00 |
| B12 Injections | $20.00 + HST |
| Nebulized Glutathione | $35.00 + glutathione |
| Intravenous (IV) Drip | $80.00 + nutrients |
| Intravenous (IV) Push | $45.00 + nutrients |

I do hereby voluntarily give my informed consent for the recommended therapeutic procedures/treatments as and for any future modifications of the procedures/treatments. I also understand that I may change the status of my voluntary consent at any time. I intend this consent to apply to all my present and future naturopathic care. State here any exceptions: _____

I further acknowledge and confirm that I have been informed of and understand the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having/following.

I, the undersigned understand that I will be made aware of any additional costs for other procedures/tests. Payment of all services rendered is due at the time of service to Naturopathic Doctor and Registered Acupuncturist, Dr. Julie Sook-Man Chan B.Sc., ND, R.Ac.

Please note that there is a 48 hour cancellation policy. If 48 hour notice is not given, a full visit fee will be charged. I acknowledge that I may purchase products/supplements prescribed from an ND or any health food store.

**I understand that emails are allowed for booking, changing and rescheduling appointments. They are allowed if there are urgent, brief questions. However, if there are new concerns and/or information or you need a new recommendation, this must be done as a follow-up visit. A regular 30 minute follow-up fee will be charged for every 30 minutes required for reviewing and/or responding to ongoing email inquiries.

## Patient Consent for Collection, Use and Disclosure of Personal Information

The privacy of your personal information is important to us at Liberty Wellness. We understand the importance of protecting your personal information and are committed to using and disclosing your personal information responsibly. In this clinic, Dr. Julie Sook-Man Chan, ND, R.Ac acts as the Health Information Custodian, and hence the Privacy Information Officer.

Our privacy policy outlines what our Clinic is doing to ensure that:

- Only necessary information is collected about you which includes your contact information, personal or family medical history
- We have your information only with your consent;
- Storage, retention and destruction of your personal information complies with existing privacy legislation and privacy protection protocols given by our regulatory body, the College of Naturopaths of Ontario
and the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario.
In cases of emergencies or life threatening situations, medical or support staff workers may have to collect this
information from family members or other listed contacts without your prior written consent.
How our clinic collects, uses and discloses patients' personal information for the following purposes:
- To assess your health concerns and provide you with health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- To communicate with your other health care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To fulfill any obligations mandated by law
- To comply with legal and regulatory requirements of our regulatory body, the CONO and CTCMPAO
- To invoice goods and services and process payments by credit card
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To insurance companies if they request further information for rendered service
- To prevent or assist patients in cases of emergencies or threat to their health and safety

By signing the consent you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above. I understand that I can access my personal health information except as outlined above. I understand that I can withdraw my consent at any time, but it may directly affect the services I can receive. My personal information can still be used/disclosed if mandated by law.

| PATIENT'S NAME | PARENT/GUARDIAN'S NAME | SIGNATURE OF PARENT/GUARDIAN |
|---|---|---|

DATE SIGNED