DR. JULIE CHAN
NATUROPATHIC DOCTOR
REGISTERED ACUPUNCTURIST

INTAKE FORM CHILDREN AND TEENS (NB)

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				
Who is the child living with?				

Parent/Guardian Information #1

Last Name	First Name	DOB: _____/____/_____ DD/MM/YYYY	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: _____/_____/_____ DD/MM/YYYY	Relation to Patient
Address		City, Province	Postal Code
Home Phone	Work Phone	Cell Phone	Email address:

Health Concerns Please give a brief summary of the main problems and the main purpose of this consultation

When did you first notice your child's problems and what did you notice?
When was the official diagnosis made?
Was there any event or illness that you or others think brought on your child's symptoms?

What are your goals for your child, yourself or your family?

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?	
Any history of head trauma? (describe)	
Ever any seizure or seizure like activity?	
Any periods of spaciness or confusion?	
Any abnormal lab tests, Xrays, EEG, hearing tests etc:	
Does your child have any siblings? Do any of the siblings have health issues?	
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 including dosages and brands

Medications	Supplements and Vitamins
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Patient's Family Information

Family Structure (who lives in the current household with the child, please give relationship to the child):
Current marital situation/satisfaction of parents:
Family Development (include marriages, separations, divorces, deaths, traumatic events, losses etc.)
Natural Mother's History Name: Age: School - Highest Grade Completed:
Employment
Learning or Behavioural Problems:
Other health Problems:
Marriages:
Medical Problems:
Childhood atmosphere (family position, abuse, illnesses etc.)
Has mother every sough psychiatric treatment?
If yes, for what purpose?
Was the mother ever exposed to the following during pregnancy? Alcohol, smoking, second hand smoking, recreational drugs, prescription drugs, over the counter drugs? If yes, explain.
Has any of the mother's blood relatives ever had any behavioural, learning, neurological or developmental issues? (Eg. Anxiety, depression, aggression, learning difficulties, alcohol/drug use, suicide attempts, hyperactivity etc.)
Natural Father's History Name: Age: School - Highest Grade Completed:
Employment:
Learning or Behavioural Problems:
Other health Problems:

Marriages:
Medical Problems
Childhood atmosphere (family position, abuse, illnesses etc.)
Has mother every sough psychiatric treatment?
If yes, for what purpose?
Mother's alcohol/drug use history
Has any of the mother's blood relatives ever had any behavioural, learning, neurological or developmental issues?
(Eg. Anxiety, depression, aggression, learning difficulties, alcohol/drug use, suicide attempts, hyperactivity etc.)
Step or Adopted Mother's History (indicate which): Age: School - Highest Grade Completed:
Employment:
Learning or Behavioural Problems:
Other health Problems:
Marriages:
Medical Problems
Childhood atmosphere (family position, abuse, illnesses etc.)
Has mother every sough psychiatric treatment?
If yes, for what purpose?
Mother's alcohol/drug use history
Step or Adopted Father's History (indicate which): Age: School - Highest Grade Completed:
Employment:
Learning or Behavioural Problems:
Other health Problems:
Marriages:
Medical Problems
Childhood atmosphere (family position, abuse, illnesses etc.)
Has mother every sough psychiatric treatment?
If yes, for what purpose?
Mother's alcohol/drug use history
Siblings
Does the patient have siblings? Y / N If yes, please list the information below.
List patient's siblings:

Name	Male/Female	DOB (DD/MM/YYYY):
Name	Male/Female	DOB (DD/MM/YYYY):
Name	Male/Female	DOB (DD/MM/YYYY):
Describe patient's relationship with the family/siblings:		
List any allergies, major illness, genetic diseases or problems for the following:		
Siblings:		
Maternal Grandparents:		
Paternal Grandparents:		
Uncles/Aunts/Cousins:		

Child's Developmental History

Prenatal events:
How would you describe the health of the parents at the time of conception?
How would you describe the health of the mother during the pregnancy?
Was this your 1st pregnancy?
Please describe any health problems, stress, or complications, and the emotional state of the mother during pregnancy
Was conception easy? YES NO
Was it a natural conception or assisted conception? Explain.
Illnesses/Complications during pregnancy eg. bleeding, vomiting, infections, exposure to radiation or chemicals, smoking, alcohol/drug use etc.):
Medication during pregnancy:
Birth and Postnatal History
Maternal age at delivery: ____________ years Was it Full term or premature? How many weeks? _____
Mode of delivery: Vaginal or C-section If C-section, explain why:
If vaginal delivery, were any forceps or vacuum used?
Medication(s) during labor and delivery?
Complications during labor and delivery? If yes, please describe.
Birth Weight _________ Length _________ Labour duration _________ APGAR score (if known)________
Complications after delivery eg. Jaundice, post-delivery blues?
Any medications given to child during hospital stay?
Was there anything significant that happened during pregnancy? Any trauma/life changing events?
Primary caregiver up to one year of age:

Has there been any physical/sexual abuse? If yes, please explain.

Motor development (please write in age, parentheses are approximate normal limits)

Rolls over (3-5m) _____ Sits without support (5-7m) ______ Crawls (5-8m) _____ Walks well (11-16m) _____

Runs well (2y) _____ Rides tricycle (3m) _____ Throws ball overhand (4y) _____

Language development

Several words besides dada, mama (1y) ______ Can name several objects (15m) ______

Can say simple 3-word phrases (24m)_____ Vocabulary ______ Articulation _____ Comprehension ______

Compared to peers ____________________ Any current problems ________________________________

Social development

Smile (2m) _____ Shy with strangers (6-10m) ______ Separates from mother easily (2-3y) ______

Cooperative play with others(4y) ____ Peer interactions ______ Interests/hobbies:

How does your child interact with other children?

With adults:

What makes your child happy?

Sad?

Angry?

Stressed?

How do you as a parent deal with these emotions in your child?

Emotional Development

Current personality:

Mood:

Fears/phobias:

Habits:

Special objects

Ability to express feelings:

School History

Current Grade: School Contact:

Number of schools attended: Average grades:

Homework problems:

Specific learning disabilities:

What have teaches said about the child/teen:

Overall Strengths (viewed by parents)
Overall Strengths (viewed by child/teen)

Nutritional and Dietary History

Breast-fed? Y/N (Circle One) If yes, how long? __________ Brand of formula? ____________________

Began solids at what age? _______ What were the first foods? ____

Whole milk? Y/N (Circle One) If yes, begun at what age? _________

Known allergies to food? (Please list): ____

Food cravings? (Please list)____

Food aversions? (Please list) ____

FOODS MY CHILD EATS: (Place a ✓ appropriate column)

Food	Daily	3-5 times/week	1-3 times/week	Rare/never	Ate in the past
Cookies					
Candy					
Sweet Foods					
Caffeine (soda, tea etc.)					
Chocolate					
Milk: Whole					
2%					
1%					
Skim					
Cheese					
Ice Cream					
Salty Foods					
Meat					
Pasta					
Bread					

Typical Diet
Breakfast:
Morning snack(s):
Lunch:
Afternoon snack(s):

Dinner:
Other
How often does your child have a bowel movement?
Describe your child's stool pattern (Eg. foul, large, mushy, stinky etc.)
Does your child complain of stomach aches, gas or other digestive complaints?
Toilet Training: Age reached bowel control _________ Day ______ Night ______ Bladder control good?

Child's Environmental History

Location of the home: City/Suburban/Wooded/Farm Other: (describe) Country of Birth:
Water: City/well Purification system: Yes/No If yes, please describe:
Type of heat: Electric/gas/oil/other Do you live near: Power lines/woods/industrial areas/water?
If you live near water, list type: Swamp/river/other
Does your home have: Dust/mold/down or feather items (pillows, upholstery, stuffed animals?) If so, give details:
Describe your child's bedroom (Circle) Bedding: Synthetic/down/feather? Mattress cover: Yes/No Crib/Junior Bed/Adult Bed
Flooring: Carpet (wall-to-wall or rug) Wood? Glued down? Synthetic pad?
Window treatment: Shades/blinds/thin curtain/valance/other? If other, describe:
Other items in room including furniture, toys, stuffed animals:
Flooring in other rooms:
Is your child sensitive to or bothered by any of the following? _____ Perfumes/cosmetics? _____ Mold? _____ Cleaning products? _____ Pollen/grasses? _____ Soaps? _____ Animals (dander)? _____ Detergents? _____ Gasoline? _____ Dust? _____ Paint? _____ Other?

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, assessment reports 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
□ Fatigue
□ Chills
□ Seizures
□ Dizziness
□ Fainting
□ Paralysis
□ Mood swings
□ Quick temper
□ Speech problems
□ Insomnia
□ Feeling stressed
□ Poor memory
□ Loss of balance
□ Headaches
□ Feeling anxious
□ Feeling nervous
□ Phobias
□ Neuralgia
□ Numbness/ tingling
□ Jerking
□ Tremors
□ Alcohol/drug use
□ Learning difficulties
□ Confusion
□ Dementia
□ Prolonged sadness/ grief
□ Depression
□ Irritability
□ Mental illness
□ Panic attacks
□ Hyperactivity
□ Poor focus
□ Aggression
□ Autism
□ Schizophrenia
□ Had Concussion
□ Poor Self Esteem
□ Other _______________

GASTRO-INTESTINAL TRACT
□ Poor appetite
□ Poor thirst
□ Bloating
□ Burping or gas
□ Heartburn
□ Ulcers
□ Bad breath
□ Abdominal pain
□ Constipation
□ Laxative Use
□ Difficult digestion
□ Diarrhea
□ Difficulty swallowing
□ Vomiting
□ Nausea
□ Incomplete bowel movements
□ Hard stools
□ Loose stools
□ Hemorrhoids
□ Mucus in stool
□ Green stool
□ Undigested food in stool
□ Black tarry stool
□ Blood in stool
□ Pale stool
□ Anal itching
□ Anal fissures
□ Rectal pain
□ Rectal bleeding
□ Liver disease
□Gallbladder disease
□ Gall stones
□ Jaundice
□ Fatty Liver
□ Other _______________

NOSE & SINUSES
□ Allergies
□ Itchy nose
□ Nasal discharge
□ Loss of smell
□ Postnasal drip
□ Nosebleeds
□ Sinus infections
□ Nasal congestion
□ Hoarseness
□ Sinus pain
□ Snoring
□ Sleep apnea
□ Other _______________

RESPIRATORY and IMMUNE SYSTEM
□ Prone to getting sick
□ Colds
□ Sore throats
□ Ear infections
□ Swollen lymph nodes
□ Chest pain
□ Chronic cough
□ Phlegm
□ Wheezing
□ Bronchitis
□ Pneumonia
□ Tuberculosis
□ Asthma
□ Emphysema
□ Pleurisy
□ Coughing blood
□ Pain breathing
□ Smoking
□Shortness of breath (SOB)
□ Chronic Fatigue Syndrome
□ Frequent antibiotic use
□ Chronic infections
□ Steroidal use
□ Other _______________

EYES
□ Impaired vision
□ Glasses/contacts
□ Colour blindness
□ Far-sighted
□ Near-sighted
□ Double vision
□ Blind spots
□ Difficulty seeing at night
□ Sensitivity to sun
□ Infections
□ Eye pain
□ Redness
□ Discharge
□ Dryness
□ Blurring
□ Excessive tearing
□ Spots/Floaters
□ Glaucoma
□ Cataracts
□ Styes or lumps
□ Eye strain
□ Eye fatigue
□ Other _______________

MOUTH AND THROAT
□ Swollen/sore lips
□ Swollen/sore tongue
□ Swollen/sore gums
□ Bad breath
□ Mouth Sores/Cankers
□ Gum bleeding
□ Cold Sores
□ Dentures
□ Cavities
□ Mercury Fillings
□ Sensitive Teeth
□ Grinding teeth
□ Other _______________

Liberty Wellness Clinic, Dr. Julie Chan Naturopathic Doctor and Registered Acupuncturist - 3621 Highway 7 East, Suite 307, Markham, ON, L3R 0G6 T: (905) 604-8480 F: (905) 604-8484 E: info@libertywellness.ca W: www.libertywellness.ca

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:

____

____

Thank you for filling out the forms!

DR. JULIE CHAN
NATUROPATHIC DOCTOR
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