Brantford Integrative Health Centre

Osteopathy | Naturopathy | Accupuncture | Counselling

PATIENT INTAKE SHEET 2015

Patient Name: _____
Last First Middle

D.O.B.: _____ **Sex:** ☐ M ☐ F
Year Month Day

Address: _____
Street Address

_____
City

_____
Postal Code

May we leave a detailed message?

Phone :

_____ Residence — Yes [ ] No [ ]

_____ Work — Yes [ ] No [ ]

_____ Cell — Yes [ ] No [ ]

Email: _____

Emergency Contact Name_____**Emergency Contact Telephone Number**_____

Date of first Assessment: _____ / **Previous Patient [ ]**
(Day) (Month) (Year)

Please note: Cancellation of an appointment requires 24 hours notice. As of Jan 1, 2014 a $95 cash deposit or a Visa/MC/AMEX number will be kept on file and used if you fail to attend a scheduled appointment without 24 Hours notice.

_____ _____ _____ _____ Exp Date: _____

[ ] Visa, [ ] Master Card [ ] American Express [ ] Cash [ ] Cheque

($95 cash refunds will be returned on your last appointment, all other documents with your credit card information will be shredded)

By signing this form, you acknowledge and accept responsibility for payment of missed appointments.

_____
Signature of Patient

_____
Signature of Parent or Legal Guardian

Date: _____

94 Charing Cross Street Brantford ON N3R 2H6
Phone 519-304-7044 Fax 519-304-4635 bich2014@rogers.com

Statement of Acknowledgment

Welcome to Brantford Integrative Health Centre. Our system of health care is supportive of your body's own ability to heal. Each person seeking care in our clinic should understand that we are Naturopathic Doctors and NOT Medical doctors. We work within a Naturopathic scope of practice. Treatment and referral to other health practitioners is based upon assessment and laboratory testing. If at any time, during your course of treatment, you would like to receive services from a different clinician, please ask. In order to maintain consistency and quality of care, an administrative fee when transferring between Naturopathic Doctors will apply.

If conventional medical treatment is desired, it must be obtained from a licensed medical doctor. We encourage you NOT to abandon contact with your medical doctor. Naturopathy uses noninvasive methods for the assessment of bodily functions and natural therapies for correction (i.e. dietary recommendations, lifestyle changes, acupuncture, body work, and certain remedies and/or supplements). There is an emphasis on patient education, as the ultimate responsibility for the patient's health is his/her own.

Changes in dietary habits are not a prerequisite for treatment, but it should be understood that failure to follow sound nutritional and exercise programs could undermine the positive results.

The patient is responsible for any fees incurred during care and treatment and agrees to fully discharge this responsibility at the time of the visit. If you have not been in for an appointment in the last 12 months a reactivation fee will apply. A fee of $75.00 will be charged for any appointment missed without at least a 24 hour cancellation notice.

The patient accepts or rejects this care of his/her own free will and choice.

I, _____have read, understood and acknowledge the above Statements.

SIGNATURE DATE

WITNESS DATE

Michael Meade, HBSc, BEd., MEd (counselling), ND
Doctor of Naturopathic Medicine

Brantford Integrative Health Centre

Pediatric Intake Form
Dr. Michael Meade

Today's Date:.

Sex: Date of Birth:

Address:_

Phone #■

Child's Name:
Age:_____

Parents/ Guardians Name:. Phone:(H)_
Occupation: _____ _Phone: (B).

Address: (If different from above)

Phone #:

Family Physician:

_____

How did you hear about our Clinic?

Child's Medical History

Chief Complaints:

Specific Symptoms:.

Screening Tests Performed:.

Medications Taken:

Symptom Checklist
Put "C " for Current, or "P" for Past

Appetite Change. Constipation _____ Easy Bruising. Sore

Throat
Urine Frequency..
Stomach Aches_
Wheezing_____

Bad Breathy
Cough ____
Diarrhea __
Eczema
Nosebleeds.
Insomnia

Bed-wetting,
Cries Easily.
Dizziness __
Fatigue ____
Night Sweats.
Hair Loss

Burning Urination___
Visual Disturbances.
Hearing Loss_____
Indigestion_____
..Nervousness _____
Vomiting_____

Childhood Illnesses (Circle)

Measles	Chicken Pox	Rubella	Mumps
Tonsillitis	Pneumonia	Frequent Colds	Ear infections
Allergies	Fevers	Impetigo	Rheumatic Fever
Scarlet Fever	Anemia	Sinusitis	Acute Epigolottises

Other:

Immunizations (circle)

Measles	Mumps	Rubella	Polio
Smallpox	Diphtheria	Pertussis	Tetanus
Influenza	Hepatitis		

Other:

Reactions to Immunizations:

History

Allergies:

Specific Allergy Tests Performed:

Medications Used in Childhood:

Circumcision? YES NO

Surgery:

Anesthetics Use? YES NO

Supplements Used:

Naturopathic Treatments:

Family History
(Circle the conditions that have a history in your family, and give details below)

Alcoholism	Allergies	Asthma	Auto Immune Disorders
Cancer	Birth Defects	Diabetes	Muscular Dystrophy
Drug Abuse	Eczema	Heart Disease	Hypertension
Mental Illness	Osteoporosis	Psoriasis	Multiple Sclerosis
Tuberculosis	Rheumatoid Arthritis		

Details*

Other-

Prenatal History

Mother's health during pregnancy:

Illness during pregnancy (circle):

Hypertension	Gestational Diabetes	Preeclampsia	Bleeding
Anemia	Excessive Vomiting	Trauma	

Other:

Mother's emotional health during pregnancy:

Substances during pregnancy (circle):

Tobacco Alcohol Caffeine

Other: How often:

Medications during pregnancy:. Nutrition

How much and how often?.

during pregnancy:

Supplements during pregnancy:

History of miscarriage or abortion:

Natal History

Gestational Length:
Baby's length at birth: __

Baby's weight at birth:
Duration of labor:------

Type of labor (circle):

Spontaneous

Induced

If induced, Why?

Type of delivery:

Vaginal

C-Section

Complications during delivery:

Interventions used for labor & delivery: (circle):

Epidural

Prostaglandin Gel

Oxytocin

Other:

Episiotomy

Cather eter

Forceps

Circle

Home birth or Midwife

Hospital birth Physician

Neonatal History

Complications after delivery (circle): Jaundice

Fever ___

Rash Bleeding

Colic

Other:

Sleep Patterns

Sleep patterns during the first year:

Has there been a history of bedwetting? YES NO

If YES, when did the bedwetting begin and end?

Night terrors? YES NO

Other sleep disturbances:

Milestones

Please indicate age accomplished:

Rolling Over	Crawling	Walking
Talking	Sitting	Standing
Teething		

Social History

Day-care? YES NO If yes, what age? _____

Reaction to day-care:

Present grade: _____ _____School performance:

Socialization skills:

Extracurricular activities:

What is your child's attitude towards authority?

_____

Feeding

Breast-fed: YES NO How long?

Bottle-fed: YES NO How long?

When were solid foods introduced? _____

First foods in order of introduction (please specify whether bottle, fresh and/or organic):

Reactions to the foods above (i.e. colic, constipation, diarrhea, rash):

Special diet? (i.e. vegetarian, vegan):

Present dietary concerns:

Is your child a picky eater? _____If yes, what foods?