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## Child-Patient Information and Consent Form

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____
Suite/Apt./Unit No: _____
City: _____ Province: _____
Postal Code: _____

Gender: Male Female Age: _____ Date of Birth: _____
Month / Day / Year

Name of Primary Caregiver: _____
Relationship to Patient: _____
Work Phone:_____ Extension: _____
Home Phone: _____ Mobile Phone: _____
Fax Number:_____ Other Phone: _____
E-mail: _____
Preferred contact method: _____
May we leave a message? _____

Family Doctor or Pediatrician:
Name: _____ Phone Number: _____
Address: _____

Emergency Contact
Name: _____ Phone Number: _____
Relationship: _____

How did you hear about Gaia Integrative Clinic?
Referral Website Newspaper Yellow Pages
Advertisement Friend/Family Other:_____

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I, (print your name) _____ , acknowledge that as the parent or guardian of (print child's name) _____,a new patient of this clinic, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. I intend this consent form to cover the entire course of treatment my child receives at Gaia Integrative Clinic. With this knowledge, I understand and acknowledge that I may ask questions regarding my child's treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement in your child's condition.

I hereby consent to the collection, use and/or disclosure of my child's personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to my child. I further understand that my child's personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

_____
(parent/guardian's printed name)

_____ _____
(parent/guardian's signature) (date)

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# Naturopathic Adolescent Intake

## HEALTH INFORMATION

What is your main health concern? _____
_____
_____

Please list any other health concerns (physical, emotional, or mental) in order of importance.
1. _____
2. _____
3. _____

How do you rate your overall health? Poor Fair Good Excellent
How do you rate your overall energy? Poor Fair Good Excellent

## MEDICATIONS

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

| Medication | Dose/day | How long? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

| Supplement | Dose/day | How long? |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

How many courses of antibiotics have you had in the past 10 years? _____
Have you ever had a bad reaction to any medication? Y / N

## MEDICAL HISTORY

Please indicate if you have had any of the following childhood illnesses (circle):

| | | |
|---|---|---|
| Asthma | Measles | Rheumatic fever |
| Chickenpox | Mumps | Scarlet fever |
| Eczema | Polio | Whooping cough |
| Frequent ear infections or colds | Rubella(German measles) | Other: _____ |

Please briefly describe your dental history (root canals, fillings, etc)
_____
_____

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**Immunizations** (Check ✓)

| | | | |
|---|---|---|---|
| €DPT | €Hemophilus influenza B | €Hepatitis A | €Hepatitis B |
| €Flu shot | €Tetanus Booster | €MMR | €Polio |
| €Smallpox | €Chicken Pox | €Other: _____ | |

Any adverse reactions to vaccinations? Y / N. If yes, explain. _____
_____

Please list (with approximate dates) any medical conditions, illnesses or injuries, and any hospitalizations.

_____
_____
_____

Current Weight:_____ Weight one year ago:_____ Maximum weight and when:_____ Height:_____

**FAMILY HISTORY**

Please indicate whether any of your family members have, or have had the following:

| | Relative | | Relative |
|---|---|---|---|
| Alcoholism | | Diabetes | |
| Allergies | | Drug abuse | |
| Alzheimer's disease | | Heart disease | |
| Arthritis | | High blood pressure | |
| Asthma | | Kidney disease | |
| Cancer (indicate type) | | Osteoporosis | |
| Depression | | Stroke | |
| Other mental illness | | Suicide | |

**LIFESTYLE FACTORS**

Please list any dietary restrictions (Vegan, vegetarian, lacto-ovo vegetarian, omnivore)

_____
How much water do you drink a day?_____
Are you frequently exposed to animals? Y / N
Are you regularly exposed to toxins or other hazards? Y / N. If yes, explain. _____
_____
_____
Please list all allergies (food, environmental, or medications). _____
_____
_____
_____

**WOMEN'S HEALTH**

Are you currently pregnant? Y / N
Do you get regular Pap smears? Y / N
Date of last Pap?(month/yr) _____/_____ Have you ever had an abnormal Pap? Y / N

Age of first period? _____ Is your period regular? Y / N
Length of monthly cycle (days)? _____ Average length of period or flow (days)? _____

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Do you experience PMS? Y / N

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Have you had any of the following concerning your breasts? (circle)

Pain Lumps Infections Cysts Nipple discharge

Have you been taught self-breast exams ? Y / N

Do you experience vaginal infections? Never Rarely Frequently

Do you experience bladder infections? Never Rarely Frequently

MEN'S HEALTH

Have you had any of the following? (circle)

Testicular pain Hernia STDs Discharge Sores

Have you been taught testicular self-exams (TSE)? Y / N

## Confidential Adolescent Intake Form:

This part of the form is **confidential** and the information provided is between *you and your Naturopathic Doctor*. To ensure the best possible care, you are encouraged to provide the most accurate information possible.

Please list any current health concerns that were not listed earlier:

_____

_____

Are any of the following important to you?

[ ] Weight loss/gain
[ ] Skin/pimples
[ ] Safe sex/birth control
[ ] Time management
[ ] Stress
[ ] Emotional/physical trauma
[ ] Depression
[ ] Other _____

Please circle the option that best describes your social situation:

life of the party a few good friends one good friend no friends

Please circle the option that best describes your feelings about school:

I really enjoy school school is okay I hate school

On average, how many hours of sleep do you get on a weeknight?

less than 6 hours 6-7 hours 8 hours 9 or more hours

How many times a week do you eat fast food? 0 1-3 4-6 7+

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Please circle the option that best describes how you feel about yourself:
happy with my body weight would like to lose weight would like to gain weight

Please describe your relationship with your family: _____
_____
_____
_____

Do you have a part-time job? Y or N
If yes, how many hours per week do you work? _____

What are your goals for the next year? _____
_____
_____

Please indicate if you have ever used any of the following: (include frequency and amounts)

[ ] Cocaine _____
[ ] Marijuana _____
[ ] Heroin _____
[ ] Ecstasy_____
[ ] Tobacco_____
[ ] Alcohol _____
[ ] Diet pills _____
[ ] Laxatives _____
[ ] Caffeine pills _____
[ ] Birth control pills/implants/injections _____
_____
[ ] Other _____

**Sexual history**

Are you currently sexually active? Y / N

If yes, how many partners do you have or have you had? 1-4 5-9 10+

What is your sexual preference?
heterosexual homosexual bisexual not sure

Do you use protection against sexually transmitted diseases (STD's) Y or N

Please circle the option that best describes how often you use condoms:
every time usually once in a while hardly ever

Do you use birth control? Y or N
If yes, what method? _____

Please circle the option that best describes how often you use birth control:
every time usually once in a while hardly ever

If no, do you know where you can go to get protection against STD's and unwanted pregnancy?
Y or N

Have you discussed this with one or both parents? Y or N
If no, why not? _____

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If you have questions regarding your sexuality, do you know where you can get answers or where you can talk to someone? Y or N

Have you ever experienced physical, emotional or sexual abuse? Y or N

**Stress**

Have you ever had suicidal thoughts? Yes No (please circle one)

Describe the emotional environment of your home: _____
_____
_____

**Leisure Activities**

What do you do for fun? (Specify how often): _____
_____
_____

List any extra-curricular activities: _____
_____
_____

Is there anything important you feel has not been addressed? _____
_____
_____

What are your treatment goals and expectations?
_____
_____
_____

*Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of a treatment protocol specific to your healthcare needs.*

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