Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416.597.1604
1002 King St. West Toronto Ontario M6K 3N3 www.kingwestchiro.com

ADOLESCENT PATIENT INTAKE FORM (Ages 13-18)

We are aware of the time it takes to fill out such a lengthy intake form, however, your cooperation in completing it is essential to providing the highest standard of care. ***This is a confidential record of your medical history and will be kept in this office. The information it contains will not be released to any person without your authorization.*** All your information is strictly confidential. PLEASE PRINT.

Patient's Name: ____

Address: ____

City: __________________ Province: _________________ Postal Code: _________________

Phone (Home/Preferred Contact Number):____

Email Address: ____

Who is filling out this form? ____

With whom does the child live? ____

Do you give Dr. Sloan or her staff permission to leave messages at the above number regarding your child's visits? yes no

Male Female Date of Birth: ____

Emergency Contact: ___________________ Phone: _______________ Relation:___________

Other health care practitioners the child is seeing (ie. Medical Doctor, Pediatrician, Chiropractor)

Name: ________________________________ Phone: _________________________________

Name: ________________________________ Phone: _________________________________

Name: ________________________________ Phone: _________________________________

How did you hear about Dr. Tara or the clinic?

Referral- Whom may we thank? __________________
OAND or APND Website (please circle)
Newspaper/ magazine / flyer / Signage
Google Search
Yellow Pages
Other ________________

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Does your family have extended health benefits that cover Naturopathic Appointments and/or other health care services? ____

Health Concerns: Please list your child's health concerns in order of importance:

____

____

____

Medical History

Was this child adopted? yes no If yes, at what age? _______

List any injuries and/or major surgery your child has had and when they happened:

____

____

____

Has your child ever experienced any of the following?

Rubella	Diaper rash	Stomach aches
Mumps	Cradle cap	Headaches
Measles	Diarrhea	Heat or cold intolerance
Chickenpox	Constipation	Ear infections:
Whooping Cough	High fevers	How many?____________
Scarlet Fever	Bedwetting	How often? ____________
Polio	Strep throat	
Rheumatic fever	Frequent colds	

Other illnesses/diseases: ____

Vaccinations (please check which ones the child has received)

DPT (Diptheria, Pertussis, Tetanus)	MMR (Measles, Mumps, Rubella)	
Chicken Pox	Polio	Flu Shot
Hepatitis A	Hepatitis B	Other

Did your child experience any adverse effects from vaccination? If yes, please explain:

____

____

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Medications and Supplements

Is your child **currently** taking any medications or supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)? Please list.

____
____
____

Does your child have any medical, environmental, or food allergies or sensitivities? Please list.

____
____
____

Family History

Please indicate if any close relative *of the child* has any health condition(s) such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, autoimmune conditions etc.

Relationship	**Age (current)**	**Age at death**	**Health Condition(s)**
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister(s)/Brother(s)			
Maternal Aunts			
Maternal Uncles			
Paternal Aunts			
Paternal Uncles			

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THE FOLLOWING IS TO BE COMPLETED BY THE PATIENT

To offer you the very best in care, it is important to have a complete picture of your health. Please answer the following questions as completely and honestly as you can. The information you provide will be kept strictly confidential, unless it falls into a category that must be reported by law (i.e. alleged abuse, threat to self or others). If you have any concerns, please do not hesitate to discuss them at any time.

Sleep and Energy

What time do you usually go to bed? ______ Wake up in the morning? ______

Do you have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? ____
____

How would you rate your energy level on a scale of 1 to 10? ______________ (10 is high)

Diet and Exercise

Do you have any food allergies or intolerances? Please list.______________________________
____

Have you noticed any recent changes in your hunger or thirst? __________________________

Do you suffer from acne? (please describe the acne, its location, the severity and frequency)
____
____

Do you think you weigh: too little too much about the right amount

Do you exercise? yes no If yes, what form(s)? ____________________________________

How long? ____________________________________

How often? ____________________________________

Have you ever or are you currently dieting? yes no

Have you ever used or are you currently using any diet aids? yes no

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Please indicate what you normally consume on a typical day: (include amounts if possible)

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages/Drinks	

Do you consume soft drinks? yes no If yes, how many per day? ______
Do you consume caffeinated beverages? If yes what type: ________________________________

Social

What grade level are you in at school? ______

Do you enjoy school? yes no Why or why not? ____________________________

What are your interests and favourite activities?

How many hours of television do you watch a day? ______

Do you play on the computer or video games? yes no If yes, how many hours a day?

Do you smoke? yes no If yes, when did you start? ______
How many cigarettes per day? ______

Have you ever experimented with alcohol or recreational drugs? (please elaborate) ___________
____

Have you received any information about any of the following? (if so, indicate the source – parents, friends, school, health care provider, internet or other)

Physical or hormonal changes during puberty? ____
Sexual activity/masturbation? ____
Birth control? ____
Sexually transmitted diseases and prevention? ____

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Have you ever been, sexually active? yes no Are you currently sexually active? yes no
If so, did/do you use any type of protection against pregnancy and/or disease? yes no
If yes, what did you use? ____
Was the experience a positive one for you? ________________________
Is there any information on any of these topics that you would like provided to you?
____
____

Questions for Females

Have you begun to menstruate? yes no If yes, at what age? _____
Is your cycle regular? yes no
How many days does your cycle last from the first day of menstrual blood to the day before your next menstrual blood? ________
Describe the blood/flow (check all that apply): heavy dark red sticky
moderate bright red clots
light brown cramps
other _________________
Is there any chance you are pregnant? yes no
Date of last menstrual period ______________
Have you noticed any changes to your breasts? yes no If yes, at what age? _____
Have you ever had your breasts examined? yes no
Have you ever been shown how to do a breast self-exam? yes no
If you have begun to menstruate, do you notice any changes to your breasts? yes no
If yes, before, during, or after your period? __________
Have you ever had a yeast infection or any other vaginal infection? yes no
Have you ever had a urinary tract or bladder infection? yes no
Do you ever suffer from vaginal or rectal itching? yes no
Can you describe any vaginal discharge you may have? (colour, consistency, odour)
____
____
____

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Questions for Males

Have you noticed any changes to your penis or testes? yes no
If yes, when? ____
Have you ever experienced any pain in your penis or testes? yes no
If yes, when? ____
Have you ever experienced any sores or lesions on or around your genitals? yes no
Have you noticed any changes in growth of body, pubic or facial hair? yes no
Have you noticed any changes in your voice? yes no
Any history of urinary tract infection? yes no
Any difficulties in urination? yes no
Any discharge from the penis? yes no

Other Information (Females and Males)

Is there any other information you would like to add about anything?
____
____
____

SIGNATURE OF PATIENT

I attest that the information provided is true and accurate to the best of my knowledge.
Signature: ________________________ Date: __________________________________

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The information it contains will not be released to any person without your authorization.

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FINANCIAL POLICY AND BILLING PROCEDURES

Our Naturopathic Visit Billing Procedures Are As Follows:

Initial Consultation: 90 minutes - $175.00 + HST
Follow-up visits: 60 minutes- $140.00 + HST
45 minutes- $95.00 + HST
30 minutes- $70.00 + HST
15 minutes- $35.00 + HST
Initial Acupuncture Treatment (without prior ND visit) $125.00 + HST
Subsequent Acupuncture Treatments $60.00 + HST
Phone Consultations < 15 min - $35 + HST; >15 min - $70 +HST
Home Visits- please contact Dr. Tara directly

Please be advised that all missed appointments without a 24-hour cancellation notice will be applied to your account. Thank you for respecting our time.

INFORMED CONSENT TO TREATMENT

- I understand that Tara Sloan, B.Kin. (Hons), ND is a Naturopathic Physician, and will use only natural, non-invasive methods of assessment and treatment.
- I understand that any advice given to me as a patient at King West Village Chiropractic Clinic is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.
- I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in Ontario.
- I understand that the Naturopathic Physician reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.
- I understand that I am accepting or rejecting this care by my own free will.
- I understand that no employee or physician at King West Village Chiropractic Clinic is suggesting that I refrain from seeking the advice of another health care provider.
- I understand that the services offered by Dr. Tara Sloan, ND are not covered by OHIP, and that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory tests.
- **I understand that 24 hours notice is required for appointment cancellation otherwise I agree to be responsible for the appointment fee.**
- I understand that any therapies recommended will be explained to me in full by the naturopathic physician, and that I will give consent to treatment based on informed consent.

I ______________________________ have read, understood and agree to the above statements.

Signature_____________________________________ Date_____________________________

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PATIENT CONSENT FORM

FOR COLLECTION, USE, AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

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

- Only necessary information is collected about you.
- We only share your information with your consent.
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols.
- Our privacy protocols comply with privacy legislation and standards of our regulatory body, the Board of Directors of Drugless Therapy– Naturopathy.

HOW OUR CLINIC COLLECTS, USES, AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Our clinic understands the importance of protecting your personal information. Outlined below is how our clinic is using and disclosing your personal information. This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To comply with legal and regulatory requirements or our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners Act
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic with all regulatory requirements
- To comply generally with the law

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of you personal information as outlined above.

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information. I agree that King West Village Chiropractic Clinic can collect, use and disclose personal information about (**patient name**) ______________________________ as set out above in the information about the clinic's privacy policies.

_____________________________ _____________________________

Signature of Patient Print Name

_____________________________ _____________________________

Signature of Parent/Guardian Print Name of Parent/Guardian