Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416.597.1604
1002 King St. West Toronto Ontario M6K 3N2 www.kingwestchiro.com

CHILD PATIENT INTAKE FORM (Ages 0-12)

We are aware of the time it takes to fill out such a lengthy intake form, however, your co-operation in completing it is essential to providing the highest standard of care. All information is strictly confidential. PLEASE PRINT.

REGISTRATION INFORMATION

Child's Name_____ Date of birth___/___/___
dd/mm/yy

Age:_____ Gender:_____

Home Address:_____

Town/City:_____Postal Code:_____

Home Telephone: ( )_____ Email Contact: _____

Who is filling out this form? (name and relation) _____

May we leave messages at the above number regarding appointments? Y N

If no, please indicate an alternate number we can use if any. ( ) _____

OTHER CONTACTS (In order of preference)

Name_____ Phone_____ h
_____w
_____other
Address_____
Relationship to child_____

Name_____ Phone_____ h
_____w
_____other
Address_____
Relationship to child_____

Whom does the child live with?_____

Family Physician:_____ Phone:( )_____

Other Health Care Provider(s):_____ Phone:( )_____

_____Phone:( )_____

Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416.597.1604
1002 King St. West Toronto Ontario M6K 3N2 www.kingwestchiro.com

What are your child's health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Medical History

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates

_____
_____
_____
_____

Which of the following has your child had? (N-never, M-mild, A-average, S-severe)

N M A S rubella (German measles) N M A S roseola N M A S impetigo

N M A S measles N M A S scarlet fever N M A S mononucleosis

N M A S chicken pox N M A S mumps N M A S ear infections

N M A S whooping cough N M A S strep throat

Does your child have any allergies (medicines, environmental, food etc.)?

_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc).

_____
_____
_____
_____

Please list past prescription medications.

_____
_____
_____
_____

How many times has your child been treated with antibiotics?_____

Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine
1002 King St. West Toronto Ontario M6K 3N2
(ph) 416.597.1604
www.kingwestchiro.com

Please indicate what immunizations your child has had:

□DPT (diphtheria, pertussis, tetanus) □Haemophilus influenza B □Hepatitis B

□Tetanus booster, when?_____ □"Flu" □Hepatitis A

□MMR (measles, mumps, rubella) □Polio

Other_____

Please indicate if any vaccinations caused adverse reactions:

_____

_____

What screening tests has your child had (blood, hearing, vision, etc.)

_____

_____

Prenatal Health

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

What was the mother's age at the child's birth? _____ Father's Age at child's birth? _____

Number of previous pregnancies _____ Number of previous live births _____

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

□ Bleeding □ High blood pressure □ Nausea □ Vomiting
□ Diabetes □ Thyroid problems □ Physical or emotional trauma

Other _____

Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416.597.1604
1002 King St. West Toronto Ontario M6K 3N2 www.kingwestchiro.com

Did the mother use any of the following during the pregnancy?

□ Tobacco □ Alcohol □ Recreational drugs:_____
□ Prescription medications: _____
□ Over-the-counter medications: _____
□ Supplements: _____
□ Other: _____

Birth History

Term length: □ Full □ Premature: _____wks □ Late: _____wks

Length of Labour: _____ Weight at birth: _____

Any complications?: _____
_____

Was the birth: Vaginal C-section Induced Forceps Anesthesia used

APGAR Scores if known: _____

Did the child experience any of the following at or shortly after birth?

□ Jaundice □ Rashes □ Seizures □ Birth injuries: _____
□ Birth defects: _____
□ Other: _____

Diet

How is/was your infant fed?

□ Breast fed. How long?_____

□ Formula. Milk/soy/other:_____

□ Other:_____

Did the child experience any reactions to breastmilk and/or formula? _____
_____

What foods were introduced before 6 months? (Please list approximate month as well)
_____
_____

6-12 months?
_____
_____

Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416.597.1604
1002 King St. West Toronto Ontario M6K 3N2 www.kingwestchiro.com

Did your child ever experience colic? Y N How severe? □ mild □ moderate □ severe

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

Describe a typical day's diet

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Beverages (and total quantity)_____

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first:

Sit up_____ Crawl_____ Walk _____ Talk_____

How would you describe your child's temperament? _____

_____

Has your child experienced any pubertal changes? If yes, what changes and at what age

_____

_____

Sleep Patterns

What time does your child usually go to bed? _____ Wake in the morning? _____
Does your child nap during the day? yes no□ What time(s): _____
Does your child have nightmares? yes□ no□ How often? _____
Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? _____

_____

What is the child's bedtime routine? _____

_____

Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416.597.1604
1002 King St. West Toronto Ontario M6K 3N2 www.kingwestchiro.com

Social Habits

Is your child in: □ school □ daycare □ homecare □other: _____
What grade level? _____
How would you describe your child's behaviour at school/caregivers? _____
_____
How would you describe your child's behaviour at home? _____
_____

Does your child make friends easily? yes□ no□
What are your child's interests & favourite activities? _____
_____
According to your child, does he/she enjoy these activities? _____
Is your child physically active regularly? yes□ no□ How much & how often?
_____
Does your child have any habits (e.g. thumb sucking)? _____
Does your child have any fears? _____
How much television does your child watch? _____ hours/day
Does your child play on the computer or video games? yes□ no□
If yes, _____hours/week
How often does your child read (not for school) or How often does someone read to your child? □ Daily □ Several times a week □ Weekly □ Less than weekly

Family History

Indicate if a close relative (parent, sibling) has had any of the following:

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney Disease	
Birth Defects		Juvenile Arthritis	
Other:			

□ I don't know the family medical history.

Do either of the parents have a chronic illness? Y N Unknown
If yes, please describe _____
_____
_____

Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416.597.1604
1002 King St. West Toronto Ontario M6K 3N2 www.kingwestchiro.com

Environment

Does anyone in the child's household smoke? Y N
If yes do they smoke in the house/car when the child is present? _____

Are there animals in the home? Y N If yes, please list: _____

How is the child's home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to at home or as a result of parents'/caregivers' work or hobbies? Please describe: _____
_____

How would you describe the emotional climate of the child's home?_____
_____

Has your child ever had any significant physical or emotional traumas?
_____
_____

Please write a little about your child's personality, both positive and negative. Is there anything you would want to change? _____
_____
_____

Is there anything that you feel is important that has not been covered?
_____
_____
_____

Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416.597.1604
1002 King St. West Toronto Ontario M6K 3N2 www.kingwestchiro.com

FINANCIAL POLICY AND BILLING PROCEDURES

Our Naturopathic Visit Billing Procedures For Children Under 12 Are As Follows:

Initial consultation - $140.00 + HST
Follow Up Visits 60 minutes - $95.00 + HST
45 minutes - $85.00 + HST
30 minutes - $70.00 + HST
15 minutes - $35.00 + HST
House Calls – please contact Dr. Tara directly
Phone Consultations (up to 15 min) - $35 + HST; (20-30min)- $70 + HST

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

1. 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.

2. 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.

3. I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in Ontario.

4. 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.

5. I understand that I am accepting or rejecting this care by my own free will.

6. I understand that no employee or physician at King West Village Chiropractic Clinic is suggesting to me to refrain from seeking the advice of another health care provider.

7. I understand that the services offered by 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.

8. I understand that 24 hours notice is required for appointment cancellation, otherwise I will be responsible for the cancellation fee.

9. I understand that any therapies recommended will be explained to me in full by the physician, and that I will give consent to treatment based on informed consent.

I _____ have read, understood and agree to the above

statements on behalf of _____.

Signature of Parent or guardian _____

Date _____

Thank you for taking the time to complete this intake form. We look forward to working with you in your Naturopathic care.

Dr. Tara K. Sloan, B.Kin, ND
Doctor of Naturopathic Medicine (ph) 416.597.1604
1002 King St. West Toronto Ontario M6K 3N2 www.kingwestchiro.com

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 Parent/Guardian Print Name

_____ _____
Date Signature of Witness