FREDA TAM, BSCH, ND
NATUROPATHIC DOCTOR
138 Courtland Cres. • East Gwillimbury, ON • L9N 0B2 • Tel: (416) 723-3336
www.FredaTamND.com • fredatam.nd@gmail.com

NATUROPATHIC CHILD INTAKE FORM
(0-12 years old)

Please fill out this form as accurately and completely as possible. Completing this overview will help to obtain a more complete understanding of your child. Your time, thoughtfulness and honesty in completing this overview will greatly assist in the formulation of a treatment plan specific to your child's health needs.

Patient Privacy: Patient information will not be released to any person except when you have authorized us to do so. Information contained herein is used solely by Dr. Freda Tam, ND for administrative, diagnostic and/or treatment purposes, and will be treated in the strictest confidence.

Name:				Date:
Birth Date: MM / DD / YYYY	Age:	Sex:	Home Telephone #:	Mother / Father's Email:
Address:			City, Province:	Postal Code:
Mother's Name:	Mother's Occupation:		Mother's Work #:	Mother's Cell #:
Father's Name:	Father's Occupation:		Mother's Work #:	Father's Cell #:

EMERGENCY CONTACTS		
1. Name:	Relationship to your child:	Phone #:
2. Name:	Relationship to your child:	Phone #:

OTHER HEALTH CARE PRACTITIONERS		
1. Name of Family Doctor or Pediatrician: Phone #: Address: Date of last visit:	2. Name: Phone #: Address: Specialty / focus:	3. Name: Phone #: Address: Specialty / focus:

How did you hear about us? ☐Referral ☐Website ☐Facebook / Twitter ☐Friend / Family ☐Advertisement ☐ Other. Please specify:

_____

Have you any family members that are patients of Dr. Freda Tam?

_____

Has your child seen a naturopathic doctor previously? ☐ Yes ☐ No

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CONTEXT OF CARE REVIEW

Why did you choose to come to see us Dr. Freda Tam, ND?

_____

_____

What do you know of our approach to health and wellness?

_____

_____

What three (3) expectations do you have from this visit?

1. _____

2. _____

3. _____

What *long term* expectations do you have of Dr. Freda Tam, ND?

_____

_____

What is your present level of commitment to address any underlying cause of your child's signs / symptoms that relate to your family's lifestyle? _____ **%** (*Rate from 0 to 10, with 10 being 100% committed*)

0% 1 2 3 4 5 6 7 8 9 10 100%

What behaviours / habits do you or your child currently engage in regularly that you believe *support* your child's health? (Please list)

_____

What behaviours / habits do you or your child currently engage in regularly that you believe are *destructive* to your child's health? (Please list)

_____

What potential lifestyle factors do you foresee as barriers / obstacles that may prevent you from adopting new healthy changes that we will be sharing with you?

_____

_____

Who will sincerely support you consistently with the beneficial lifestyle changes you and your child will be making?

_____

_____

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GENERAL

Child's Preferred First Name: _____ Ethnicity: _____

What are your child's chief health concerns? Please list them in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____

Please list past health problems with dates.

_____
_____
_____

Describe your child's overall state of health at present in less than 10 words.

_____

Has your child experienced any trauma? Please describe.

Fractures? ☐ Yes ☑ No Accidents? ☐ Yes ☐ No Emotional? ☐ Yes ☐ No

_____
_____

Has your child ever been hospitalized? ☐ Yes ☐ No If so, please indicate when and why.

_____
_____

Has your child ever traveled outside Canada? ☐ Yes ☐ No Please list when and where.

_____
_____

ALLERGIES

Does your child have any drug allergies (ie. penicillin)? ☐ Yes ☐ No Please describe.

_____
_____

Does your child have any food or environmental allergies / sensitivities? ☐ Yes ☐ No Please describe.

_____
_____

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CURRENT MEDICATIONS

Is your child currently taking any medication (prescription & over-the-counter) or supplements? If so, please list, and include dosage and how long they have been taking it.

Medication / Supplements	Dose /per day	How long have you taken it?
1)		
2)		
3)		
4)		
5)		

Please list medications / supplements that your child has used in the past.

_____

_____

How many times has your child taken Antibiotics? _____

VACCINATIONS

Vaccinations received (please check all that apply, and give dates of vaccination record if available:

☐ Diphtheria, Pertussis, Tetanus _____ ☐ Measles, Mumps, Rubella _____
☐ Chicken Pox _____ ☐ Prevnar _____
☐ Haemophilus Influenza B _____ ☐ Polio _____
☐ Influenza _____ ☐ Hepatitis B _____
☐ Other vaccination (Please specify): _____

Any **adverse reactions** to vaccinations? (redness at side, crying, screaming, fever, etc) ☐ Yes ☐ No

_____

_____

Were any vaccinations given on a **delayed schedule** for any reason? ☐ Yes ☐ No Please explain.

_____

_____

CHILDHOOD ILLNESSES

Please check all that apply and indicate child's age at time of infection:

☐ Chicken Pox _____
☐ Fifth's Disease _____
☐ Frequent Colds _____
☐ Hand, Foot & Mouth _____
☐ Measles _____
☐ Mononucleosis _____
☐ Mumps _____

☐ Polio _____
☐ Pneumonia _____
☐ Rheumatic Fever _____
☐ Rubella _____
☐ Scarlett Fever _____
☐ Tonsillitis _____
☐ Whooping Cough _____

☐ Strep Throat how many times? _____
☐ Ear Infections how many times? _____
☐ Other: _____

_____

_____

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FAMILY HEALTH HISTORY

Please indicate, where applicable, if anyone in this child's family currently has or has had any of the following conditions:

	Father	Mother	Brothers	Sisters	Maternal		Paternal	
					G.Mother	G.Father	G.Mother	G.Father
Age (if living)								
Health (G=good, P=poor)								
Anemia								
Asthma								
Hay Fever / Hives								
Cancer (what type?)								
Arthritis								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Mental Illness								
Alcoholism								
Kidney Disease								
Cause of Death								

Have any of your family members had any other significant illness or health concerns?

_____

PRENATAL HISTORY

Was this child conceived naturally? ☐ Yes ☐ No

Any fertility interventions? ☐ Yes ☐ No If yes, please describe. _____

_____

_____

Any illness or difficulties during pregnancy? Check all that apply.

☐ Bleeding ☐ Hypertension ☐ Physical Trauma ☐ Other:
☐ Diabetes ☐ Illness ☐ Thyroid Problems _____
☐ Emotional Trauma ☐ Nausea ☐ Vomiting _____

List any drugs, alcohol, cigarette smoking or medications taken during pregnancy.

_____

List any vitamins or other supplements taken during pregnancy.

_____

_____

Mother: _____

Health at conception _____
Age at conception _____
Pregnancy weight gain _____ lbs

Father: _____

Health at conception _____
Age at conception _____

G = good
P = poor

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BIRTH HISTORY

How long was the pregnancy? ☐ Full Term ☐ Late ☐ Premature # of weeks: _____

Was the labor ☐ Spontaneous? ☐ Induced? Duration of labor _____ hrs

Were there any difficulties or complications? _____

_____

What type of delivery? ☐ C-Section ☐ Vaginal Birth ☐ Hospital ☐ Home Birth

Were any interventions used? ☐ Epidural ☐ Episiotomy ☐ Forceps ☐ Suction

Was mom Strep B positive? ☐ Yes ☐ No Were antibiotics given during birth? ☐ Yes ☐ No

Were there any difficulties or complications? _____

_____

Baby's birth weight: _____ Length: _____ APGAR Score: 1 min _____ 5 min _____

NEONATAL HISTORY

Any difficulties or complications soon after birth? Check all that apply.

☐ Anemia ☐ Convulsions ☐ Poor Feeding ☐ Other
☐ Birth Defects ☐ Infections ☐ Rashes _____
☐ Colic ☐ Jaundice ☐ Respiratory Distress _____

Age began: ☐ sitting _____ ☐crawling _____ ☐ walking _____ ☐ talking _____ ☐ 1st tooth _____

Any problems with child's teeth? ☐ Yes ☐ No If yes, what? _____

How would you characterize your child's development?
Physically: ☐ Slow ☐ Average ☐ Fast Mentally: ☐ Slow ☐ Average ☐ Fast

Has your child started puberty? ☐ Yes ☐ No If yes, when? _____

NUTRITION

Breast Fed
How long? _____

Formula Fed
Age Started? _____
Type? _____

Solids
Age Started? _____

What were the first foods introduced? _____

_____

Please describe childhood eating habits. _____

Are there any food groups excluded from your child's diet? Why? _____

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TYPICAL DIET

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Water: (cups /per day) _____

SLEEP PATTERNS

Please describe your child's sleep patterns during the first year. _____

_____

Usual time your child: Goes to bed _____ Awakens _____

Any napping during the day? ☐ Yes ☐ No Please describe. _____

Any difficulties falling asleep or staying awake? ☐ Yes ☐ No Please describe. _____

_____

GENERAL SYMPTOMS

For the sections below, please place one of the following in the space provided:

" Y " – If your child currently has the symptom / condition
" P " – If the condition has been a problem in the past for your child

DIGESTION & ELIMINATION

_____ Change in appetite
_____ Excessive / diminished thirst
_____ Excessive / diminished hunger
_____ Trouble chewing / swallowing
_____ Frequent vomiting
_____ Stomach / abdominal aches
_____ Excessive belching (burping)
_____ Excessive gas
_____ # of Bowel movements / day
_____ Constipation
_____ Diarrhea
_____ Age at potty training
_____ Fully potty trained?
_____ Bed wetting
_____ Blood in urine
_____ Burning urination
_____ Frequent urination

SKIN, HAIR & NAILS

_____ Acne
_____ Changes in skin odor
_____ Changes in hair / nails
_____ Cradle cap
_____ Eczema / psoriasis / rashes
_____ Hives, itching

EYES, EARS, NOSE & THROAT

_____ Sore throat
_____ Coughing
_____ Lumps / swollen glands
_____ Discharge (eyes, ears, nose)
_____ Vision problems
_____ Hearing problems
_____ Nose bleeds
_____ Wheezing / difficulty breathing

MUSCLES & SKELETON

_____ Changes in posture / gait
_____ Joint pain or stiffness
_____ Muscle pain or stiffness

GENERAL

_____ Heat / cold intolerance
_____ Excessive sweating
_____ Night sweats
_____ High fevers
_____ Motion sickness
_____ Anemia
_____ Easy bruising
_____ Slow wound healing
_____ Body or breath odor
_____ Recent weight change
_____ Weakness or fatigue

MENTAL & EMOTIONAL

_____ Cries easily or weepy
_____ Irritable
_____ Memory problems
_____ Nervous
_____ Nightmares / night terrors
_____ Strong fears / aversions
_____ Sudden changes in mood

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PERSONALITY & BEHAVIOUR

How would you describe your child's daycare of school experience (if appropriate) in term of enjoyment, performance and socialization?

What are your child's interests?

How many days per week does your child participate in out-of-school programs?

How many hours per day does your child use: Television _____ Computer _____ Video Games _____

Does your child use a cell phone? ☐ Yes ☐ No

Is your child particularly sensitive to any of the following? Check all that apply.

☐ Claustrophobia	☐ Drafts	☐ Height	☐ Smells	☐ Wind
☐ Cold	☐ Heat	☐ Music	☐ Sunlight	☐ Wool

Briefly describe your child's personality, including both positive and negative characteristics.

Is there anything else you would like to add that you feel may be relevant to your child's case?

Thank you very much for completing this form as accurately and completely as possible.

It will help to obtain a more complete understanding of your child.

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CONSENT TO TREATMENT

I would like to take this opportunity to welcome you. My naturopathic practice utilizes the principles of naturopathic medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

As a naturopathic doctor I will conduct a detailed case history, conduct physical examinations and may utilize specific blood, salivary and/or urinary laboratory reports as part of the treatment work-up. Some treatments or procedures may include:

Nutritional supplements, botanical (herbal) medicine, Traditional Chinese Medicine & acupuncture, individualized dietary and lifestyle modification, hydrotherapy, naturopathic manipulation and homeopathy.

Even the gentlest of therapies may cause aggravation in certain physiological conditions. This depends greatly on the individual and the extent of their illness. Potential health risks associated with Naturopathic Medicine may include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process
- Allergic reaction to prescribed substances
- Pain, bruising, fainting or injury from acupuncture
- Inconvenience or lifestyle changes

If there is a chance that you may be **pregnant**, **actively attempting to become pregnant**, or if you are **breast-feeding**, please alert me as some of the therapies used could present a risk to the pregnancy and your child.

Please initial beside each of the following statements as appropriate:

_____ I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy by paying the appropriate fee.

_____ I understand that Dr. Freda Tam, ND will answer any questions that I have to the best of her ability. I understand that results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I voluntarily consent to the diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions): _____.

_____ I understand that the risks will be explained to me in a manner than I can understand prior to any treatment. I understand that I may ask questions regarding my treatment at any time, and that I am free to withdraw my consent and discontinue participation in any procedure / treatments at any time.

_____ I understand that any treatment provided for me by Dr. Freda Tam, ND is not mutually exclusive of any treatment or advice that I may be receiving now or in the future from another licensed health care provider, and that I am at liberty to seek or continue medical care from a physician or other health care provider qualified to practice in Ontario.

_____ I understand the fee schedule and agree to pay billings at the time services are rendered and/or at the time products are purchased.

_____ I understand that if I have insurance coverage for Naturopathic Medicine, I am responsible for billing my own insurance company. Most policies do not cover the supplements / remedies that are prescribed.

_____ I understand that I may purchase any recommended supplements or remedies from the clinic dispensary, or from any retail store of my choice.

_____ **Parents / Guardians:** I agree that I am solely responsible for the safety of my child/children while on the premise of Dr. Freda Tam's clinic. Children are to be supervised at all times and never left un-attended by the parent.

_____ ***Cancellation Policy:** I agree that if I am unable to make my appointment, I will provide advanced notification within 24 hours. Failure to give 24 hours notice will result in a **cancellation fee of $30**.

I have read and understand the above stated information and policies. I consent to treatment by Dr. Freda Tam, ND modified as indicated above. I understand that I am free to withdraw my consent at any time.

Patient's Full Name (please print): _____

Signature of Patient (or guardian : if patient is under 18 years old) _____ Date: _____

Signature of Dr. Freda Tam, ND : _____ Date:_____

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PRIVACY POLICY

FOR COLLECTION, USE & DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of my practice, 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. We will try to be as open and transparent as possible about the way we handle your personal information.

In this office, Dr. Freda Tam, ND acts as the Privacy Information Officer.

All staff members who come into 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 uses 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 College of Naturopaths of Ontario (CONO)*

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

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns, to provide safe and comprehensive health care, and to advise you of treatment options
- To book, confirm, and remind you of upcoming appointments
- To communicate with other health-care providers involved in your care as appropriate
- To invoice for goods and services
- To comply with legal and regulatory requirements when required
- For teaching purposes anonymously

Our office will not, under any circumstances, supply your insurer with your confidential medical history. In the event this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

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 your personal information for the purposes outlined above.

Patient Consent: I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I agree that Dr. Freda Tam, ND can collect, use, and disclose personal information about measures set out above in the information about the office's privacy policies.

Patient's Full Name (please print): _____

Signature of Patient /or Guardian : _____ Date: _____
(if patient is under 18 years old)

Signature of Naturopathic Doctor: _____ Date:_____