DR. ANDREA GRI
naturopathic doctor | family medicine

CHILD INTAKE FORMS - CONTACT INFORMATION

Child's Name: ____
(Last) (First) (Preferred Name)

Mother's Name: ____________________ Father's name: ____________________

Address: ______________________________ City: ____________________

Postal Code: ____________________ Email: ______________________________

Home/Cell phone number: ____________________ Work: ____________________

Preferred form of contact for reminder/follow up calls:

□ Home number □ Cell phone □ Email□ Other – Please specify: ____________________

Age: __________ Date of Birth: ____________ Sex: □ M □ F Ethnicity: ____________________

Height: ______________ Length: ______________ Weight: ____________________

Name of Family Physician: ____

Phone Number of MD: ______________________________ Fax: ____________________

Health Card #: ____________________

Emergency Contact Name: ______________________________ Phone Number: ______________

Relation: ____

How did you hear about Dr. Gri?

- □ Brochure/newsletter at the clinic
- □ Another health care provider: ______________________________
- □ Google search on the internet
- □ Sign outside the clinic
- □ Health talk given by Dr. Gri
- □ Health food store
- □ Friend/Relative/Co-worker
- □ Other (please specify): ______________________________

Would you like to be added to the patient email newsletter list to receive healthy living tips and recipes (one email per month)? □ Yes □ No Signature: ______________________________

CHILD INTAKE FORM (10 years and younger)

Child's Name: ____
(Last) (First) (Preferred Name)

Mother's Name: ______________________ Father's name: ______________________

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

1. ____
2. ____
3. ____

Please list all medications (prescription, over-the-counter) and natural products your child is currently taking.

Medication/Natural Product	Dose/quantity per day	Why are you taking this product?

Please list your child's past prescription medication (if any).

Medication	Dose/quantity per day	Why are you taking this product?

Has your child ever experienced adverse effects or an allergic reaction to any of the above products?

□ No □ Yes – Please specify: ______________________________________

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

Please list any allergies or sensitivities (food, environment, medication) your child has experienced.

____

____

____

Please list all hospitalizations, surgeries and/or major injuries your child has experienced.

Description	Year	Outcome/complications?

Prenatal Health

How was the health of the parents at conception? Please specify any relevant health conditions.

Mother:____________________________________

Father: ____________________________________

How was the health of the mother during the pregnancy? Please specify any relevant health conditions.

____

What was the mother's age at the child's birth? __________

How was the mother's diet during pregnancy? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ 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 – please specify: ____________________________

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: ____________________
☐ Prescription medication: ____________________________
☐ Over-the-counter medication: __________________________
☐ Supplements: ________________________________
☐ Other: __________________________________

Birth History:

Duration of pregnancy: ☐ Full term ☐ Premature: ______weeks ☐ Late: _______ weeks

Birth weight: _________ Length: __________ Duration of Labour: ______ hours

Type of birth: ☐ Vaginal ☐ C-Section ☐ Induced ☐ Forceps ☐ Anesthesia used

Any labour complications: ____________________________

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

☐ Jaundice ☐ Rashes ☐ Seizures
☐ Birth injuries, please specify: ________________________
☐ Birth defects, please specify: ________________________

Please check off the immunizations your child has had.

☐ Hepatitis B Date: ________ ☐ Rotavirus Date: ________
☐ HiB Date: ________ ☐ Diptheria, Tetanus, Pertussis Date: ________
☐ Polio Date: ________ ☐ Measles, mumps, rubella Date: ________
☐ Chicken pox Date:________ ☐ Hepatitis A Date: ________
☐ Influenza Date: ________ ☐ Tetanus booster Date: ________
☐ Other, please specify: ____________Date: ________

Did your child experience any adverse effects following these immunizations?______________

Hours of sleep per night: ______ hours. Any sleep disturbances? ________________________________

Nutrition:

How was your child first fed?

☐ Breast milk. How long? ____________ ☐ Formula: Cow/Soy/Goat milk ☐ Other _________

Were foods introduced before 6 months? ☐ Yes ☐ No

Does your child have any dietary restrictions (religious, vegetarian/vegan)? ☐ Yes ☐ No

If yes, please specify: ____

Review of Systems - Please list any conditions that your child currently or has previously experienced:

____

SKIN (example – eczema, psoriasis, rashes, hives, chicken pox, impetigo)

____

HEAD (example – headaches)

____

EYES (example – infection, pain, itching, near/far sighted)

____

EARS (example – infection, discharge, hearing impairment)

____

NOSE (example – sinus problems, nose bleeds, frequently congested)

____

MOUTH (example – cavities, problems swallowing)

____

THROAT (example – tonsillitis, strep throat, hoarseness)

____

LUNGS (example – cough, asthma, wheezing)

____

HEART (example – rheumatic fever, murmurs, chest pain)

____

NEUROLOGICAL (example – seizures, paralysis, memory, vision changes, speech problems)

____

GASTROINTESTINAL (example – diarrhea, constipation, vomiting, difficulty swallowing)

URINARY (example – urinary tract infections, increased frequency, pain, blood)

MUSCLE AND SKELETON (example – joint pain, stiffness, weakness, fractures)

Environmental Exposures

Does anyone in your child's household smoke? ☐ Yes ☐ No

Are there any animals in your child's home? ☐ Yes ☐ No

Has your child ever been exposed to mold, solvents, lead paint, heavy metals, fumes, or other toxic substances at home, at school, or while traveling? ☐ Yes ☐ No

Has your child ever experienced health problems after putting down new carpeting, painting your home, doing renovations or having your lawn sprayed with herbicide? ☐ Yes ☐ No

Is your child particularly sensitive to perfume, gasoline or other vapours? ☐ Yes ☐ No

Has your child ever lived near a refinery or a polluted area? ☐ Yes ☐ No

Has your child ever lived in a home that was built in or prior to the 1970's? ☐ Yes ☐ No

Does your child have any mercury dental fillings? ☐ Yes ☐ No

Is there anything else I should know about your child's health?

____

____

____

Thank you for taking the time to complete this form. I look forward to meeting you and working with you towards your health goals.

Yours in Health,
Dr. Andrea Gri, B.Kin, ND

DR. ANDREA GRI
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INFORMED CONSENT AND PRIVACY POLICY

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional, and genetic aspects of the individual. Treatment modalities may include diet, lifestyle counseling, clinical nutrition (primarily via supplementation), botanical medicine, homeopathy, and Asian medical theory and acupuncture.

During your initial visits your Naturopathic Doctor will take a thorough case history, perform a basic/complaint-oriented physical examination, and when indicated order laboratory testing. Even the gentlest of therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness.

Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, in young children, those taking multiple medication, or pregnancy/lactation. It is very important, therefore, that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, please advise your Naturopathic Doctor immediately.

Health risks associated with Naturopathic Medicine include, but are not limited to:

- Aggravation of pre-existing symptoms during the healing process
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles

I understand that the Naturopathic Doctor will answer my 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 the risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):______________________________

____

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 of it by paying the appropriate fee.

I understand that fees and supplements are to be paid for at the time of the consultation. I also understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient name:______________________Signature of Guardian: _____________________Date: _________

Naturopathic Doctor: ____________________________________ ND Signature: _____________________

Collection, Use and Disclosure of Personal Information.

Privacy of your personal information is an important part of our Clinic, and protecting your personal information is something we take very seriously. We are committed to collecting, using and disclosing your personal information responsibly.

In this Clinic, Dr. Andrea Gri, Naturopathic Doctor acts as the Information Officer for naturopathic patient files. All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed and they have been 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 legislature, and privacy protection protocols;
- To advise you of treatment options;
- To establish and maintain contact with you;
- To send you newsletters and other information mailings;
- To remind you of upcoming appointments;
- To provide health care

Our privacy policy protocols comply with privacy legislation and standards of our regulatory body, the College of Naturopaths of Ontario.

The Clinic will collect, use and disclose information about you for the following purposes:

- To communicate with other treating health care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the College of Naturopaths of Ontario
- To invoice for goods and services
- To collect unpaid accounts
- To assist this Clinic to comply with all regulatory requirements
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

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

Patient name:______________________Signature of Guardian: ____________________Date: ________

Witness Signature: ____Date: ________