Naturopathic Child History Form

Please complete the following as completely as possible. If you need assistance, please ask the front desk staff and they will be glad to assist you.

Child's Name: _____ Date: _____
Parent(s) Name: _____
Sibling(s) Name(s) (Ages): _____
Address: _____ City: _____ Prov. _____
Postal Code: _____ Home Phone: (____)_____ Bus Phone: (____)_____
Date of Birth: _____ Age: ____ Gender: ☐ M ☐ F Referred by: _____
Has your child ever received chiropractic care? ☐ Yes ☐ No If yes, previous DC's name and last visit date?
_____
Name of Medical Doctor: _____
Date of last MD visit and reason: _____

Present Health Complaints/Concerns:

Major: _____
_____
Minor: _____
_____
When did this problem begin? _____
Is this problem: ☐ Occasional ☐ Frequent ☐ Constant ☐ Intermittent
Does problem radiate? ☐ Yes ☐ No If yes, where? _____
What makes this worse? _____
What makes this better? _____
Is the problem worse during a certain time of the day? ☐ Yes ☐ No If yes, when? _____
Does this interfere with the child's ☐ Sleep? ☐ Eating? ☐ Daily Routine?
Is this becoming worse? _____
Other professionals seen for this condition? _____
Results with that treatment? _____
_____

Growth and Development

Was the infant alert and responsive within 12 hours of delivery? ☐ Yes ☐ No If no, please explain _____
_____
At what age did the child: Respond to sound_____ Follow an object _____ Hold up head_____ Vocalize_____
Sit alone _____ Teeth _____ Crawl_____ Walk _____
Do you consider the child's sleeping pattern normal? ☐ Yes ☐ No If no, please explain_____
_____

Vaccination History

Vaccinations and age given? _____
Any negative reactions? ☐ Yes ☐ No If yes, what were they? _____
Any antibiotics given? ☐ Yes ☐ No Reason? _____

OFTEN SEEMINGLY UNRELATED SYMPTOMS CAN MANIFEST AS OTHER HEALTH CONCERNS: (please check if your child has had any of the following)

☐ Headaches	☐ Loss Of Taste	☐ Weight Gain	☐ Upper Back Pain
☐ Dizziness	☐ Light Sensitivity	☐ Dental Problems	☐ Neck Pain
☐ Fainting	☐ Face Flushed	☐ Fevers	☐ Low Back Pain
☐ Fatigue	☐ Cold Sweats	☐ Heart Palpitations	☐ Radiating Pain
☐ Irritability	☐ Bronchitis	☐ Chest Pressure	☐ Stiffness
☐ Depression	☐ Pneumonia	☐ Breast Pain	☐ Reduced Mobility
☐ Loss Of Balance	☐ Difficulty Breathing	☐ Frequent Colds	☐ Numbness In Leg(s)
☐ Loss Of Concentration	☐ Shortness Of Breath	☐ Sinus Congestion	☐ Numbness In Feet
☐ Loss Of Memory	☐ Asthma	☐ Sore Throats	☐ Numbness In Hand(s)
☐ Ears Buzzing	☐ Urinary Problems	☐ Ear Pain / Infections	☐ Weakness
☐ Poor Coordination	☐ Constipation	☐ Allergies	☐ Muscle Cramps
☐ Vision Changes	☐ Diarrhea	☐ Heartburn	☐ Sleeping Problems
☐ Loss Of Smell	☐ Weight Loss	☐ Bloating / Gas	

☐ Other: _____

History of Birth

What was the child's gestational age at birth? _____ Weeks.

Birth weight_____ lbs. _____ oz._____ Birth length _____ inches

Was your child's birth ☐ at home ☐ in a birthing center ☐ in a hospital

Was the birth considered ☐ medical ☐ midwife

What was the duration of the labour and birth? _____ hours

Was child born ☐ Cephalic (head first) ☐ Breech (feet first)

Were there any complications? ☐ Yes ☐ No If yes, please explain _____

_____

Please check any assistance which was used during the birth:

☐ Forceps ☐ Vacuum Extraction ☐ C-Section ☐ Episiotomy

Was labour ☐ Spontaneous ☐ Induced

Were medications or epidurals given to the mother during birth? ☐ Yes ☐ No If yes, what was given? ____

_____

APGAR score: at Birth_____/10 After 5 minutes_____/10

Family Health History

Please note any health problems (Eg. Cancer, hereditary conditions, diabetes, heart disease, etc.) that are present in:

Mother's family _____

Father's family _____

Sibling(s) _____

Since problems that naturopaths look for and detect can be related to many types of stressors, the following information is also very important to us.

Physical Stressors

Any traumas to the mother during pregnancy? (Eg. Falls, accidents, etc.) ☐ Yes ☐ No If yes, please explain _____

Any evidence of birth trauma to the infant?

☐ Bruising ☐ Odd Shaped Head ☐ Stuck In Birth Canal

☐ Fast Or Excessively Long Birth ☐ Respiratory Depression ☐ Cord Around Neck

Any falls from couches, beds, change tables, etc? ☐ Yes ☐ No If yes, please explain _____

_____

Any traumas resulting in bruises, cuts, stitches, or fractures? ☐ Yes ☐ No If yes, please explain _____

_____

Any hospitalizations or surgeries? ☐ Yes ☐ No If yes, please explain _____

_____

Any sports played? _____

Is a school backpack used? ☐ Yes ☐ No If yes, is it ☐ Heavy ☐ Light

Chemical Stressors

Was this child breast-fed? ☐ Yes ☐ No If yes, how long? _____

Formula introduced at what age? _____ What formula? _____

Introduction of cow's milk at what age? _____

Began solid foods at what age? _____ Type of foods? _____

Food / Juice intolerance? ☐ Yes ☐ No If yes, what type? _____

During pregnancy, did the mother, smoke? ☐ Yes ☐ No How much? _____

drink? ☐ Yes ☐ No How much? _____

Any illnesses during the pregnancy? ☐ Yes ☐ No If yes, what illnesses? _____

_____

Any supplements taken during pregnancy? ☐ Yes ☐ No If yes, what supplements? _____

_____

Any drugs taken during pregnancy? ☐ Yes ☐ No If yes, what drugs? _____

_____

Any ultrasounds? ☐ Yes ☐ No How many and reasons for being done? _____

_____

Any invasive procedures during pregnancy (Eg. Amniocentesis, CVS, etc.)? ☐ Yes ☐ No Please explain ___

_____

Any pets at home? ☐ Yes ☐ No If yes, what kind(s)? _____

Any smokers in the home? ☐ Yes ☐ No

Psychosocial Stressors

Any difficulties with lactation? ☐ Yes ☐ No If yes, what are they? _____

Any problems with bonding? ☐ Yes ☐ No If yes, what are they? _____

Any behavioural problems? ☐ Yes ☐ No If yes, what are they? _____

Any ☐ night terrors ☐ sleep walking ☐ difficulty sleeping

Age of child when he/she began daycare? _____

Average number of hours of television per week? _____

Do you feel that your child's social and emotional development is normal for their age? ☐ Yes ☐ No If yes,

how?_____

Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet and nutritional supplements, botanical medicine, homeopathy, Asian medicine and acupuncture, hydrotherapy, physical medicine, and lifestyle counseling.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, increased gastrointestinal function, improved immunity, and general well-being.

Botanical Medicine is a plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Laws of Similars – that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal, or mineral origins are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Asian Medicine includes the use of acupuncture, eastern herbs and dietary changes to eliminate disease and balance body function. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advise is based on traditional Chinese Medical Theory.

Physical Medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle Counseling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visit, your Naturopathic Doctor will take a thorough case history.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g. Pregnancy, lactation, very young children, or those taking multiple medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver, or kidney disease. It is very important, therefore, that you inform your 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, advise your doctor immediately.

There are some slight health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles.
- Muscle strains and sprains, disc injures from spinal manipulation.

• The potential for stroke is a concern in neck manipulation. Clinical research has shown that stroke-like occurrences are rare – approximately 1 in 1.5 million manipulations.

Please initial in spaces below

_____ 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 the Naturopathic Doctor will answer any question that I have to the best of his ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all 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 charges are to be paid at the time of the visit unless specific arrangements have been made **prior** to my scheduled appointment. Payment for all dispensary items is due at the time of the visit.

_____ I understand that a fee will be charged (Missed Appointment Fee) for any missed appointment or late cancellations (less than 24 hours).

As the patient, you are responsible for the total charges incurred for each visit. We accept Visa, Mastercard, cash or check. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company – we will provide you with all of the information necessary to send your claim for reimbursement.

Your Naturopathic Doctor may prescribe supplements that can be purchased at Cranton Wellness Centre, nutritional stores or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

_____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. We respectfully request that you inform us if or when you choose to discontinue care.

Patient Name: (please print): _____

Signature of Patient or Guardian: _____

Date: _____

AUTHORIZATION FOR CARE OF A MINOR (UNDER 16 YEARS)

PARENT(S) NAME(S):_____ WORK TEL:_____

I hereby authorize and consent to the Naturopathic evaluation and care of my child.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____

EXTENDED HEALTH BENEFITS

CHECK-OFF LIST

Name_____ Date_____

We have prepared this list for you to help you get <u>ALL</u> the information you need when you call for your work Extended Health Benefits. We have included questions for all of the services we offer in our office. Dr. Cranton is licensed as both a Chiropractor and a Naturopathic Doctor, performs acupuncture, and is certified to cast and order custom orthotics.

Do you have Extended Health Benefits through your work or school? Yes No
Does your spouse, mother or father have Extended Health Benefits though his/her work?
☐ Yes ☐ No (you are done with this form)

<u>INFORMATION TO RECORD **BEFORE YOU CALL**</u>:
Your work Insurance Company - Name: _____ Phone #:_____
Employer: _____ Employee: _____
Employee ID#: _____ Group policy #: _____

<u>INFORMATION TO GET **WHEN YOU CALL:**</u>
Is there a deductible? ☐ Yes - How much? $_____ ☐ No
Is this a family plan? ☐Yes ☐ No
Is your limit: ☐ per calendar year ☐ per fiscal year _____ to _____ ☐ per 12 consecutive months

<u>DO YOU HAVE **CHIROPRACTIC** COVERAGE?</u> Yes No
What is your limit per year? $_____
What is your limit per visit? $_____
Do you have x-ray coverage? ☐ Yes ☐ No - Is it included in your maximum? ☐ Yes ☐ No

<u>DO YOU HAVE **NATUROPATHIC** COVERAGE?</u> Yes No
What is your limit per year? $_____
Is there a maximum per visit? $_____
Are there a maximum number of visits? ☐ No ☐ Yes _____
Are supplements covered if prescribed by a Naturopath? ☐ No ☐Yes - maximum $ _____

<u>DO YOU HAVE **ACUPUNCTURE** COVERAGE?</u> Yes No
What is your limit per year? $_____
What is your limit per visit? $_____
Are there a maximum number of visits? ☐ No ☐ Yes _____

<u>DO YOU HAVE **PRIVATE LAB COVERAGE**?</u> Yes No
Are private labs covered? (E.g. hair analysis, blood or urine or allergy tests) ☐ No ☐Yes - maximum $_____

<u>**OTHER** ITEMS TO CHECK ON:</u>
Do they cover orthopedic cervical pillows? ☐ Yes ☐ No
Do you have coverage for COMPRESSION HOSIERY OR STOCKINGS? ☐ Yes ☐ No
What is your limit per year? $_____

Do you have <u>**CUSTOM ORTHOTICS**</u> coverage?
What is your limit per year $_____
How many pairs can you order? ____
Do you need a referral ☐ Chiropractor ☐ M.D. ☐ No
Do you get one pair per year or every second year?

CRANTON WELLNESS CENTRE
701 Memorial Ave., Unit 3 Thunder Bay, On P7B 3Z7
Phone (807)343-7932 Fax (807)343-0439
www.crantonwellness.com