SUZANNE HO-MIECZNIKOWSKI, B.SC., N.D.
NATUROPATHIC DOCTOR

PAEDIATRIC INTAKE FORM

To better understand how I can help your child, please fill out this form to the best of your ability.

Child's Name:_____ Birth date:_____

Address:_____
Street City Province Postal Code

Mother/Guardian's Name:_____Home phone:_____

Email: _____Work phone: _____

Father/Guardian's Name:_____Home phone:_____

Email:_____Work phone:_____

With whom does the child live?_____

Does the child have any siblings? Yes / No Sisters:___Age(s):_____Brothers:_____Age(s):_____

Emergency Contact Name:_____ Relationship:_____ Phone:_____

Child's medical physician:_____Phone:_____

Is the child under the care of a specialist? Name _____Phone:_____

Is the child under the care of other healthcare providers? _____

Please indicate how you found out about my practice?_____

Would you like to receive my quarterly information-packed e-newsletter? Yes No

CURRENT HEALTH INFORMATION

What is the **main** reason for bringing your child to my office today? When did it start? _____

_____

_____

Past treatment(s) and results:_____

List in order of importance **other** health concerns you may have about your child:

1)_____

2)_____

3)_____

Please list allergies/intolerances your child may have to any drug, herb, food, animal, pollen or other substance_____

_____

Is your child currently taking any medications, herbs or vitamins? _____

_____

_____

What medications has your child taken in the past (i.e. antibiotics, Tylenol)?_____

_____

Please circle the immunizations your child has received:

MMR (Measles, mumps, rubella) *Hepatitis B* *Varicella* *Pneumococcal* *Meningicoccal*

DPT-Polio-HiB (Diphtheria, pertussis, tetanus, polio, Haemophilus influenza) *other*

Did your child experience any reactions to these immunizations? Yes / No

If yes, which one and what was the reaction?_____

Please describe any adverse reactions your child has had to prescription drugs, over-the-counter drugs, or naturals medicines: _____

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FAMILY MEDICAL HISTORY

Please circle any of the following that blood relatives have had (not including your child):

Alcoholism	*Allergies*	*Asthma*	*Arthritis*	*Bleeding conditions*	*Cancer*	*Diabetes*
Depression	*Epilepsy*	*Hayfever*	*Heart conditions*	*Heart attack*	*High blood pressure*	*Kidney conditions*
Mental health disorders	*Obesity*	*Stroke*	*Substance abuse*	*Tuberculosis*	*Thyroid conditions*	

MEDICAL HISTORY

Please circle any of the following that your child may has experienced.

Measles	*Mumps*	*Chicken pox*	*Diphtheria*	*Rheumatic fever*
Whooping cough	*Rubella*	*Scarlet fever*	*Anemia*	*Diabetes*
Jaundice	*Chronic infections*	*Weight problems*	*Leukemia*	*Malaria*
Worms/parasites	*Warts*	*Typhoid fever*	*Acne/boils/impetigo*	*Abscess*
German measles	*Eating disorder*	*Mononucleosis*	*Cancer*	*Epilepsy/seizure*
Tuberculosis	*Colic*	*Blue baby*	*Undescended testicles*	*Bed wetting*

Please list any surgeries or major injuries your child has had:_____

_____

Is there any illness, hereditary condition or other condition that the natural family has: _____

_____

MENTAL/EMOTIONAL

Abuse	*Easily angered*	*Bipolar disorder*	*Panic attacks*
Anxiety/nervousness	*Indecision*	*Mood swings*	*Depression*
Prolonged sadness/grief	*Irritability*	*Phobias*	

ENDOCRINE

20 lbs change in weight in the last year	*Sluggish after eating*	*Hypoglycemia (low blood sugar)*	*Generally feel hot*
Mental dullness	*Thyroid condition*	*Poor concentration*	*Generally feel cold*

How many hours of sleep does your child get each night? _____

Does your child have trouble falling asleep? Yes / No Or staying asleep? Yes / No
Does your child nap during the day? Yes / No

IMMUNE SYSTEM

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Chronic infections *Frequent antibiotics* *Frequent colds/flu* *Swollen glands/nodes*

Frequent sore throats *Slow wound healing* *Cold sores* *Shingles*

How often does your child get colds, flu, or sore throats in a year? _____

HEAD

Headaches/migraine *Dizziness* *Fainting* *Cataracts* *Seizure/epilepsy* *Hearing loss*

Ringing in ears *Ear infections* *Loss of taste* *Concussion* *Cold sores* *Canker sores*

Allergies *Hayfever* *Influenza* *Sinusitis* *Strep throat* *Vision changes*

CHEST

Heart disease *Chronic cough* *Palpitations/murmurs* *Asthma* *Pneumonia*

Tuberculosis *Bronchitis* *Emphysema* *Shortness of breath* *Wheezing*

EXTREMITIES

Cold hands/feet *Numbness/tingling* *Warts* *Raynaud's Disease* *Eczema/psoriasis*

Bleeding conditions

DIGESTIVE

Heartburn *Nausea/vomiting* *Diarrhea*

Constipation *Excessive gas* *Bloating*

Blood in stools *Mucous in stools* *Undigested food in stools*

Black stools *Light-coloured stools* *Floating stools*

Hemorrhoids *Parasites* *Irritable bowel*

Candida (yeast) *Appendicitis* *Bad breath*

Change in appetite *Change in thirst* *Chronic laxative use*

Gastric or duodenal ulcers

KIDNEYS AND BLADDER

Inability to urinate *Frequent urination* *Blood in urine* *Cloudy urine*

Bladder infections *Burning during urination* *Incontinence* *Late toilet training*

BIRTH HISTORY

Mother

Age of mother at conception:_____ Was this a planned pregnancy? Yes / No

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Please list any medications, supplements or other therapies that were taken at the time of conception: _____

_____

_____Did the natural mother, previous to this child, experience any of the following: *previous pregnancy* *miscarriage* *abortion* *difficulty conceiving* *difficult pregnancy* *difficult labour*

Father

Age of the father at conception:_____

Please list any medications, supplements or other therapies that were taken at the time of conception: _____

_____

Pregnancy

During the pregnancy, did the natural mother experience any of the following: *vaginal bleeding* *thyroid problems* *diabetes* *nausea* *physical/emotional trauma* *illness* *high blood pressure*

Please list any medications, herbs, vitamins or therapies that the natural mother was taking during the pregnancy:____

_____

How many ultrasounds did she have during the pregnancy?_____

Was she exposed to toxic chemicals, smoke, alcohol or recreational drugs during the pregnancy? Yes / No

What was the mother's total weight gain during the pregnancy?_____

Labour

Place of birth:_____

Was the pregnancy (please circle): *full term* *premature* *past term*

Number of hours in labour:_____Type of birth (please circle): *vaginal* *caesarean section*

Were there any complications during the labour with the mother or child?_____

_____Please list medications and interventions used during labour, including instruments (i.e. epidural, episiotomy, forceps)_____

_____

Neonatal

Weight of child at birth:_____ Length at birth: _____APGAR scores:_____

Please list any abnormalities, treatments (i.e. phototherapy) or surgeries (i.e. circumcision) your child received immediately following birth:_____

Was your child breastfed? Yes / No If yes, until what age: _____

If no, what formula was the child fed?_____

At what age was the following food introduced: *milk*_____ *eggs*_____*wheat*_____ *meat*_____ *fruit*_____*vegetables*_____

At what age did your child begin to: *sleep through the night*_____ *lift head*_____*rollover*_____ *sit*_____ *hold objects*_____ *crawl*_____ *walk*_____ *first words*_____ *dress alone*_____ *toilet train*_____

Has your child ever failed to make progress or lost any ability she/he once had? Yes / No

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PERSONAL HABITS AND HOUSEHOLD

What are your child's hobbies and interests? _____

Does your child get regular physical activity? Yes / No If yes, how often? _____

What physical activities does your child do: _____

For how long? _____

Please circle if any of the following apply to your home: *Damp or mouldy* *Live in city* *Air filtration*

Please circle if any of the following apply to your workplace:

Office building *Windows do not open* *Air filtration* *Work in presence of fumes or chemicals*

Are you currently exposed to second-hand smoke? *Yes / No*

What type of water do you drink? *Tap* *Bottled* *Filtered* *Reverse osmosis* *Distilled*

Have you ever been exposed to mould, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations), at work, or while travelling?	Y	N
Have you ever experienced health problems after putting in new carpeting, painting your home, doing renovations, or having your lawn sprayed with herbicide?	Y	N
Are you particularly sensitive to perfume, gasoline or other vapours?	Y	N
Have you ever lived near a refinery or a polluted area?	Y	N
Have you ever lived in a home more than 50 years old?	Y	N
Do you have mercury dental fillings?	Y	N
Have you had any dental root canal procedures?	Y	N
Do you have any surgical implants (cosmetic/medical)?	Y	N
Do you live near large power lines?	Y	N

Is there any thing else I should know about your child?_____

_____

_____

Thank you for taking the time to fill out this questionnaire. This information will assist me in understanding your child's health. - Suzanne

VISIT FEES

Office visits:

Initial consultation (90 minutes) $165
Intake session and complaint-based physical exam

Second visit (60 minutes) $165
Discussion of comprehensive treatment plan

Follow-up visits (45 minutes) $95
M*onitoring of treatment plan*

* These rates are available for children (12 years and under).
* There is no GST charged on fees.

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Telephone consultations:

Please note: these are generally intended for follow-up consultations and clarification of treatment protocols. Telephone consultations are offered to new patients only after an initial visit has been conducted and a treatment plan has been initiated.

First 5 minutes	No charge
20 minute consults	$50
30 minutes or longer	Follow-up visit fees apply

Cancellled and missed appointments

Please ensure to give at least 24 hours cancellation notice. This will allow Suzanne to accommodate other patients who would also like to schedule an appointment. For appointments cancelled ON THE SAME DAY or missed appointments, 50% of the cost of the appointment will be charged. Consideration will be given to unforeseeable circumstances.

Payment for services

Payment for services is due at the end of each visit and a receipt will be given when payment is received. Please retain your receipt for claiming your insurance, if applicable. **Fees may be paid by cash or cheque.** Any prescribed botanicals, supplements, or homeopathics are not included in the above consultation fees.

Confidentiality

Everything that you communicate, directly or indirectly, to Suzanne is confidential unless you give written permission to disclose information to a third party.

It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to:

1. report incidents of child abuse (physical, sexual or emotional) and neglect;
2. comply with court-ordered subpoena;
3. prevent harm to yourself or another person should such plans be disclosed;
4. report a health professional who has sexually abused a patient;
5. share information in a supervision format.

Privacy consent form

Privacy of your personal information is an important part of providing you with quality naturopathic care. I understand the importance of protecting your personal information. I am committed to collecting, using, and disclosing your personal information responsibly. I will take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal.

With regard to uses and disclosures of personal health information, it will be used to:
• treat and care for you,
• get payment for your treatment and care (from WSIB, your private insurer or others),
• plan, administer and manage my internal operations,
• conduct risk management and quality improvement activities,
• compile statistics,
• comply with legal and regulatory requirements, and
• fulfill other purposes permitted or required by law.

I understand that **Suzanne Ho-Miecznikowski, B.Sc., N.D.** will only collect, use and disclose my personal health information with my consent unless a particular collection, use or disclosure is permitted or required by law without my consent.

I also understand that I can refuse to sign this consent form. I can also withdraw my consent any time by writing to Suzanne Ho-Miecznikowski.

I hereby authorize Suzanne Ho-Miecznikowski to collect, use and disclose my personal health information for the purposes that have been indicated above.

INFORMED CONSENT TO NATUROPATHIC TREATMENT OF A MINOR

Each parent/guardian must sign this document before any treatment will be rendered.

SUZANNE HO-MIECZNIKOWSKI, B.SC., N.D.
NATUROPATHIC DOCTOR

My signature acknowledges that I have been informed and understand that:

i) The treatments that I receive in this office are different from those usually offered by a medical doctor or other licensed health care practitioner.

ii) I am at liberty to seek or continue to seek medical care from a physician or surgeon or other health care practitioner qualified to practice in Ontario.

iii) I have received a complete explanation of the diagnostic or treatment protocols that I may receive at this office and hereby authorize and consent to treatment.

iv) I acknowledge that Suzanne Ho-Miecznikowski, ND endeavours to provide the best possible diagnosis and course of treatment, but that no warranty is made with respect to any treatment, action, or medical advice given, as many factors will be important in determining actual results.

v) I have been informed of (with respect to diagnostic and treatment procedures) financial costs, expected benefits, potential risks and side effects, likely consequences of not following the treatment plan, and what alternative course(s) of action are available to me.

vi) I agree to pay the fees for each visit or treatment, on the day of the treatment. I am aware that these fees are not covered by OHIP.

I do hereby voluntarily give my informed consent for Suzanne Ho-Miecznikowski, ND, who has been engaged by me, to examine and administer Naturopathic care and treatment to_____whose relationship to me is as a _____.

I also understand that I may change the status of my voluntary informed consent at any time.

_____ _____

Signature of Parent/Guardian Date

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