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

CHILD INTAKE FORM (12 and under)

Welcome! To better understand how I can help your child, please fill out this form to the best of your ability. This is a confidential record of your child's medical history and information will not be released to any person without your authorization.

Child's Name:____ Birth date:___________________________

Address:____
Street City Province Postal Code

Parent 1/Guardian's Name:____Home phone:__________________

Email: ____Work phone: ________________________

Parent 2/Guardian's Name:____Home phone:__________________

Email:____Work phone:_________________________

With whom does the child live?__________________ Custody (If applicable): parent 1 parent 2 other

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?____

Do you give permission for me to communicate with you or your parents/guardians by email, knowing that it is not fully secure nor PHIPA (privacy) compliant? Yes No

CURRENT HEALTH INFORMATION

What is the **main** reason for bringing your child to my office today and when did it start? _______________________
____

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

Please circle the immunizations your child has received:

MMR (Measles, mumps, rubella) *Hepatitis B* *Chickenpox* *Pneumococcal*

Meningococcal *DPTP-HiB (Diphtheria, pertussis, tetanus, polio, Haemophilus influenza)* *Flu*

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

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

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:____

____

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

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 at conception:______________

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

____

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:____

____

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

Labour

Place of birth:____

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

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)?____

Neonatal

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: ___________

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

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*

Is your child exposed to second-hand smoke? *Yes / No*

What type of water does your child 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 anything else I should know about your child?____

____

____

Thank you for taking the time to fill out this questionnaire - Suzanne

VISIT FEES

Online and in-office visits:

Initial consultation (90 minutes) $230
Intake session and complaint-based physical exam (in-person exams are done case-by-case during COVID-19)

Second visit (60 minutes) $230
Discussion of comprehensive treatment strategy/plan

Follow-up visits (45 minutes) $130
M*onitoring of treatment plan*

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

Email and phone correspondence:

This is intended for *brief* clarification of treatment protocols.

Diagnostic services and naturopathic supplements

Suzanne has functional laboratory services provided by LifeLabs and In-Common Laboratories. This enables her to perform comprehensive blood work, urine and stool testing, as well as special tests using saliva and hair. OHIP does not cover laboratory services requested by naturopathic doctors, therefore, patients are required to pay for these services.

Suzanne also carries professional quality products online through Fullscript for supplements that are not available through health food stores.

Cancelled 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 insurance, if applicable. **Fees may be paid by cash, e-transfer or credit card.** 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

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

For shared custody, both parents/guardians must sign this document before any treatment will be rendered.

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 ________.

____ ____________________________________

Signature of Parent/Guardian #1 Date

____ ____________________________________

Signature of Parent/Guardian #2 (only for shared custody) Date