Informed Consent to Treatment

General Information

This form applies to patients of Priority Massage and Health – Naturopathic Medicine. By consenting to treatment, your naturopathic doctor will have access to your file and personal information.

Though gentle, naturopathic therapies have complications associated with certain conditions. It is essential to be complete in informing your doctor of your current state of physical and mental health, if you are on prescription, over-the-counter or recreational drugs, or if you suspect you are pregnant or are currently breastfeeding.

There are some minor risks associated with naturopathic therapies which include but are not limited to: bruising, pain or injury from venipuncture or acupuncture, fainting, organ puncture from acupuncture, aggravation of pre-existing symptoms and conditions, allergic reactions to botanicals or supplements, muscle sprains, strains or disc injury from spinal manipulation. The utmost care will be taken to prevent such outcomes.

Patient Consent to Treatment

1. This is to acknowledge that I have been informed and understand that any advice or treatment that I receive as a patient at this clinic is not mutually exclusive from any other treatment I am currently receiving or may in the future receive from another licensed health care provider.

2. I understand that I may seek and/or continue to receive medical care from another healthcare provider qualified to practice in Ontario.

3. I understand that no one at this clinic is suggesting I refrain from seeking advice from another qualified health care provider.

4. I understand that my Naturopathic Doctor (ND) keeps a record of services provided to me, and this record is kept confidential, only to be released to others if directed by myself or if required by law. I may request to see this record at any time and have a copy of this record by paying a fee.

5. I understand that my ND reserves the right to determine if my health concerns fall out of the scope of her practice, in which case an appropriate referral may be recommended.

6. I understand that services at this clinic are not covered by OHIP, and I will be paying for fees at the time of the appointment; including fees for the visits, prescriptions, services and tests.

7. I understand that of my own free will, I would accept or reject the treatment protocol recommended by this clinic.

8. I understand that therapies recommended to me will be explained in full by my doctor, and that my questions will be answered as best as possible, in a manner which I can comprehend.

9. I understand that the results are not guaranteed. I do not expect my ND to anticipate all risks and complications, but rely on her to utilize appropriate judgment in my best interests, based on the facts and findings then known.

10. I understand that 24 hours notice is required for visit cancellation or change of appointment, or I will be charged the full cost of a visit.

11. I understand that my naturopathic doctor may prescribe to me medicines or devices, and that I may purchase them from my naturopathic doctor, a pharmacy, a health food store, or a medical supply company of my choice.

I voluntarily consent to treatment at Priority Massage and Health – Naturopathic Medicine using the diagnostic and therapeutic procedures mentioned except for (please list treatments you do NOT want to receive below):

I have read, understand and agree to the above statements.
I understand I am free to withdraw my consent to discontinue treatment at any time, informing the clinic in a written or verbal format.

Patient Name: __________________________________________________________

Parent/Guardian Signature if under 18: ____________________________________

Patient Signature: _______________________________________________________
Please help us provide you with the highest standard of care by carefully completing this intake form. Identify anything you don’t understand with a question mark. All information is strictly confidential. Please PRINT CLEARLY.

### Confidential Pediatric Health Record

<table>
<thead>
<tr>
<th><strong>Personal Information</strong></th>
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</thead>
<tbody>
<tr>
<td>Date: _________________</td>
</tr>
<tr>
<td>Child’s Name: ________________ Age: _______ Birth Date: ________________</td>
</tr>
<tr>
<td>Gender: ____________________</td>
</tr>
<tr>
<td>Who is completing this form? ______________ Relationship to Child: ______________</td>
</tr>
<tr>
<td>Address: ____________________________________________________________________________</td>
</tr>
<tr>
<td>City: ____________________ Province: ______ Postal Code: ____________________</td>
</tr>
<tr>
<td>Telephone (Home): ________________ (Work): ________________</td>
</tr>
<tr>
<td>Email: ____________________________________________________________________________</td>
</tr>
<tr>
<td>Where may we leave messages regarding your child’s visits? ________________________________________________________________________________</td>
</tr>
<tr>
<td>Family Physician: __________________________________________________________________</td>
</tr>
<tr>
<td>Phone number: ________________ Fax number: ________________</td>
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<tr>
<td>Health Insurance Number (e.g. OHIP): ____________________________________________________________________________________________</td>
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</tbody>
</table>

In case of emergency contact: __________________________________________________________________|
| Address: ____________________________________________________________________________ |
| Phone number: ________________ Relationship: ____________________ |

How did you hear about the clinic? __________________________________________________________________|

Has your child seen a Naturopathic Doctor before? ☐ Yes ☐ No
If yes, for what ailment(s)? ________________________________________________________________________

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Dr. Kristina Kastelanac, ND  
Naturopathic Doctor  
172 Wortley Road  
London, Ontario N6C 3P7  
519.642.7469
Are any other members of your family being treated at this clinic?  □ Yes □ No

Current History

Please list the reasons for your child’s visit today and when the concerns began:
1. __________________________________________
2. __________________________________________
3. __________________________________________
4. __________________________________________

Has anything changed recently or become worse? __________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Any religious affiliations or beliefs relevant to your child’s health care and treatment?
____________________________________________________________________________________
____________________________________________________________________________________

How would you describe your child’s current state of health?  □ Excellent  □ Good  □ Fair  □ Poor

Does your child have any dietary restrictions?  □ Yes □ No
If yes, which ones and why (religious or otherwise)?
____________________________________________________________________________________
____________________________________________________________________________________

Has your child ever been prescribed an Epi-pen?  □ Yes □ No
Reason: __________________________________________
____________________________________________________________________________________

Please list all of your child’s known allergies (medications, food, pollen etc.):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Medication and Supplement History

History of antibiotic use (when approximately): __________________________________________
How long: __________________
For what condition(s): __________________________________________
____________________________________________________________________________________
Please list all supplements, herbs and medications your child is currently taking:

<table>
<thead>
<tr>
<th>Medication/supplement</th>
<th>Dosage</th>
<th>Started</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Early Life History**

Please check relevant conditions:

**Mother’s pregnancy**
- [ ] Uncomplicated
- [ ] Bleeding
- [ ] Diabetes
- [ ] Early labour
- [ ] Excessive vomiting
- [ ] High blood pressure
- [ ] Physical/emotional trauma
- [ ] Smoking/alcohol/drug use
- [ ] Thyroid problems
- [ ] Other __________________

Medications during pregnancy:  [ ] Yes  [ ] No
Supplements during pregnancy:  [ ] Yes  [ ] No

**Birth History**

Birth weight: __________________ Weeks: ___________
- [ ] Full term
- [ ] Premature
- [ ] Past term

Mother’s age at child’s birth: _______________

Birth complications or interventions used? Describe: __________________________________________

________________________________________

Post-natal Complications
- [ ] None
- [ ] Birth defects
- [ ] Birth injuries
- [ ] Cardiac
- [ ] Gastrointestinal
- [ ] Infections
- [ ] Jaundice
- [ ] Respiratory
- [ ] Other: __________________

**Nursing**

Was your child breastfed?  [ ] Yes  [ ] No  If so, how long? _______________

Difficulty nursing?  [ ] Yes  [ ] No _______________________________________

Formula used?  [ ] Yes  [ ] No  If so, what age? __________________________

When were solids introduced? _______________ 1st foods: ______________________
Vaccination History

Is your child vaccinated?  □ Yes □ No  If yes, were all boosters given?  □ Yes □ No

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age received</th>
<th>Date(s) of immunization(s)</th>
<th>Reactions/side effects (ie fever)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hep A</td>
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<tr>
<td>Hep B</td>
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<tr>
<td>HiB (influenza)</td>
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<td></td>
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<tr>
<td>Polio</td>
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<td></td>
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<tr>
<td>MMR (measles, mumps, rubella)</td>
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<tr>
<td>DPT (diphtheria, pertussis, tetanus)</td>
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<tr>
<td>Small pox</td>
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<tr>
<td>Varicella</td>
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<td></td>
<td></td>
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<tr>
<td>Tetanus booster</td>
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<tr>
<td>Meningococcal</td>
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<tr>
<td>Pneumococcal</td>
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<td></td>
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<tr>
<td>“flu” shot</td>
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<td></td>
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<tr>
<td>Other</td>
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</tr>
</tbody>
</table>

Please indicate if your child had any hospitalizations, surgeries or serious injuries:

<table>
<thead>
<tr>
<th>Hospitalization/Surgery</th>
<th>When (age)</th>
<th>Complications?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Injuries:

<table>
<thead>
<tr>
<th>Injury</th>
<th>When (age)</th>
<th>Long-term effects?</th>
</tr>
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<tbody>
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</tbody>
</table>
General Health History (Please check relevant and circle: C=current, P=past)

- Bleeds/bruises easily C/P
- Change in appetite C/P
- Chills C/P
- Cravings C/P
- Fatigue C/P
- Fevers C/P
- Night sweats C/P

- Peculiar tastes/smells C/P
- Poor appetite C/P
- Poor sleep C/P
- Strong thirst C/P
- Sudden energy drop (when in day?) C/P
- Weight gain C/P
- Weight loss C/P

Skin, Hair and nails (Please check relevant and circle: C=current, P=past)

- Dandruff C/P
- Dryness C/P
- Eczema C/P
- Itching C/P
- Loss of hair C/P
- Loss of nails C/P
- Nail changes C/P
- Nail fungus C/P

- Pimples C/P
- Psoriasis C/P
- Rashes C/P
- Recent moles C/P
- Ulcerations C/P
- Other skin, hair or nail concerns?

Head, Eyes, Ears, Nose and Throat (Please check relevant and circle: C=current, P=past)

- Blurry vision C/P
- Colour blindness C/P
- Concussion/head injury C/P
- Dental cavities C/P
- Discharge from ear C/P
- Ear infections C/P
- Earaches C/P
- Eye pain C/P
- Eye strain C/P
- Eyeglasses C/P
- Facial pain C/P
- Frequent colds C/P
- Gum problems C/P
- Hay fever C/P
- Headaches C/P
- Jaw clicks or pain C/P
- Mercury tooth fillings C/P
- Neck pain C/P
- Neck pain C/P
- Night blindness C/P
- Nose bleeds C/P
- Poor hearing C/P
- Recurrent sore throats C/P
- Ringing in ears C/P
- Sores on lips or tongue C/P
- Stiffness C/P
- Tooth pain C/P

Lungs and Breathing (Please check relevant and circle: C=current, P=past)

- Asthma C/P
- Bronchitis C/P
- Cough C/P
- Coughing blood C/P

- Difficulty breathing C/P
- Phlegm (colour: _________)
- Other ___________________
Abdomen and Digestion (Please check relevant and circle: C=current, P=past)
- Abdominal pain C/P
- Bad breath C/P
- Blood in stool C/P
- Constipation C/P
- Diarrhea C/P
- Gas C/P
- Green/Gray stool C/P
- Hepatitis C/P
- Indigestion C/P
- Nausea C/P
- Rectal itching C/P
- Vomiting C/P
- Other __________

Genito-Urinary (Please check relevant and circle: C=current, P=past)
- Bed wetting C/P
- Decreased flow C/P
- Distinctive or odd colour C/P
- Frequent urination C/P
- Other __________
- Pain on urination C/P
- Rash on genitals C/P
- Sores on genitals C/P
- Urgency C/P

Brain, Nervous System and Emotions (Please check relevant and circle: C=current, P=past)
- ADHD C/P
- Anxiety C/P
- Areas of numbness C/P
- Autism C/P
- Concussion C/P
- Depression C/P
- Dizziness C/P
- Lack of coordination C/P
- Loss of balance C/P
- Muscle weakness C/P
- Poor memory C/P
- Quick temper/irritable C/P
- Seizures C/P
- Susceptible to stress C/P
- Talks about/attempted suicide C/P
- Has your child ever had treatment for emotional problems? __________________________
- Any other neurological or psychological concerns? _________________________________

Interaction with other children
- Very good
- Average
- Poor
- Excellent
- Disruptive
- Variable
- Other __________

Behaviour
- Excellent
- Disruptive
- Variable
- Other __________

Immune System/Infections (Please check relevant and circle: C=current, P=past)
- Chicken pox
- Diphtheria
- Frequent colds/flu
- Hay fever
- Allergies
- Measles
- Mumps
- Rheumatic fever
- Rubella
- Scarlet fever
- Strep infection
- Urinary tract infections
- Whooping cough
- Anaphylaxis
- Hypersensitivities
**Household**

How long has your child lived at this present address? ______________________________________
Where has your child lived previously? _______________________________________________________
Please describe location, if old or new building, i.e., new construction, older construction, damp or moldy etc. ________________________________________________________________

Who lives in the home with your child? _______________________________________________________
Are there any pets in your child’s home? □ Yes □ No __________________________________________
Is there specialized air filtration at home? □ Yes □ No _______________________________________
Does your child live in the city? □ Yes □ No _________________________________________________
Do any of your child’s hobbies involve toxic materials? □ Yes □ No ____________________________
Is your child currently exposed to second hand smoke? □ Yes □ No ______________________________
What does your child use for drinking water? □ Bottled □ Filtered □ Tap water ____________________

**Family Health History**

Please indicate each relevant condition for blood relatives only.

- □ Abscesses
- □ Addiction
- □ ADHD
- □ AIDS
- □ Alcoholism
- □ Allergies
- □ Amnesia
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Cancer: type(s)
- □ Celiac disease
- □ Chicken pox
- □ Cold sores
- □ Depression
- □ Diabetes
- □ Eczema
- □ Emphysema
- □ Epilepsy
- □ Eye problems
- □ Frequent colds
- □ Gall stones
- □ Genital herpes
- □ Goiter
- □ Gonorrhea
- □ Gout
- □ Hay fever
- □ Heart disease
- □ Hepatitis
- □ HIV
- □ Hypertension
- □ Influenza
- □ Kidney disease
- □ Learning disabilities
- □ Leukemia
- □ Liver disease
- □ Lupus
- □ Malaria
- □ Measles
- □ Mental illness
- □ Migraines
- □ Miscarriage
- □ Mononucleosis
- □ Multiple sclerosis
- □ Mumps
- □ Obesity
- □ Parasites
- □ Peritonitis
- □ PID
- □ Pleurisy
- □ PMS
- □ Pneumonia
- □ Prostatitis
- □ Rheumatic fever
- □ Rubella
- □ Scarlet fever
- □ Seizures
- □ Sexual abuse
- □ Sinusitis
- □ Skin diseases
- □ Stroke
- □ Strep throat
- □ Sunstroke
- □ Syphilis
- □ Thyroid problems
- □ Tonsillitis
- □ Tuberculosis
- □ Typhoid
- □ Ulcers
- □ Venereal disease
- □ Warts
- □ Whooping cough
- □ Worms
- □ Yellow fever
Any other condition(s) not listed:

______________________________________________________________________________
______________________________________________________________________________

Indicate which of the above conditions have affected your child’s relatives:

<table>
<thead>
<tr>
<th>Family member</th>
<th>Age (if alive)</th>
<th>Age at death</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Brother</td>
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<td></td>
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<tr>
<td>Brother</td>
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<td></td>
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<tr>
<td>Sister</td>
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<td></td>
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<tr>
<td>Sister</td>
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<td></td>
</tr>
<tr>
<td>Maternal grandmother</td>
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<tr>
<td>Maternal grandfather</td>
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<tr>
<td>Maternal aunts/uncles</td>
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<tr>
<td>Paternal grandmother</td>
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<tr>
<td>Paternal grandfather</td>
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</tr>
<tr>
<td>Paternal aunts/uncles</td>
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</table>

I do not know my family history

Is there anything else I should know about your child?

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Thank you for completing this extensive health record for your child, your time is appreciated.