DR. CHRISTINE MATHESON, ND

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PEDIATRIC NATUROPATHIC INTAKE FORM

Today's Date:_____
Child's First Name:_____Last Name: _____
Date of Birth (mm/dd/yy): _____Age_____
Gender_____

Who is filling out this form (name and relation)?

_____

_____

CONTACT INFO

NAME: _____ Relation:_____
Address _____
_____
_____

PHONE: _____
WORK:_____
OTHER:_____
EMAIL:_____

Whom does the child live with? _____
Other health care providers:

1. _____

Specialty:_____Phone:_____

2. _____

Specialty_____ Phone:_____

What are the child's health concerns, in order of importance?

1. _____

2. _____

3. _____

4. _____

5. _____

MEDICAL HISTORY

How would you describe your child's general state of health?

_____

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

_____
_____
_____
_____
_____
_____

Which of the following has your child had?

(n = never m = mild a = average s = severe)

n m a s impetigo

n m a s mononucleosis

n m a s ear infections

n m a s rubella (german measles)

n m a s measles
n m a s chicken pox
n m a s mumps

n m a s roseola
n m a s scarlet fever
n m a s whooping cough

n m a s strep throat

Does your child have any allergies (medicines, environmental, etc.)?

_____
_____
_____

Please list all current medications (prescription, over-the-counter):_____
_____
_____
_____

Please list all current vitamins, herbs, homeopathics, etc: _____

_____
_____
_____

Please list past prescription medications;

_____
_____

How many times has your child been treated with antibiotics?

_____

Please indicate what immunizations your child has had;

DPT (diphtheria, pertussis tetanus) Haemophilus influenza B Hepatitis B

Polio "Flu" Hepatitis A MMR (measles, mumps, rubella)
Tetanus Booster When? _____

Other

_____

_____

Please indicate if any caused adverse reactions

_____

What screening tests has your child had, if any? (blood, hearing, vision, etc.)

_____

_____

_____

PRENATAL HEALTH

1. What was the health of the parents at conception?
   Mother: Poor Fair Good

   Father: Poor Fair Good

2. What was the health of the mother during the pregnancy?
   Poor Fair Good Excellent

3. What was the mother's age at child's birth? _____

4. Did the mother receive prenatal medical care? Y N

5. 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_____

Did the mother use any of the following during the pregnancy?
Natural Supplements or Vitamins:

_____

Prescription medications:_____

Over-the-counter medications:_____

Tobacco Alcohol Recreational drugs: _____

BIRTH HISTORY

Term length: Full Premature: _____ wks Late: _____ wks
Length of labour: _____Weight at birth_____
Any complications?

_____

_____

Was the birth:

Vaginal C-section Induced Forceps Anaesthesia used

Did the child experience any of the following at or shortly after birth?
Jaundice Rashes Seizures Birth Injuries:

_____

Birth defects

_____

_____

Other

_____

DIET

How was your infant fed? Breast fed and how long? _____

Formula Milk/Soy/Other: _____ Other: _____

Were foods introduced before 6 months? (Please list approximate month and which foods)_____

If foods were introduced at 6 months? Which foods and what order?_____

_____

Did your child ever experience colic? Y N

How severe? mild moderate severe

Does your child have any food allergies or intolerances? Please list.

_____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

Describe a typical day's diet;
Breakfast_____
Lunch_____
Dinner_____

Snacks_____

_____

Amount of Water intake daily:_____

Other Beverages (and total quantity):_____

HEALTH AND DEVELOPMENT

How was your child's health in the first year? Poor Fair Good Excellent

At what age did your child first;
Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern

_____

_____

How would you describe your child's temperament?

_____

_____

How would you describe your child's behaviour at daycare or school?_____

_____

FAMILY HISTORY

Indicate if a close relative (parent, sibling) has had any of the following and list who:

Allergies: _____ Asthma: _____ Diabetes:_____
Birth Defects: _____ Kidney Diesease: _____

Juvenile Arthritis: _____ Other: _____ ___

(I don't know the family medical history)

Do either of the parents have a chronic illness? Y N

Please describe:

_____

ENVIRONMENT

Is the child in school, daycare, home care, or other?_____

What are your child's favourite activities?

_____

Does the child exercise regularly? Y N

How much, how often? _____

How much television does your child watch? _____hours a week

How often does your child read (not for school), or how often does someone read to your child? Daily Several times a week Weekly Less than weekly

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N
How is the child's home heated?
_____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)?
Please describe:_____

How would you describe the emotional climate of the child's home?
_____

Is there anything that you feel is important that has not been covered?
_____
_____
_____
_____
_____
_____
_____
_____

Informed Consent to Naturopathic Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. The principles and practices of naturopathic medicine and other supportive therapies are used to assist the body's own ability to heal and to improve the quality of life and health through natural means. Naturopathic doctors assess the whole person by taking into consideration the physical, mental, and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to promote healing. The naturopathic doctor will conduct a thorough case history and a screening physical exam may be used as well specific laboratory tests being suggested as part of the treatment work-up. Depending on your case, the physical may include, with your consent, more specific examinations such as breast or external genital exams.

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With your consent, other practitioners you choose to work with within the Vital Physiotherapy clinic will have access to your case history in order to improve the quality of your care while maintaining complete confidentiality.

It is very important that you inform your naturopathic doctor of any disease you are suffering from, any allergies you have, and any medications or over the counter drugs that you are currently taking. Please advise your naturopathic doctor if you are pregnant, suspect you are pregnant, or if you are breastfeeding.

Statement of Acknowledgement

Printed name (or Patient's Parent /Guardian)_____

As a patient, I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As Vital Physiotherapy is a collaborative health clinic, I give permission for all the practitioners that are working with me at this clinic to communicate about my case for my benefit. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.
I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

I UNDERSTAND:

My naturopathic doctor does not guarantee treatment results. My naturopathic doctor will explain to me the exact details of any treatments provided and will answer any questions I may have. Costs above those included in the naturopathic visit fee will be

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explained prior to engaging in any treatment or diagnostic test that involves additional fees. I am free to withdraw my consent and to discontinue treatment at any time.

Name of Child:_____

Parent/Guardian Name:_____

Parent/Guardian Signature:_____Date (mm/dd/yy)_____

Consent for the Collection, Use, and Disclosure of Personal Information

We understand the importance of protecting the privacy of your personal information and are committed to collecting, using, and disclosing your personal information responsibly. All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. As such, we strive 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 legislation and privacy protection protocols.
- Our privacy protocols comply with privacy legislation, the standards of our regulatory body, and the law.

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

- To assess your health needs and advise you of treatment options.
- To communicate with you and remind you of upcoming appointments.
- To communicate with all other health care providers in your health care team.

- To allow us to efficiently follow-up for treatment, care, and billing.
- To assist in complying with all regulatory requirements and the law, including requirements to advise authorities of child abuse and to report diseases and individuals who may be an imminent threat to themselves or others.
- To invoice for goods and services, process payments, and collect unpaid accounts.

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If a new purpose arises, we will seek your written approval in advance. We will not, under any circumstances, supply your insurer with your confidential medical history. In the event that this kind of request is made, we will forward the information directly to you for review, and for your specific consent.

PATIENT CONSENT:

I have reviewed the above information that explains how my naturopathic doctor will use my personal information. Should the need arise, I agree that my naturopathic doctor can email me and I understand that this is not considered a secure form of communication. I agree that my naturopathic doctor can collect, use, and disclose my personal information for the purposes listed above.

Child's
Name_____

Parent/Guardian Name:_____

Parent/Guardian
Signature_____

Date (mm/dd/yy)_____

PATIENT HEALTH STATUS SCREENING POLICY AND PROCEDURE

For In-Office Visits with Christine Matheson, ND

It is of utmost importance that patients thoroughly read and sign this document with respect and sensitivity for the reasons it has been created.

Dr. Christine Matheson, ND has created the 'Patient Health Status Screening Policy and Procedure' for the purpose of **controlling and preventing the spread of contagious infections to her other patients, to herself and to her family** therefore she appreciates your respect and compliance.

Because as part of her services, Dr. Matheson provides the Arvigo Techniques of Maya Abdominal Therapy with hands-on treatments through her 'Belly Be Well' Program, she wants to be particularly cautious about avoiding coming into contact with or

spreading infection. Dr. Matheson also wants to remain well so she can continue to be in service to her patients and family and doesn't want to unnecessarily be exposed to contagious conditions.

Dr. Matheson has implemented this policy to clearly outline that **she will not see patients for in-office visits IF they have recently experienced or are experiencing the following signs or symptoms due to an acute, contagious and/or infectious cause, for example:**

- **Cough, cold, flu, fever, sore throat, respiratory infection, bronchitis, pneumonia, viral infection, sinus infection or nasal congestion caused by an acute infection**

Dr. Matheson will most certainly continue to see all patients when they are generally "well" and free of any acute, contagious and/or infectious symptoms.

In the event that a patient is experiencing or has recently experienced an acute, contagious and/or infectious illness, Dr. Matheson can offer the below options in an effort to assist you.

- A **phone consultation** to provide you with health recommendations for your acute health symptoms or to review your other main health concerns
- To **Reschedule the appointment** for once the patient is completely recovered and symptoms have subsided.
- A referral to the patient's family doctor if strongly suggested.

*If a patient is not sure if his/her symptoms are contagious and not sure whether or not he/she should attend an in-office visit, it is strongly advised to contact Dr. Matheson at **christine@christinemathesonND.com** to speak with Dr.Matheson directly to assess his/her patient health status to be on the safe side.

I_____ (**print patient /or patient Guardian's name**) have read and understand the above 'Patient Health Status Screening Policy and Procedure' and will respectfully comply with this policy by not attending (or having my child attend) any in-office visits with Dr. Christine Matheson, ND if I (or my

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child) have **recently experienced or am experiencing the following signs or symptoms due to an acute, contagious and/or infectious cause, for example:**

- **Cough, cold, flu, fever, sore throat, respiratory infection, bronchitis, pneumonia, viral infection, sinus infection or nasal congestion caused by an acute infection**

Please answer the following health status screening questions accurately and honestly;

1. Are you or have you (or your child) recently experienced signs or symptoms due to an acute, contagious and/or infectious cause, for example ; cough, cold, flu, fever, sore throat, sneezing, respiratory infection, bronchitis, pneumonia, viral infection, sinus infection or nasal congestion and sneezing caused by an acute infection?

YES or NO (Circle answer)

2. If you (or your child) have recently experienced signs or symptoms due to an acute, contagious and/or infectious cause, how many days have you (or your child) been completely symptom free? _____ days

3. If you (or your child) have recently experienced signs or symptoms due to an acute, contagious and/or infectious cause, did you seek medical attention for these symptoms? YES or NO (Circle answer)

If so, please explain further:

_____

I respect the seriousness of this health status policy and have answered the above questions accurately and honestly.

Print PatientName_____

Guardian Name_____

Guardian Signature _____

Date (mm/dd/yy)_____

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Thank you for your cooperation and for respecting the safety of my health, the health of my other patients and family.

THANK YOU FOR TAKING THE TIME TO COMPLETE ALL ABOVE FORMS

Sincerely, Dr. Christine Matheson, ND

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