RESTORATION HEALTH CLINIC

Dr Julie Durnan, ND | Dr Jennie Weisenburger, ND
Dr Ann Grimwood, ND | Dr Kathleen Mahannah, ND
Dr Tanner Alden, ND | Dr Lyndsey Zigar, ND
Dr Alexandra Power, ND
Jen Cherewaty RAc, TCMP | Dr Carla Cupido, DC

NEW PATIENT INTAKE FORM – CHILD (AGE 0-12)

Please print this form, complete as much as possible, and bring with you on the day of your first appointment to our clinic. We look forward to meeting you.

Child's Name	Date of Birth	Age	Gender
Today's Date	Primary Phone (circle: home / cell / work)	Alternate Phone (circle: home / cell / work)	
How would you prefer to receive appointment reminders?	O Text	O Voicemail	O Email
Mailing Address			
City	Province	Postal Code	
Email Address			
Parent/Guardian Name	Relationship to Child		
Emergency Contact Name / Relationship	Emergency Contact Phone		
Are you currently receiving healthcare at another location/s? Please name other healthcare providers and their role in your medical care:			
How did you hear about us?			

1. Why did you choose to come to Restoration Health Clinic? What do you know about our approach?

2. What **three** expectations do you have for your first visit to our clinic?

3. What is your present level of commitment to make lifestyle changes, if necessary, to treat your child's condition? (Rate from 0-10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. What do you believe are the biggest factors affecting your child's health?

Primary Concerns
List in order of priority. Describe your concerns below if necessary.

Concern Example: Headaches	Onset Example: January 2013
1	
2	
3	
4	
5	

Infant History

Birthplace: Birth Weight: Birth Length:

1. Were there any of the following illnesses or problems during pregnancy?

○ Rubella ○ High blood pressure ○ Excessive weight gain ○ Accident/injury ○ Bleeding
○ Gestational diabetes ○ Pre-eclampsia ○ Eclampsia
○ Any other problems during the pregnancy? (Please describe)

2. At delivery was your baby:

○ Breech ○ Cesarean section ○ VBAC ○ Resuscitated
○ Any other problems with birth or the first days of life? (please describe)

3. Did your baby deliver early? (If so, by how many weeks?)

4. Any problems with the baby's health? (Please describe)

5. ○ Breastfed? (List duration) ○ Formula fed? (List duration) Type of formula:

Any feeding problems? (please describe)

Accident History

Has your child had: ○ Broken bones? ○ Severe burns? ○ Poisoning episodes? ○ Cuts needing stitches? ○ Frequent injuries or accident prone?

Your Child's Medical History

Head Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**		
C P ○ ○ Headaches	**C P** ○ ○ Migraines	**C P** ○ ○ Head injury

Ear/Nose/Mouth/Throat/Neck Please check ✓all that apply. ○ Current = C and/or ○ Past = P

C P	C P	C P
○ ○ Impaired hearing	○ ○ Frequent colds or flus	○ ○ Dental cavities or infections
○ ○ Sensitivity to noise	○ ○ Teeth/gum problems	○ ○ Cold sores
○ ○ Frequent ear infections	○ ○ Copious saliva	○ ○ Mercury (silver) amalgam fillings
○ ○ Nose bleeds	○ ○ Mouth ulcers	○ ○ Root canals
○ ○ Stuffiness	○ ○ Teeth grinding	○ ○ Regular dental cleanings
○ ○ Loss of smell	○ ○ Hoarse voice	○ ○ Swollen nodes/glands
○ ○ Hayfever	○ ○ Loss of voice	

Eyes Please check ✓ all that apply. ○ Current = C and/or ○ Past = P

C P	C P	C P
○ ○ Glasses or contacts	○ ○ Blurred vision	○ ○ Eyes watery or dry
○ ○ Colour blind	○ ○ Eye pain/strain	○ ○ Bloodshot eyes
○ ○ Recent change in vision	○ ○ Sensitivity to light	○ ○ Puffy eyes

Respiratory Please check ✓ all that apply. ○ Current = C and/or ○ Past = P

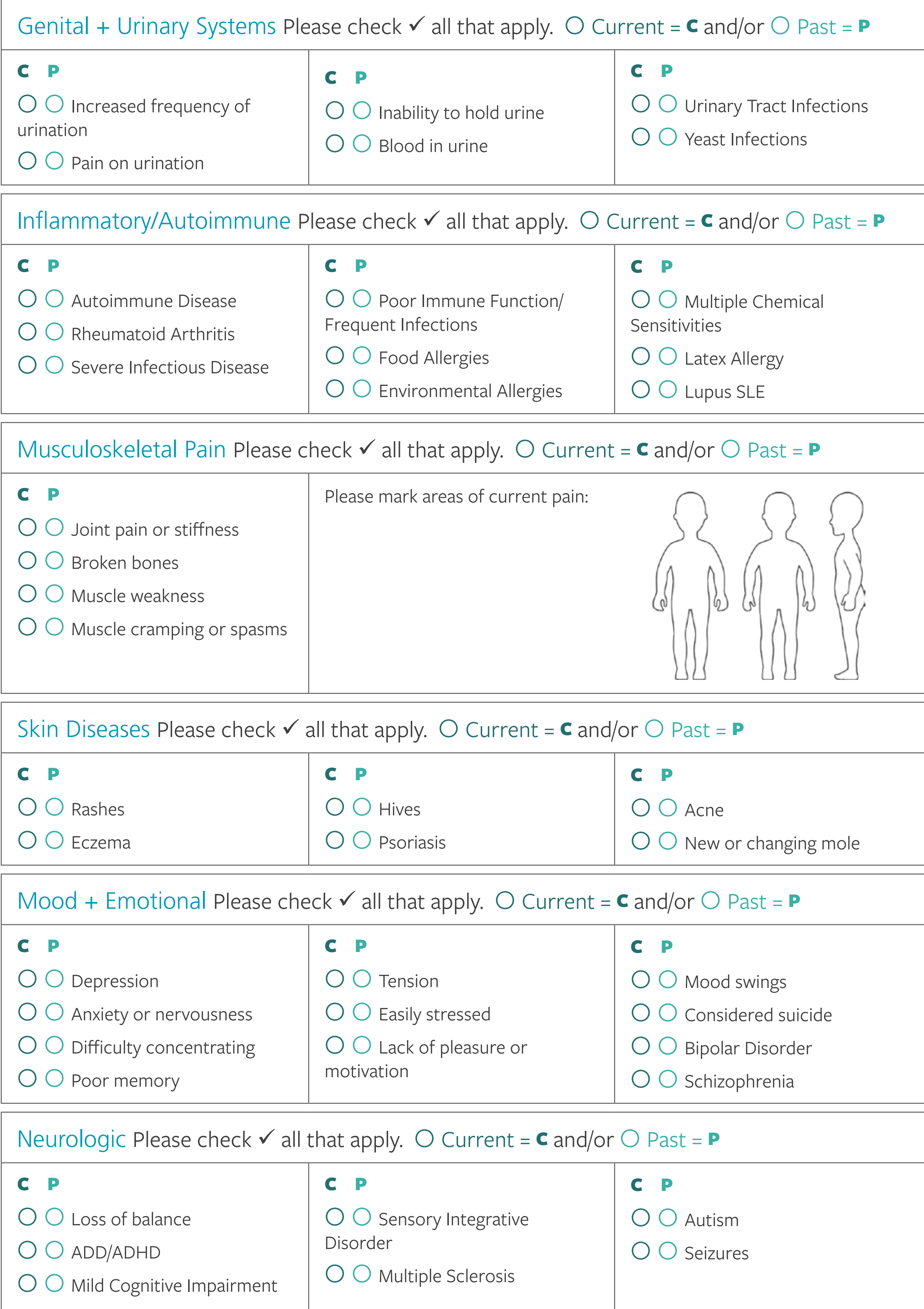
C P	C P	C P
○ ○ Cough	○ ○ Difficulty breathing	○ ○ Bronchitis
○ ○ Mucous/phlegm	○ ○ Asthma	○ ○ Pneumonia
○ ○ Wheezing		

Cardiovascular + Blood Please check ✓ all that apply. ○ Current = C and/or ○ Past = P

C P	C P	C P
○ ○ Heart disease	○ ○ Valve prolapse	○ ○ Cold hands/feet
○ ○ Rheumatic Fever	○ ○ Easy bleeding or bruising	○ ○ Anemia
○ ○ Arrythmia		

Gastrointestinal Please check ✓ all that apply. ○ Current = C and/or ○ Past = P

C P	C P	C P
○ ○ Constipation	○ ○ Nausea	○ ○ Irritable Bowel Syndrome
○ ○ Diarrhea	○ ○ Vomiting	○ ○ Crohn’s
○ ○ Change in thirst	○ ○ Black or dark tarry stools	○ ○ Ulcerative Colitis
○ ○ Change in appetite	○ ○ Blood or mucous in stool	○ ○ Gastitis or Peptic Ulcer
○ ○ Abdominal cramping or pain	○ ○ Undigested food in stool	○ ○ GERD
○ ○ Burping	○ ○ Jaundice (yellow skin)	○ ○ Celiac Disease
○ ○ Flatulence	○ ○ Gallbladder disease	



Genital + Urinary Systems
Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C P	C P	C P
○ ○ Increased frequency of urination	○ ○ Inability to hold urine	○ ○ Urinary Tract Infections
○ ○ Pain on urination	○ ○ Blood in urine	○ ○ Yeast Infections

Inflammatory/Autoimmune
Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C P	C P	C P
○ ○ Autoimmune Disease	○ ○ Poor Immune Function/ Frequent Infections	○ ○ Multiple Chemical Sensitivities
○ ○ Rheumatoid Arthritis	○ ○ Food Allergies	○ ○ Latex Allergy
○ ○ Severe Infectious Disease	○ ○ Environmental Allergies	○ ○ Lupus SLE

Musculoskeletal Pain
Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C P	
○ ○ Joint pain or stiffness	Please mark areas of current pain:
○ ○ Broken bones	
○ ○ Muscle weakness	
○ ○ Muscle cramping or spasms	

Skin Diseases
Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C P	C P	C P
○ ○ Rashes	○ ○ Hives	○ ○ Acne
○ ○ Eczema	○ ○ Psoriasis	○ ○ New or changing mole

Mood + Emotional
Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C P	C P	C P
○ ○ Depression	○ ○ Tension	○ ○ Mood swings
○ ○ Anxiety or nervousness	○ ○ Easily stressed	○ ○ Considered suicide
○ ○ Difficulty concentrating	○ ○ Lack of pleasure or motivation	○ ○ Bipolar Disorder
○ ○ Poor memory		○ ○ Schizophrenia

Neurologic
Please check ✓ all that apply. ○ Current = **C** and/or ○ Past = **P**

C P	C P	C P
○ ○ Loss of balance	○ ○ Sensory Integrative Disorder	○ ○ Autism
○ ○ ADD/ADHD	○ ○ Multiple Sclerosis	○ ○ Seizures
○ ○ Mild Cognitive Impairment		

Behaviour Please check ✓ all that apply. ◯ Current = C and/or ◯ Past = P		
◯ ◯ Unusual play ◯ ◯ Doesn't do for self ◯ ◯ Very cautious ◯ ◯ Hides knowledge/skill ◯ ◯ Lost in thought/unreachable ◯ ◯ Poor focus, attention ◯ ◯ Sits for a long time, staring ◯ ◯ Poor sharing ◯ ◯ Rejects help ◯ ◯ Curious/gets into things ◯ ◯ Destructive	◯ ◯ Hyperactive ◯ ◯ Constant movement ◯ ◯ Melt downs ◯ ◯ Tantrums ◯ ◯ Self mutilation ◯ ◯ Runs away ◯ ◯ Jumps when pleased ◯ ◯ Flaps arms ◯ ◯ Head banging ◯ ◯ Falls, gets hurt running, climbing	◯ ◯ Does opposite of asked ◯ ◯ Teases others, bullies ◯ ◯ Shrieks ◯ ◯ Toe walking ◯ ◯ Arches back with crying or bright lights ◯ ◯ Licking ◯ ◯ Rhythmic rocking ◯ ◯ Bites fingers, nails ◯ ◯ Chews on things

Cancer Please describe.

Developmental History

Please indicate the approximate age in months for the following milestones: (example: walking 14 months or check the box for never)

Sitting up ________ months ◯ Never

Pulled to stand ________ months ◯ Never

Walked alone ________ months ◯ Never

First words _______ months ◯ Never

Lost language _______ months ◯ Never

Crawl ________ months ◯ Never

Potty trained ________ months ◯ Never

Dry at night _______ months ◯ Never

Spoke clearly _______ months ◯ Never

Lost eye contact _______ months ◯ Never

Family Medical History

List any diseases for each family member. Please include family member's age and cause of death if no longer alive.

Mother	Maternal Grandmother	Maternal Grandfather
Father	Paternal Grandmother	Paternal Grandfather
Siblings		

Vaccinations

If relevant, attach a copy of your child's vaccination record.

1. Is your child up to date with vaccinations? ◯ Yes ◯ No
2. Do you feel vaccinations have had an impact on your child's health? ◯ Yes ◯ No

Stress/Coping

1. Has your child experienced any major life changes that may have impacted his/her health? ◯ Yes ◯ No
2. Has your child ever experienced any major losses? ◯ Yes ◯ No
3. Has your child ever seen a counsellor? ◯ Yes ◯ No
4. Does your child have a favourite toy or object? ◯ Yes ◯ No
5. Has your child ever experienced a significant trauma? ◯ Yes ◯ No

Sleep/Rest

1. Average number of hours your child sleeps per night ________
2. Does your child have trouble falling asleep? ◯ Yes ◯ No
3. Does your child feel rested upon awakening? ◯ Yes ◯ No
4. Does your child snore? ◯ Yes ◯ No
5. Who are the main people who care for your child?

Surgeries & Hospitalizations Include when, where and injuries.

Diet & Lifestyle

1. What does your child typically eat in one day?

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

2. What are the least healthful foods in your child's diet?

3. Does your child drink: ◯ Water ◯ Juice ◯ Pop ◯ Milk (note if dairy alternative) :

5. Do you have any questions or concerns about your child's diet?

Medications & Supplements:

Medication (Over the counter / prescription)	Dosage & Frequency
Supplements (Including brand name)	Dosage & Frequency

Allergic reaction/intolerances to Medications Example: penicillin causes hives

Allergic reaction/intolerances (Foods, Environment) Example: cow's milk causes bloating

Have you or your child had any prior experiences with natural medicine? If yes, please describe:

AUTHORIZATION AND CONSENT

Dear Patient,

Thank you for your interest in retaining Restoration Health Clinic Inc. (“Restoration”) to provide you or your child with naturopathic care and guidance to support and improve your or your child’s health and well being.

Prior to Restoration agreeing to accept you or your child as a patient and provide you or your child with its naturopathic services, Restoration requires that you review and agree to the terms and conditions contained in this letter agreement.

Throughout this letter agreement the terms “you”, “I”, “me” and “my” shall refer to you the undersigned individual or your child (as applicable), specified at the end of this letter agreement.

I wish to retain Restoration to provide me or my child with naturopathic care, treatment and guidance to support and improve my or my child’s health and well being (the “Treatment”). I understand and agree that prior to Restoration providing me the Treatment, Restoration requires, and is relying on, my consent and the following representations, warranties and covenants:

1. I understand and acknowledge that Restoration employs naturopathic doctors (“ND”) to provide the Treatment and does ***not*** employ traditional medical doctors to provide the Treatment. For the purposes of providing the Treatment, I consent to one or more of Restoration’s NDs or staff to carry out the following tasks:

    (a) take a thorough case history and conduct a screening physical examination; which may include a breast exam, gynaecological, rectal, prostate, and blood and urine samples as required; and

    (b) recording your personal medical information and sharing your personal medical information with Restoration Staff and other medical professionals solely in connection with your Treatment and subject to strict confidentiality guidelines implemented by Restoration.

2. I understand and acknowledge that Restoration employs the use of Botanical Medicine, Traditional Chinese Medicine, Acupuncture, Bony manipulations, Massage, Hydrotherapy, Nutrition, Lifestyle Counseling, Psychological counseling, Homeopathy, Intramuscular injections, intravenous injections, Pharmaceutical prescriptions, or Vaccinations in providing the Treatment.

3. I represent and warrant that all medical information provided by me to Restoration during my initial health assessment is true and correct. I will advise Restoration as soon as possible of any errors in the medical information I provided to Restoration or any changes to my current health status including any disease or ailments that I may be suffering from, any medication or over the counter drugs that I am consuming and whether I am pregnant, suspect I may be pregnant or am breast-feeding.

4. I hereby acknowledge and agree that Restoration has not made any warranties or representations of any kind to me regarding results that may be achieved from the Treatment. I understand that any results or outcomes arising from the Treatment are individual and may vary from person to person. I understand that the results of the Treatment are not guaranteed and do not expect the ND’s will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the Treatment provided to me by Restoration.

5. I hereby acknowledge and agree that the Treatment may lead to certain unforeseen complications, including but not limited to: aggravation of pre-existing symptoms; allergic reactions to pharmaceuticals, supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations. I also acknowledge that I have the right to accept or reject this medical care of my own free will and choice.

6. I recognize that specific foods, botanicals and medications may create allergic and possible serious reactions, in particular, products containing nuts. I further acknowledge that these allergies may cause me serious bodily harm. I represent and warrant that I have provided to Restoration during my initial health and assessment a list of all items which, to the best of my knowledge, I am allergic or sensitive to.

7. I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. 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 unless so directed by myself or unless law requires it. Notwithstanding, I understand that the Staff and ND's at Restoration are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats or harm to any individual and/or serious threat of suicide involved with my case. I understand that I may look at my medical records at anytime and can request a copy of it by paying the appropriate fees. I understand that information from my medical records may be analyzed for research purposes and that my identity will be protected and kept confidential.

8. In consideration for Restoration agreeing to provide me with the Treatment, I hereby irrevocably and unconditionally release and forever discharge Restoration, its directors, officers, employees, agents and contractors and Restoration's successors, assigns, heirs and legal representatives (all such persons and entities being called the "Released Parties") of and from all manner of actions, causes of action, suits, demands, debts, accounts, covenants, contracts, damages and all other claims whatsoever, which the undersigned or its successors or assigns ever had, now has or may in the future have against any of the Released Parties for or by reason of any cause, matter or thing related to or arising from the Treatment provided to me including (but not limited to) any bodily harm or injury sustained by me or any other person. I further acknowledge and agree that the Released Parties will in no way be responsible for any bodily harm or injury suffered by me as a result of the Treatment.

9. I further agree and acknowledge that Restoration has the right to cease providing the Treatment to me at any time effective immediately, without any compensation to me whatsoever. This letter agreement will cover the entire course of my Treatment and I am free to withdraw my consent and to discontinue participation Treatment at any time.

10. Please note we require 48 hours notice for all cancelled appointments or the full visit fee will be charged.

We thank you for the opportunity of being able to work with you on improving your health, and wellbeing.

Yours truly,

RESTORATION HEALTH CLINIC INC.

I hereby certify that the representations and warranties contained in this letter agreement are true and correct and I hereby agree to the foregoing covenants and terms and conditions.

I hereby consent to ________________________________ [enter name of ND] on behalf of Restoration and Restoration Health Clinic Inc. to provide me or my child with the Treatment described above.

Dated the _____ day of ___________, 201___.

Print Name of Patient (if patient is a minor, print name guardian and relationship of guardian to patient):	
Signature of Patient (or signature of guardian if applicable):	
Address of Patient (and address of guardian if applicable):	
Telephone Number:	Email Address: