Dr. Erica Thomson, ND
Vital Links Integrated Health Professionals
745 Bridge St W, Waterloo, ON 519 725-1300
(519) 725-1300

Personal Child History (0-13 years old)

Child's name ______________________________________ Sex ________ Age _________

Child's date of birth _____________ (dd/mth/yy)

Child's address _______________________________ City ____________ Postal ________

Parents/Guardian name(s) ____

Address (if different)________________________ City _____________ Postal _________

Phone (home)______________________________ (work)________________________
Okay to leave a message? Yes/No

Email ____

Emergency contact___________________________________Relation_________________
Phone_____________________

Siblings ____
(names & ages)

Family Dr./Pediatrician ____

Phone ________________ Address ____

Midwife/Obstetrician (child under 2) ____

Phone ________________ Address ____

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Confidential Health History - Child

What are your major health concerns?

____

____

When did this problem begin? __________________________
What medications are you trying? __________________________
What treatments have you tried? __________________________

Are there any other concerns about your child's health?

____

____

Have any of the above conditions been diagnosed? Y / N
If so, by whom?________________________________

Please list any medications, past or present (including over the counter)

Taken in the past ________________ Presently ________________

____________________ ____________________

____________________ ____________________

FAMILY HISTORY

What was the age of the parents of this child at the time of conception?
Mom _________ Dad __________

What was their level of health?
Mom ______________________ Dad ______________________

	Age if Living	Age at Death	Cause of Death	Health Concerns
Sister(s)				
Brother(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Any other blood relatives with notable health conditions (i.e. Cancer, heart disease, stroke etc.)				

Please check any of the following that pertain to your immediate family:

Allergies		Arthritis		Asthma		Autoimmune diseases	
Birth defects		Bleeding disorders		Cancer		Deafness	
Depression		Diabetes		Eczema		Heart disease	
Hepatitis		Herpes		HIV/AIDS		Hypertension	
Kidney disease		Mental illness		Peptic Ulcer		Thyroid disease	
Tuberculosis		Visual problems		Other			

If other, please explain: ____

PRENATAL HISTORY

Please check any conditions experienced by mom during pregnancy:

Diabetes		Edema (swelling)		Emotional trauma		Fainting	
German Measles		Herpes		Hypertension		Infections	
Nausea		Physical trauma		Pregnancy Induced hypertension (PIH)		Thyroid Problems	
Vomiting		Weight gain/loss		Other			

If other, please explain: ____

Please indicate any emotional traumas that mom experienced during pregnancy: ___________________________
____

Please list any medications taken during the pregnancy (include over the counter): ___________________________
____
____

Did mom use any of the following during pregnancy?
Cigarettes: Y / N how often? ______________ Alcohol: Y / N how often? ______________________
Caffeine: Y / N Drugs: Y / N If yes, please list: ____

Please list any supplements taken during pregnancy: ____
____
____

How would you describe the pregnancy? ____
____

Was there any history of a complicated pregnancy before the birth of this child? ___________________________
____

BIRTH HISTORY

Length of gestation? 9months _______ Early ___days ___wksLate ___days ___wks
Length of labour? ___________________________
Was labour spontaneous? Y / N If no, how was it induced? ____
Type of delivery? Vaginal _____ C-section _____ Emergency c-section ______
Location of delivery? Home _____ Hospital _____ Birthing center _____ other ___________________________

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Parties present for birth: ____
Any interventions used? Anesthesia ____ Epidural ____ Episiotomy ____ Forceps ____
Vacuum ____ Other____
What was the child's weight at birth? _____________ length? ____________

Please check if any of the following were experience at or soon after your child's birth:

Allergic reactions		Birth defects		Colic		Difficulty feeding	
Fevers		Failure to thrive		Hypoxia		Jaundice	
Meningitis		Rashes		Respiratory difficulties		Seizures	
Unusual weight gain/loss		Other					

If other, please explain: ____

Did your child undergo any of the following interventions? Incubation ____ Medications ____
Respirator ____ Surgery ____ Billi-lights ____ Other _________________________________

CHILD'S HEALTH HISTORY

Does your child sleep through the night? Y / N # of hours _____
What is their napping pattern during the day? ____
Do they suffer from nightmares? Y / N
Does your child have any known allergies? If yes, please list: ___________________________________
____
Have they ever been hospitalized? (reason and dates):____
____

Please check any of the following that pertain to your child:

Allergies		Asthma		Bed wetting		Bladder infections	
Bloody urine		Body/breath odor		Bronchitis		Burning urine	
Chicken pox		Colds		Constipation		Cough	
Cradle cap		Croup		Diarrhea		Ear infections	
Easy bleeding		Easy bruising		Eczema		Emotional trauma	
Eye infections		Fatigue		Fever		Fractures	
Frequent urination		Fungal infections		Gas		Growing pains	
Hair loss		Hearing problems		Lice		Measles	
Meningitis		Mood changes		Mumps		Nausea	
Nervousness		Night sweats		Nose bleeds		Pneumonia	
Physical trauma		Rash		Rheumatic fever		Rubella	
Scarlet fever		Seizures		Sleeping problems		Sore throat	
Stomach flu		Strep throat		Tonsillitis		Unusual fears	
Vision problems		Vomiting		Walking/crawling problems		Whooping cough	
Other							

If other, please explain: ____

Has your child ever traveled outside this country? Y / N Where? ________________________________

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IMMUNIZATION HISTORY

Please indicate approximate dates where possible:
Measles, Mumps, Rubella (MMR): _______________ Polio: ____________ Small Pox: _____________
Influenza: ____________ Hepatitis: ___________ Chicken Pox: __________
Diphtheria, Pertussis, Tetanus (DPT): ____________ Other: ______________
Please check if any adverse or odd reactions?

Fever		Excessive crying		Pain		Swelling	
Joint pain		Limping		Mood changes		Rash	
Loss of appetite		Vomiting		Insomnia		Other	

If other, please explain: ____

NUTRITIONAL HISTORY

Was your child breastfed? If yes, for how long? ____
If no, please indicate what food was used and include brand: _____________________________
What was the first liquid introduced to your child after this (excluding water)? _______________

Please make a brief list of solid foods in the rough order of introduction:

FOOD	**AGE OF INTRODUCTION**
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Did you notice any adverse reaction to the above mentioned or any other foods?
____
Is your child a vegetarian? Y / N
How would you describe your child's eating habits? ____
____

Please give a rough outline of your child's daily diet:
Breakfast: ____
Lunch: ____
Supper: ____
Snacks: ____
Water intake: ____
Other fluids: ____
Nutritional Supplements: ____

SOCIAL HISTORY

How would you describe your child's temperament? ____
____
How does your child interact with other people? Adults? _____________________________________
Other children? ____
Have they experienced any emotional traumas? ____
____
How do they handle stress? ____

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How does your child express their emotions?

How would you describe your child's performance at school?

How do you think other people would describe them?

Have you ever noticed any behavioral problems at school/daycare/sitters?

Does your child take part in any extracurricular activities?

HOME ENVIRONMENT

How many people live in your home?
Are there any smokers in your home? Y / N
Do you have any pets?
How old is your home, approx.?
How is your home heated?
How would you describe the emotional climate in this child's household? (I know this is a tough question, please just give me your best idea)

Is there anything else you would like to tell me about your child?

Any other comments?

Thank you for taking the time to fill in this lengthy questionnaire. It will be a valuable resource for us as well as a great time saver in your first appointment. Looking forward to seeing you in the near future.

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Privacy Form for Dr. Erica Thomson, ND
At Vital Links Integrated Health Professionals

PATIENT CONSENT FORM FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collection, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

Erica Thomson acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what our clinic is doing 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 and standards of our regulatory body, the College of Naturopathic Doctors of Ontario (CONO).

How Our Clinic Collects, Uses and Discloses Patients' Personal Information

Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our clinic is using and disclosing your information.

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

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you any pertinent information and mailings
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the *Drugless Practitioners Act*
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this clinic to comply with all regulatory requirements

- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale

By signing this consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above.

Patient Consent

I have reviewed the above information that explains how your clinic will use my personal information, and the steps your clinic is taking to protect my information.

I agree that Dr. Erica Thomson, ND via Vital Links Integrated Health Professionals can collect, use and disclose personal information about ____________________________ as set out in the information about the clinic's privacy policies.
(**patient name)**

________________________________ signature

________________________________ print name

________________________________ date

________________________________ signature of witness

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Informed Consent

Welcome to my office. By coming in today you have made a commitment to your health. I hope you enjoy your experience with naturopathic medicine as we work together to help you attain your full health potential.

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, and spiritual aspects of the individual.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease, and promote health.

Botanical Medicine is the use of plant-based medicine that involves herbal teas, tinctures, capsules and other forms of herbal preparations to assist the body as it moves towards health and healing.

Homeopathy is a form of medicine based on the Law of Similars – that is, the use of tiny doses of the very substance that causes symptoms in a healthy person will eliminate those symptoms in a sick person. These tiny doses are used to stimulate the body's ability to heal itself.

Asian Medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at any of the hundreds of specific points on the body.

Physical Therapies refer to the use of hands-on techniques such as soft tissue manipulation, cranial sacral therapy, and hydrotherapy, which is the use of hot and cold water to stimulate the immune system and improve circulation.

Lifestyle counseling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visit, your Naturopathic Doctor will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take blood or urine samples.

Even the gentlest therapies have the potential to cause adverse reactions under certain physiological conditions. This depends greatly on the individual and the extent of the illness. To help reduce this possibility, it is very important that you inform your Naturopathic Doctor of any and all disease processes that you are suffering from; any medications (prescription or over-the-counter) that you are taking; if you are pregnant, suspect you are pregnant or are actively attempting to become pregnant, or are breastfeeding.

Potential health risks associated with Naturopathic Medicine may include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process.
- Allergic reactions to supplements or herbs.
- Pain, bruising or injury from venipuncture or acupuncture/cupping/bodywork.

______ Initials — 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 without my consent, unless required by law.

______ Initials — I understand that Dr. Thomson will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. I consent to diagnostic and

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therapeutic procedures mentioned above, except for (please list any exceptions):

______ Initials — I understand that any treatment or advice provided to me by Dr. Erica Thomson is not mutually exclusive of any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider.

______ Initials — I understand that I am at liberty to seek or continue to seek medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. Dr. Erica Thomson has not suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

______ Initials — I understand that I may purchase recommended medicines or supplements from the dispensary of Dr. Thomson OR any pharmacy/retail store of my choice.

______ Initials — I understand that email use is strictly limited to answering simple questions about a given treatment plan and is not allowed as a means of diagnosing or addressing new concerns or for communicating lab results. Email is not guaranteed to be secure or confidential and I knowingly accept this risk.

______ Initials — I understand the fee schedule as stated below and I agree to pay my account in full at the time of each visit or treatment, including fees for services, lab testing, supplements/remedies, administrative fees.

______ Initials — **If I am unable to keep my appointment, I must give advance notice of 2 business days in which case no charge will be applied. Appointments missed without notification will be subject to the full visit cost. Charge for cancellation of an initial appointment with less than 48 hours notice is $85 and $50 for a follow up appointment.**

Cost of consultation only:_

Adults: Initial Visit (60-90min) $190; 60 min follow up: $140
Children (under 13): Initial visit (60mins): $140; 60 mins follow up: $140;
45 mins follow up: $110
Acute 15 min visit/ 15 min Phone consult: $40

I have read and understand the above-stated policies and information. I voluntarily intend this consent form to cover the entire course of treatment for my present conditions. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): ________________________________**Date:**___________

Signature of Patient (or Guardian): ____

Signature of Naturopathic Doctor:____