Dear Parent/Guardian,

Thank you for your interest in Naturopathic Medicine. You have just taken an important step towards optimizing your child's health. It is essential to remember that you need to be patient to see changes. Just as it probably took quite some time for your child's condition to develop, it may also take up to several months to notice significant improvements.

Please fill out these new patient forms for your child (under the age of 12) and bring them to your first visit. These forms include the child intake form, and consent form. Please note that the intake form asks for your email address. This will be used only for the purposes of electronic appointment and supplement pick up reminders, as well as periodic patient emails regarding relevant health and office information. The information you share on the intake and during all appointments will be kept confidential and will not be shared with anyone else, unless your written consent is given to do so.

The first visit will be approximately 60 minutes in length. It will involve taking a detailed history, performing a physical exam, and getting started with a treatment plan aimed towards helping to address the root cause(s) of your child's symptoms. Follow up visits are typically 4-6 weeks after the initial visit, but may be scheduled more frequently depending on your child's particular condition. The optimal treatment plan will be discussed with you at each visit.

Any supplements prescribed at the visits can be purchased from Maple Shores Health Centre, a pharmacy, a health food store or a medical supply company **of your choice**.

Please note that payment is due at the end of each visit. For your convenience we accept Visa, Mastercard, Debit, cash and cheque. If you are unable to make a scheduled appointment, please give at least 24 hours' notice, so that time can be made available to another patient. If less than 24 hours' notice is given, you will be charged the full appointment fee for the scheduled visit.

Maple Shores Health Centre is located at the northwest corner of Goderich Street (Hwy 21) and Mill Street in Port Elgin. Free street parking is available on all of the downtown streets. There is also a free public parking lot off of Elgin Street (one street north of Mill Street), behind the Port Elgin Library, that is a short walk to the clinic.

If at any time you have questions or concerns about your child's treatment, please feel free to voice them during the visits, contact the office at (519) 832-4500, or email me at jennifer@mapleshores.ca. I look forward to working together with you to help you enjoy long lasting improvements in your child's health.

Yours in health,

Dr. Jennifer Haessler, BScH
Naturopathic Doctor

MAPLE SHORES HEALTH CENTRE

Child Intake

Child's Name:_____ Date of Birth: _____ Age: _____ Gender: ☐M ☐F

Who is filling out this form? Name: _____ Relationship to child: _____

Contacts (in order of preference)

1. Name: _____ Home Phone: _____ Work: _____

Address:_____ City:_____ Postal Code:_____

Email:_____ *Do you consent for your email to be used for the purposes of appointment reminders and occasional emails regarding relevant office and/or health information? You may contact the office at any time to withdraw your consent.* ☐ ***YES*** ☐ ***NO***

Relationship to Child: _____

2. Name: _____ Home Phone: _____ Work: _____

Address (if different than above):_____City:_____ Postal Code:_____

Relationship to Child: _____

Whom does the child live with? _____

Other health care providers:

Name:_____ Designation:_____ Phone:_____

Name:_____ Designation:_____ Phone:_____

How did you hear about Maple Shores Health Centre or the practitioner?: _____

THIS IS A CONFIDENTIAL MEDICAL RECORD AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT FOLLOWING APPROPRIATE WRITTEN AUTHORIZATION.

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

1. _____

2. _____

3. _____

Has your child seen any specialists? Yes No If yes, please indicate name of doctor and year of visit.

_____

_____

Please indicate any serious conditions, illnesses, injuries, and/or any hospitalizations you child has experienced, along with approximate dates: _____

_____

_____

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MAPLE SHORES HEALTH CENTRE

MEDICAL HISTORY:

Please list all **CURRENT prescribed medications your child is taking**.

Medication	Dose	How long taken	Reason for Use

How many times has your child been treated with antibiotics? _____

Please list any **over the counter medications your child is presently taking** (e.g. Aspirin, Tums).

Medication	Dose	How long/often taken	Reason for Use

Please list any **vitamins/minerals, herbs or homeopathic remedies that your child takes on a regular basis**:

Supplement	Dose	How long taken	Reason for Use

Please list all sensitivities/allergies/reactions to the following:

Drugs:_____

Environment:_____

Food:_____

Immunizations (please check):

- ☐ Flu Shot
- ☐ Diptheria/Pertussis/Tetanus
- ☐ Measles/Mumps/Rubella
- ☐ Haemophilus Influenza
- ☐ Chicken Pox
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B

Describe any adverse reactions: _____

Has your child had any of the above diseases? If so, which one(s): _____

Which of the following diseases has your child had?

- ☐ Roseola
- ☐ Impetigo
- ☐ Whooping Cough
- ☐ Scarlet Fever
- ☐ Mononucleosis

Has your child had any of the following tested?

Hearing Tests ☐ YES ☐ NO Vision Tests ☐ YES ☐ NO

Speech ☐ YES ☐ NO Learning Disorder ☐ YES ☐ NO

If yes, please provide details if there were any concerns identified in the testing?_____

_____

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Please check if your child has had any of these concerns:

- ☐ Jaundice as Baby
- ☐ Cradle Cap
- ☐ Eczema or Psoriasis
- ☐ Constipation
- ☐ Finicky Eating
- ☐ Poor Teeth/Cavities
- ☐ Night Terrors/Nightmares
- ☐ Frequent Colds/Sniffles
- ☐ Overly Shy/Social Problems
- ☐ Overweight/Obese
- ☐ Colic
- ☐ Anemia (low iron)
- ☐ Diarrhea
- ☐ Asthma
- ☐ Warts
- ☐ Bed-wetting
- ☐ Tantrums
- ☐ Disobedient
- ☐ Lethargic/Low Energy
- ☐ Diaper Rash
- ☐ Hyperactive/Impulsive
- ☐ Growing Pains/Leg cramps
- ☐ Stomach Aches
- ☐ Fears/Phobias
- ☐ Acne
- ☐ Attention Deficit
- ☐ Ear Infections
- ☐ Has Issues with his/her Appearance
- ☐ Cognitive Problems
- ☐ Strep Throat

Please provide more details, if applicable, if you checked off any of the items above: _____

_____

_____

FAMILY MEDICAL HISTORY:

Relation	Current Age	Health problems	Cause, if deceased
Father			
Mother			
Grandparents			
Siblings			

PRENATAL HEALTH:

What was the health of the parents at conception?

Mother ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

Father ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

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

How was the mother's diet during pregnancy? Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown ☐

Did the mother receive prenatal medical care? Yes ☐ No ☐ Unknown ☐

Did the mother experience any of the following during pregnancy?

☐ Bleeding ☐ Diabetes ☐ High Blood Pressure ☐ Nausea

☐ Vomiting ☐ Thyroid Problems ☐ Physical/ emotional trauma

Other: _____

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Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational Drugs: _____
☐ Prescription medications: _____
☐ Over-the-counter medications: _____
☐ Supplements:_____

BIRTH HISTORY:

Pregnancy Length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Location of birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other: _____

Type of birth: ☐ Vaginal ☐ C-section

Types of Intervention: ☐ Induced labour ☐ Use of forceps ☐ Epidural/anesthesia
☐ Other:_____

Length of Labour: _____ Birth Weight: _____

If the birth was difficult, please explain _____

Did the child experience any of the following at, or shortly after, birth?
☐ Jaundice ☐ Seizures ☐ Colic ☐ Respiratory Difficulties: _____
☐ Birth injuries: _____ ☐ Birth defects: _____
☐ Skin Disorders: _____ ☐ Other: _____

FEEDING HISTORY:

How was your child fed as an infant?
☐ Breast fed: How long? _____ ☐ Formula: Milk / Soy / Other: _____
Please describe any reactions you observed: _____

When was your child first introduced to solid foods, and in what order? _____

_____

If any adverse reactions were noticed, what were they? _____

Please describe a typical day's diet:
Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (and total quantity): _____

What are your child's favourite foods? _____

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What foods does your child strongly dislike?: _____

How much of your food is organic? _____

Is your family's diet: ☐ Omnivore ☐ Vegan ☐ Vegetarian ☐ Other (please define):

Does your child drink caffeine (i.e. pop, tea)? ☐ YES ☐ NO Type: _____ Frequency: _____

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: _____

Is your child in: ☐ school ☐ daycare ☐ homecare ☐ other: _____

If so, how many times a week and for how long? _____

Who spends the most time caring for your child? _____

Child is: Oldest ☐ Middle ☐ Youngest ☐ Only ☐ # Sisters: _____ # Brothers: _____

What are your child's favourite activities? _____

_____

How many hours of sleep does your child get per night? _____

Does your child have any problems associated with sleeping (e.g., trouble falling asleep, waking up, etc.)? _____

Does your child exercise regularly? Yes ☐ No ☐ How much and how often? _____

How much screen time (TV, tablet, computer) does your child usually get? _____ hrs per day

Is your child exposed to second hand smoke? ☐ YES ☐ NO Where?

Is your child frequently exposed to animals? ☐ YES ☐ NO What type? _____

Do any animals sleep with your child? ☐ YES ☐ NO

Does your child interact well with family members & other children? YES ☐ NO ☐

Who, if any person, does your child struggle to act well with? _____

Has your child experienced any bullying at school? YES ☐ NO ☐

What, if any, are the most challenging behaviors you face with your child? _____

_____

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What reward system do you have in place for your child? _____

What are the preferred methods of discipline/correction in your home by each parent? _____
_____

How is your child doing at school? _____

Any particular household stressors that your child has witnessed or gone through?
1._____
2._____
3._____

ENVIRONMENTAL TOXIN EXPOSURE

Has your child ever lived near a refinery or other highly polluted area? _____

Has your child ever lived in a house with lead paint? _____

Has your child ever lived in a house during renovations (i.e. new paint, cabinets, carpeting, etc ? YES☐ NO☐
Did that seem to affect his/her health at all? _____

Do you spray pesticides or herbicides around or in the house, or use other toxic chemicals? _____

Does your child seem sensitive to perfumes, scented products or other odours? _____

Please list any other relevant health/ personal information that you feel is missing: _____
_____
_____
_____

Thank you for choosing the Maple Shores Health Centre for your health care needs.
Helping you live better…now and into the future

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MAPLE SHORES HEALTH CENTRE

INFORMED CONSENT TO TREATMENT OF A MINOR

This is to acknowledge that I, _____,

parent/legal guardian of _____, whose relationship to me is as

a _____, have been informed and understand that:

Naturopathic medicine is the treatment and prevention of disease(s) by natural means. Naturopathic doctors assess the whole person, taking into consideration the physical, mental, and emotional aspects of an individual. A number of different approaches are used: Clinical Nutrition and nutritional supplements, Botanical (Herbal) Medicine, Homeopathy, Traditional Chinese Medicine and Acupuncture, Physical Medicine (Bowen therapy and Hydrotherapy) and Lifestyle Counseling.

Jennifer Haessler, ND will take a thorough personal case history, and perform a screening physical exam before developing and implementing an individualized treatment plan. Certain laboratory assessments may also be required on a case specific basis (i.e. blood, urine, hair and/or stool testing as deemed appropriate to the presenting case). All of this will be discussed with you, prior to any treatment being administered.

Even the gentlest therapies can occasionally cause complications. Some therapies must be used with caution in conditions such as diabetes, heart, liver or kidney disease, and while taking other prescriptive medications.

There are some slight health risks with Naturopathic Medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms or conditions
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles

I, as the parent/legal guardian, understand that I am at liberty to seek or continue medical care from a medical doctor or other health care provider licensed to practice in Ontario. This consent form is intended to cover the entire course of treatment for this child's present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that results are not guaranteed.

I understand that treatment advice will not be given over the phone or via e-mail, unless directly relating to specifics discussed during a clinic visit. I also understand that the Maple Shores Health Centre cancellation policy requires me to cancel and/or reschedule a booked appointment at least 24 hours prior to a given, scheduled appointment. Failure to do so will incur the full visit fee that must be paid at the next visit.

☐ Should I wish for my child to see another practitioner at the Maple Shores Health Centre, I agree to the sharing and dissemination of pertinent medical information between practitioners within the office.

With this knowledge, as parent/legal guardian, I voluntarily consent to the examination and administration of Naturopathic Medical care and treatment mentioned above, except for:

_____

Dated in Port Elgin, ON this_____ day of _____, _____

Guardian's Name: _____

Signature of Guardian: _____

Signature of Witness: _____

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