

CHILD INTAKE FORM

Please take the time to fill in the following information. It provides a basis for further questions during your visit and helps provide insight into your health. All information is for office use only and is strictly confidential, and would only be release with written consent.

Patient Information

Full Name: _____ Date of Birth: _____ Age: _____ Gender: _____
Address: _____ City: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ Parent's Email: _____
Parents Names: _____
Parents' Occupations: _____
Parents' Marital Status: single married common-law separated divorced other: _____
Number of Siblings: _____ Ages: _____ Who lives at home? _____
How did you find out about the naturopathic services at this clinic? If referred please indicate from whom.

Emergency Contact

Full name: _____
Relationship to Patient: _____
Home Phone/Cell: _____

Please List Other Health Care Providers

1. _____	Specialty: _____	Phone: _____
2. _____	Specialty: _____	Phone: _____
3. _____	Specialty: _____	Phone: _____

Current Health Concerns

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

1. _____ 2. _____
3. _____ 4. _____

How do you rate your child's general state of health? poor fair good very good excellent

Comments: _____

Medical History

Current and past diagnosed conditions (incl. year diagnosed)

Current or past illnesses, accidents, or hospitalizations (incl. year):

Allergies or sensitivities (food, drugs, environmental, pets, etc.)

Which of the following immunizations has your child had?

DPP (diphtheria, pertussis, tetanus) Tetanus Booster
 MMR (measles, mumps, rubella) Hepatitis B
 Haemophilus influenza Polio
 Flu Chicken Pox Hepatitis A

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

Have any caused an adverse reaction? _____

Any adverse reactions? _____

Medications and Supplements

List all CURRENT medications (prescribed, over the counter, vitamins, herbs, homeopathics, etc.):

Drug name: _____	Dosage: _____	Length taken: _____
Drug name: _____	Dosage: _____	Length taken: _____
Drug name: _____	Dosage: _____	Length taken: _____
Drug name: _____	Dosage: _____	Length taken: _____

List any medication your child has had an ADVERSE REACTION to in the past. Indicate name, when taken, and the reaction they had: _____

Diet & Lifestyle History

How was your infant fed? Breast-fed: how long? _____ Formula: ___ Milk ___ Soy Other: _____

Did your child ever experience colic? ___ No ___ Yes Your child's appetite is: ___ poor ___ fair ___ good ___ very good

Please list any food allergies & intolerances: _____

What solid foods were started prior to 6 months of age? _____

What will your child eat and drink in a typical 24-hour period? _____

Child's sleep patterns: _____

Does your child: ___ wake early ___ have difficulty falling asleep ___ have nightmares/terrors ___ no sleep problems

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

Indicate whether your child is exposed to or consumes the following (and if so, how much/how often)

Tobacco smoke: _____

Pop & Candy: _____

Pets & animals: _____

Excess stress: _____

Chemicals: _____

How many hours a day does your child:

Play on the computer or video games: _____ Exercise/Play: _____

Read or read to (not for school): _____ Watch television: _____

Birth History

Were there any pregnancy or birth complications? (ie. Breech, gestational diabetes, pre-eclampsia, etc.) _____

Please list all medications taken during pregnancy: _____

___ Full term ___ Premature ___ Late Mother's age at birth: _____ Father's age at birth: _____

Please indicate if any of the following interventions were applied: Length of labour? _____ Jaundice? _____

Induction Forceps Vacuum Extraction C-section APGAR score: _____ Anemia? _____

Epidural Antibiotics Oxytocin/Pitocin Weight: _____ Length: _____

Other: _____

Family History

Indicate if either parent or sibling has had any of the following:

___ Alcoholism ___ Depression ___ Hepatitis ___ Tuberculosis Other: _____

___ Allergies ___ Diabetes ___ Leukemia ___ Heart Disease _____

___ Asthma ___ Epilepsy ___ Pneumonia ___ Hypertension ___ I don't know my child's

___ Cancer ___ Gonorrhoea ___ Syphilis ___ Kidney Disease medical history

Review of Systems: please check if your child has had this in the past.

___ Allergies ___ Cold sores ___ Frequent colds ___ Muscular dystrophy ___ Tonsillitis

___ Asthma ___ Colitis ___ Hives/Rash ___ Mumps ___ Tuberculosis

___ Anxiety ___ Depression ___ High blood pressure ___ Pneumonia ___ Veneral Disease

___ ADHD ___ Diarrhea ___ Hyperactivity ___ Psoriasis Other: _____

___ Austim ___ Diabetes ___ Influenza (flu) ___ Rubella _____

___ Bed wetting ___ Eczema ___ Kidney disease ___ Scarlet fever _____

___ Celiac disease ___ Epilepsy/Seizures ___ Learning disability ___ Schizophrenia _____

___ Cancer ___ Ear infections ___ Measles ___ Sinus problems _____

___ Chicken Pox ___ Epiglottitis ___ Mental disease ___ Stomach ulcer _____

___ Constipation ___ Fatty liver ___ Mononucleosis ___ Strep Throat _____

Dr. Erika Schimek, ND

Doctor of Naturopathic Medicine

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INFORMED CONSENT TO TREAT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Dr. Erika Schimek, ND will take a thorough case history, perform a physical examination, and prepare an individualized treatment protocol. Dr. Erika Schimek, ND is a licensed naturopathic doctor and will adhere to the standards of practice outlined by the governing bodies of the profession. Treatment protocols may include usage of any naturopathic modality, including but not limited to: botanical medicine; nutraceutical supplementation; physical medicine; homeopathy; hydrotherapy; traditional Chinese medicine and acupuncture.

Botanical Medicine: this modality will make use to plant-based medicinal products such as tinctures (alcohol extractions), glycerates (glycerate extractions), decoctions (hot water extractions), infusions (cold water extractions), or supplements. Specific contraindications and adverse reactions will be outlined at the time of prescription. It is possible to have allergic reactions to botanicals, so please inform Dr. Erika Schimek, ND of any known allergies.

Nutraceutical supplementation: this includes minerals, vitamins, enzymes, extracts, and any combination of the above list. It is possible to have an allergic or adverse reaction to nutraceuticals. Please advise Dr. Erika about any known allergies prior to prescription. Unknown reactions are always a risk to novel substances.

Physical medicine: this includes spinal manipulation, stretching and exercise prescriptions, and massage.

Homeopathy: homeopathy is a principle of 'like curing like'. It uses extremely diluted substances that in a strong dose, would produce the symptoms that a homeopathic dose would be used to treat. This type of treatment is very effective in pediatric populations.

Traditional Chinese Medicine & Acupuncture: Eastern medicine can include Chinese herbs as well as acupuncture treatments. The approach with this style is to look for disease patterns in a person with the totality of their symptoms.

Diet and Lifestyle counseling: The foundation of our health is that we are what we eat. Assessing how you nourish yourself as well as how you allow yourself to function is a key aspect of improving health and wellness.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking. Please advise your Naturopathic Doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. There are some risks to treatment by Naturopathic Medicine. These include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain/bruising/injury from acupuncture, fainting or puncturing of an organ with acupuncture needles.

_____ I understand that a record will be kept of the health services provided to me. This record will be
Initials I understand that I may look at the medical record at any time and can request a copy of it by
paying the appropriate fee.

_____ I understand that Dr. Erika Schimek, ND, will answer any questions that I have to the best of her
Initials ability. Because each individual responds differently to treatment, 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. With this knowledge, I voluntarily consent to diagnostic and therapeutic
procedures mentioned above, except for (please list any exceptions): _____

_____ I understand that fees and supplements are to be paid for at the time of the consultation and
Initials visit.

_____ I understand that a fee will be charged (Cost of Visit) for any missed appointments or
Initials cancellations with less than 24 hours' notice.

I have read and understand the above-stated policies and information. I hereby authorize and consent to
naturopathic treatment and examination by Dr. Erika Schimek, ND. I intend this consent to apply to all my present
and future naturopathic care. I understand that I am free to withdraw my consent and to discontinue
participation in these procedures at any time.

FEE SCHEDULE

The following fees are to be acknowledged by the patient.

Initial Consult (Adult)	\$160.00	Failure to cancel an appointment with 24hrs notice will result in a \$50 cancellation fee
Initial Consult (Child)	\$130.00	
Follow-up Appointment: 60 minutes	\$130.00	
Follow-up Appointment: 30 minutes	\$65.00	
Follow-up Appointment: 15 minutes	\$35.00	
Phone consultation: 15 minutes	\$35.00	
Initial Acupuncture Visit	\$80.00	
Acupuncture follow-up	\$65.00	

If patient has not been seen for one year or more, than a 60 minute appointment is required for the subsequent visit.

Signature of Patient or Lawful Guardian

Date Signed