SAGE ELEMENTS
NATUROPATHIC CLINIC

Dr. ColinJ.L Huska, ND
5991 Spring Garden Road, Suite 465
Halifax, NS B3H 1Y6
Phone: 902-406-0100

Date: _____

Child Intake

Child's name: _____ Date of birth: _____ Age: _____ Sex: M __ F __

Referred by: _____ Who is filling out this form (name and relation)? _____

Contacts (in order of preference)

Name _____
Address _____
Phone (Home) _____
(Work) _____
Email (Optional) _____

Relationship to child _____

Name _____
Address _____
Phone (Home) _____
(Work) _____
Email (Optional) _____

Relationship to child _____

Whom does the child live with? _____

Other health care providers (please fill in their name, type of provider, address and phone/fax)

1. _____
_____
_____
_____
Phone: _____
Fax: _____

2. _____
_____
_____
_____
Phone: _____
Fax: _____

3. _____
_____
_____
_____
Phone: _____
Fax: _____

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? Excellent __ Good __ Fair __ Poor __

Please indicate any past serious conditions, illness, accidents or hospitalizations:

1. _____ (Date: _____)
2. _____ (Date: _____)
3. _____ (Date: _____)
4. _____ (Date: _____)
5. _____ (Date: _____)

Which of the following has your child had?

____ Rubella (german measles)	____ Impetego	____ Mononucleosis	____ Ear Infections
	____ Measles	____ Chicken Pox	____ Mumps
____ Roseola	____ Scarlet Fever	____ Whooping Cough	____ Strep Throat

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

Y __ N__ If yes, to what? _____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list past prescription medications.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

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

Please indicate what immunizations your child has had

____ DPT (diptheria, pertussis, tetanus)
____ MMR (measles, mumps, rubella)
____ Haemophilus influenza B
____ Hepatitis A
____ Hepatitis B
____ Tetanus Booster ; When? _____
____ Flu
____ Polio
____ Other: _____

Please indicate if any vaccination lead to adverse reactions: _____

Has your child had any screening assessments (blood, hearing, vision, etc.)?

Y __ N -_ If yes, which ones?

_____ **Prenatal health**

How would you describe the health of the parents at conception?

Mother Poor__ Fair__ Good __ Excellent __ Unknown __
Father Poor_ Fair __ Good __ Excellent __ Unknown __

_

What was the health of the mother during the pregnancy?

Poor __ Fair __ Good __ Excellent __ Unknown __

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

How would you describe the mother's diet during pregnancy?

Poor __ Fair __ Good __ Excellent__ Unknown __

Did the mother receive prenatal medical care? Y __ N __ Unknown __

If yes, what sort of medical care? _____

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?
____ Tobacco
____ Alcohol
____ Recreational Drugs; which ones: _____
____ Prescription Medications; which ones: _____
____ Over the counter meds; which ones: _____
____ Supplements; which ones: _____
____ Other: _____

Birth history

Term length: ___ Full ___ Premature: _____ wks ___ Late: _____ wks
Length of labour:_____ Weight at birth _____
Did you have any complications during labor? Y N In yes, what: _____
Was the birth: ___ Vaginal ___ C-section ___ Induced ___ Forceps ___ Anesthesia used
Did the child experience any of the following at or shortly after birth?
___ Jaundice ___ Rashes ___ Seizures ___ Birth injuries, what? _____
___ Birth defects, what? _____ ___ Other _____

Diet

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

Did you follow a food introduction schedule? Y N

What types of foods were introduced before 6 months?

_____ _____
_____ _____
_____ _____
_____ _____

What types of foods were introduced between 6 and 12 months?

_____ _____
_____ _____
_____ _____
_____ _____

Did your child ever experience colic? Y __ N__ If yes, how severe? Mild __ Moderate __

Severe Does your child have any food allergies or intolerances? Y __ N __ If yes, please list:

_____ _____
_____ _____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)? Y __ N __ If yes please list:

_____
_____
_____
_____

Describe your child's typical daily diet:

Breakfast _____
Lunch _____
Dinner _____
Snack _____
Beverages _____

Health and Development

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

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 and performance at school? (if applicable) _____

Family history

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

___ allergies ___ Kidney Disease ___ Other: _____
___ Diabetes ___ Birth Defects ___ Don't know
___ Asthma ___ Juvenile arthritis

Do either of the parents have a chronic illness? Y __ N __ If yes, please describe : _____

Environment

Is the child in school daycare home care other? Y __ N__
What are your child's favorite activities? _____
Does your child exercise regularly? Y__ N__How much, how often? _____
Does your child watch television? Y__ N__If yes, how much? ____ hrs/day
Does your child read (recreationally)? Y__ N__ If yes, how much? _____
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? Gas Electric Wood Other: _____
Do you know of any toxins or other hazards your child is regularly exposed to? Y __ N__ If yes, what? _____
How would you describe the emotional climate of the child's home? _____

Is there anything you feel is important, that hasn't been covered?

_____
_____
_____
_____

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MUTUAL UNDERSTANDING AND CONSENT TO TREATMENT

The following information is provided to enable our sharing of a common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agreed to the following.

- Information revealed during counseling and discussion sessions is strictly confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor. Your record and the information within will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.

- Naturopathic medical treatments are in no way meant to replace conventional medical care or care from another licensed health practitioner. Please let your naturopathic doctor know if you are being treated by other health care providers. It is your responsibility to disclose changes in your condition, symptoms, contact information or treatments between visits.

- Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction and the use of natural therapeutics for their correction. This may include: physical examination, nutrition, supplementation, homeopathy, botanical medicine, acupuncture/traditional Chinese medicine, hydrotherapy, detoxification techniques, bodywork, counseling, and lifestyle modifications. If at any time the patient wishes to discontinue a particular therapy/treatment they are free to do so.

- The treatment plan will be explained to you, as well as potential side effects of any therapies. You are encouraged to ask any questions you may have. As with any form of medicine, we cannot guarantee the outcome of any treatment offered.

- If you have a serious health problem that requires immediate attention, call your other doctor(s), call 911 or have someone take you to the emergency room. If you notice an adverse effect from one of the components of your health plan, discontinue it and call your doctor and the naturopathic clinic to inform them of what has occurred.

- I agree to pay my full account at the time of each visit for services, cost of supplements/remedies, lab tests or other fees. I am aware that said fees are not covered by MSI.

- CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hours notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for missed sessions without such notification.

- The contact information, health history, and other information that I provided on my intake form are complete and accurate.

I _____ (Print Name) understand and agree to the information on this page and give my consent to treatment. My questions, if any, were answered to my satisfaction.

_____ _____

SIGNATURE of patient or guardian Date

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Fee Schedule and Cancellation Policy

FEE SCHEDULE

Initial Visit - Adult	Up to 90 Minutes	$215
Initial Visit – Student/Senior (>65yo)	Up to 90 Minutes	$190
Initial Visit - Child (<12yo)	Up to 60 Minutes	$165
Subsequent – Adult Subsequent	Up to 45 Minutes	$120
Subsequent - Student/Senior/Child	Up to 45 Minutes	$105
Emergency/Acute Visit	Up to 15 Minutes	$65
Acupuncture Visit	Up to 45 Minutes	$120

NSF Cheques are subject to a $25 fee.

Phone consults may be arranged (depending on circumstances and with the exception of initial visits) with the same fees outlined above.

All payments are due as services are rendered

While fees are not covered by MSI, many insurance companies offer coverage of naturopathic services. Check with your insurance provider for more information.

CANCELLATION POLICY

In naturopathic medical practice, scheduled visits are significantly longer than in other forms of medicine. As such, missed or inappropriately cancelled appointments can account for a significant amount of lost appointment time over the course of the day. We do not overbook patients in this practice to account for missed or cancelled appointments. It is therefore necessary to enforce the following cancellation policy.

You are responsible for the full fee of a missed appointment unless you provide at least 24 hours notice of cancellation.

At this time, we are unable to provide reminder calls. As such, should you need please feel free to call the clinic to confirm your appointment time.

During unusual circumstances, such as illness or bad weather, in the absence of adequate cancellation or attendance, you can request that your appointment be conducted over the phone. Please note, however, normal visit charges will apply.

If you need to cancel or rebook your appointment time, please call 406-0100 at your earliest convenience.

By signing below you acknowledge your understanding of the above listed fee structure and cancellation policy.

Thank you in advance for your cooperation.

_____ _____

Name/Signature Date