FOUNDATION STONE MEDICINE

Dr Sandy Musclow
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PEDIATRIC PATIENT INTAKE

Patient Information:

Name: _____ Date: _____
Age: _____ Date of Birth: _____ Gender: female _____ male _____
Parent 1 Name: _____ Parent 2 Name: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Parent Home Phone: _____ Parent Work Phone: _____
Email address: _____
Dr office where child's health records kept: _____
How did you hear about Foundation Stone Medicine? _____
Reason for visit: _____
_____

MEDICATIONS

	Now	Past
Aspirin		
Tylenol		
Decongestant		
Ibuprofen		
Antibiotics		
Anti-histamine		
Other		

Allergies to medicines or foods:

_____

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MEDICAL HISTORY

CHICKEN POX:		TONSILLITIS (#s):	
MEASLES:		EAR INFXNS (#s):	
MUMPS:		PNEUMONIA:	
RUBELLA:		Other (List):	
SCARLET FEVER:			

Has your child had any of the following tests, please include date, where performed, and the results:

Electroencephalogram	
Psychological Evaluation	
Hearing Tests	
Speech/Language	
Injuries	
Surgeries	
Hospitalizations	

IMMUNIZATIONS

Measles:		Polio:		MMR:		Smallpox:		Diphtheria:	
Mumps:		DPT:		Tetanus:		Influenza:		Other:	

Were there any adverse reactions? Y N What were they? _____

FAMILY HISTORY

Heart Disease:		Mental Illness:		Tuberculosis:		Birth Defects:		Hypertension:	
Arthritis:		Diabetes:		Asthma:		Cancer:		Allergies:	

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____
Mother's age at child's birth: _____

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Mother's health during pregnancy:

Bleeding:		Physical/Emotional Trauma:	
Nausea:		Cigarettes, Alcohol, Drug use:	
Illnesses:		Medications:	
Hypertension/Diabetes:		Thyroid problems:	

BIRTH HISTORY

Term: FULL _____ PREMATURE _____ LATE _____ Weight at Birth _____
Length of Labor: _____ Complications? _____

Did your child have any of the following problems shortly after birth?

Birth defects:	Blue Baby:	Cerebral palsy:	Rashes:	Jaundice:
Birth injuries:	Fever:	Seizures:	Colic:	Other:

Child's sleep patterns in first year: _____
Food intolerances (if any): _____
Feeding: Breast-fed?: _____ How long?: _____ Formula?: _____ Milk/Soy _____
Age began solids: _____ Which foods? _____
Age began: Sitting _____ Crawling: _____ Walking: _____ Talking: _____

SYMPTOMS

Mark Y if current and P for past symptoms:

___ Hives
___ Eczema
___ Bleeding Gums
___ Nose bleeds
___ Acne
___ High fevers
___ Chronic rash
___ Hearing loss
___ Diarrhea
___ Burning of urine
___ Frequent urination
___ Heart murmur
___ Vomiting spells
___ Anemia
___ Stomach Aches
___ Jaundice
___ Easy Bruising
___ Flat Feet
___ Bloody Urine
___ Cries Easily
___ Nervous
___ Sleep issues
___ Night sweats
___ Sensitive to light
___ Body/Breath odor
___ Motion/Car sickness
___ No appetite
___ Sore throats
___ Headaches
___ Frequent Colds

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___ Wheezing
___ Cough
___ Constipation
___ Gas
___ Bleeding Tendency
___ Joint pains
___ Dizzy spells
___ Nightmares
___ Canker sores
___ Unusual fears
___Excessive Fatigue
___ Hair loss

DIET

What foods were introduced before 6 months (please list approximate months as well): _____

_____

6-12 months? _____

Did your child ever experience colic: _____ How severe? _____

Please list any allergies or food intolerances, and the reaction that occurs: _____

_____

What foods does your child insist upon? _____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc)? _____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____

Drinks: _____

ENVIRONMENT

Describe your child's sleep pattern: _____

How would you describe your child's temperament? _____

Is your child in school? _____ What grade? _____ Daycare? _____ Other? _____

How would you describe your child's behaviour and performance in school? _____

What are your child's favorite activities? _____

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Does your child exercise regularly? _____ How much, how often? _____

How much TV/screen time does your child get? _____ hrs/day or week

Does anyone in the child's home smoke, even just outside? Y N

Are there animals in the home? Y N What are they? _____

Thank you for filling this out. I look forward to working with you and your child!

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INFORMED CONSENT FOR TREATMENT

Naturopathic medicine is a distinct system of primary care that addresses the whole body and root cause of illness and disease. It promotes health by assisting the body's own healing mechanisms according to current medical research and ancient healing knowledge. Naturopathic doctors are primary care providers who integrate standard medical diagnostics with a broad range of natural therapies, including clinical nutrition, herbal medicine, acupuncture, homeopathy and counseling. They work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your first naturopathic appointment will generally last 60-90 minutes and may include a physical exam and referral for laboratory tests. Follow-up appointments may range from 15-60 minutes each according to individual health requirements. The first consultation fee is generally $175 to $200 and does *not* include the cost of laboratory testing or prescription items. Follow-up consultation fees are prorated at $150 per hour. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare insurance providers do.

I, _____, as a patient of Dr. Sandy Musclow (ND, MAc, MSc) understand that this form of medical care is based on naturopathic principles and practices. I will inform Dr. Musclow of all health concerns, medications and medical interventions, including over-the-counter drugs and supplements, because safe care requires that I truthfully and completely disclose this information. I will also inform Dr. Musclow if I am pregnant or breastfeeding.

I understand that I am entitled to know about my diagnosis and treatment, including costs, benefits, risks and potential side-effects. I am entitled to know the consequences of *not* accepting treatment and of alternative courses of action. I am encouraged to request more information as needed, and to take an active role in my care. I am aware that I am always at liberty to seek or continue care from another healthcare provider.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs and bruising or injury during acupuncture.

I understand that Dr. Musclow is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at any time. I accept full responsibility for any fees incurred during care and treatment, including a **50% cancellation fee if providing less that 48 hours notice for cancelling appointments** _____ (please initial).

Signature _____ Date: _____

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CONSENT FOR COLLECTION, USE & DISCLOSURE OF PERSONAL HEALTH INFORMATION

Your health privacy is a primary concern. The personal health information you disclose to Dr. Sandy Musclow (ND, MAc, MSc) during your appointments will be handled in accordance with current privacy legislation and standards determined by the naturopathic regulatory body, the College of Naturopaths of Ontario. Personal health information includes identifiable information such as age, gender, family status and health history.

Dr. Musclow and administrative staff of Foundation Stone Medicine will collect, use and disclose information about you for the following purposes:

- TO ASSESS YOUR HEALTH CONCERNS;
- TO PROVIDE HEALTH CARE AND ADVISE YOU OF TREATMENT OPTIONS;
- TO COMMUNICATE WITH OTHER HEALTH PROVIDERS;
- TO ESTABLISH AND MAINTAIN CONTACT WITH YOU;
- TO INVOICE FOR GOODS AND SERVICES, PROCESS CREDIT CARD PAYMENTS; AND
- AS REQUIRED BY LAW.

Administrative staff of Foundation Stone Medicine will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. They will collect, use and disclose your personal health information so as to protect your privacy and the confidentiality of your information.

I have reviewed the above information and authorize Dr. Sandy Musclow (ND, MAc, MSc) and administrative staff of Foundation Stone Medicine to collect, use and disclose my personal health information as outlined above.

Signature _____ Date: _____

Printed Name _____