Women's Balance Wholistic Health

Nadia Houle, B.Sc, R.Ac 780-919-6870

Pediatric Intake Form

Date: _____

Who is filling out this form? (name, relationship): _____

Child's Name: _____ Birthdate: ___/___/___ Age: ____ Male__ Female__
(Last) (Middle)(First) (dd/mm/yy)

Parent's Names: _____ **Occupation:** _____
_____ _____

Contact Information for child's primary caregiver(s) (Who the child lives with):
Name: _____ **Relation:** _____
Address: _____
City: _____ Postal Code: _____
Phone: (home)_____ **Phone:** (work/cell)_____
Email: _____

Contact Information for child's secondary caregiver(s):
Name: _____ **Relation:** _____
Address: _____
City: _____ Postal Code: _____
Phone: (home)_____ **Phone:** (work/cell)_____
Email: _____

EMERGENCY CONTACT:
Name: _____ **Relationship:** _____ **Phone #:** _____

Current Health Care Provider
Family Physician: _____ Phone number: _____

Other medical treatment received: Physiotherapy__ Massage__ Naturopath__ Chiropractor__
Other_____

How did you hear about our clinic?
Phone book___ Walked by the clinic___ Clinic website___ Print advertising___
Brochure___ Facebook___ Referral by: _____

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Prenatal Information

Conditions Mom experienced during pregnancy (e.g. elevated blood pressure, gestational diabetes, bleeding, infections, thyroid problems, nausea, vomiting, bed rest, edema (swelling), fainting, anemia, weight gain/loss, physical trauma):

_____

_____

Tests performed during pregnancy (ultrasound, amniocentesis, sample, triple screen, maternal serum screening, other):

_____

_____

Please indicate any physical or emotional traumas Mom experienced during pregnancy:

_____

Birth History

Term Length: Preterm (37 wks or less) Full-term (38-42 wks) Post-term (42 + wks)

Length of labour: _____

Type of Deliver: Vaginal / C-Section / Breech / Emergency C-Section (Please Circle)

Interventions of Birth (e.g. anesthesia, epidural, episiotomy, forceps, vacuum, other):

_____

Birth injuries: Y/N If Yes please describe: _____

Congenital defects: Y/N If Yes please describe: _____

Birth Weight: _____ Length: _____ APGAR Score (if known): _____

Early complications (e.g. failure to thrive, illness, jaundice, hypoglycemia, respiratory difficulty, meningitis, rashes, seizures, difficulty feeding):

_____

Interventions following birth (e.g. medications, respirator, surgery, phototherapy, other):

_____

Medical History

How would you describe the child's general state of health?: _____

Please indicate any serious conditions, surgeries, illnesses or injuries, and any hospitilizations; along with approximate dates:

_____

Please list past prescription medications:

_____

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How many times has the child been treated with antibiotics?:

_____

Does your child have any allergies (e.g. food, medicines, environmental, etc.)?:

_____

What screening tests has the child had to date (e.g. blood, hearing, vision, etc. including approx. date):

_____

Statement of Consent

I consent to having treatments and procedures from this clinic. I understand that the professional treatment I receive is for the purpose of improving, restoring and/or maintaining my personal health. I further understand that the treatment should not be construed as a substitute for medical examination, diagnosis or treatment. I also understand that I can refuse treatment at any time.

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile, and understand that there shall be no liability on the therapist's part should I forget to do so.

I wish to rely on my practitioner to exercise judgment during the course of treatment, which, based upon the facts then known, is in my best interests. I understand the practitioner may review my medical records and lab reports, but all my records will be kept confidential and will not be release without my written consent.

By voluntarily signing below I show that I have read this consent to treatment, have been told about the risks and benefits of treatments provided by this clinic, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and further conditions for which I seek treatment.

Name: _____ Signature: _____

(Print name of representative if represented by another) (Signature of Representative)

Date: _____

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Privacy Policy

The information received and collected about our clients/patients from their visit is strictly private and confidential. It is used and viewed only by the healthcare professionals and staff employed by Women's Balance Health, unless, in the best interest of the client/patient, a practitioner determines that there is a need to communicate with another person or healthcare professional outside of Women's balance Health (also, Women's Balance Health will not give, share, sell, or transfer any personal information to a third part unless required by law). Under absolutely no circumstances would this communication happen without the signed consent of the client/patient. The client/patient information will be stored both in digital and hard copy format, on Women's Balance Health premises. On occasion, Women's Balance Health may use client/patient information to conduct clinical studies to help us improve upon services provided.

Appointment Policy

Welcome to Women's Balance Health. We are delighted to have you as a patient and look forward to providing you with the highest quality care. In order to optimize your relationship with us, please take a minute to read our appointment policy.

Please plan to arrive for appointments on time. Visits that begin late due to a patient's late arrival will be charged the full visit fee.

Cancellation Policy

We know life can bring unavoidable circumstances that will cause you to change your appointment. In consideration to your therapist and clients on our wait list, please allow 24 hours cancellation notice. We appreciate your thoughtfulness and will do our best to rebook your appointment as soon as possible. There will be a $40.00 cancellation fee charged. This fee may be waived at the discretion of reception &/or management for significant life events and illness.

If you fail to show up for your scheduled appointment without giving any notice, you will be charged for the full cost of the treatment. Health Benefits will not cover this charge.

Statement of Acknowledgement

I, _____ have read, understood and agree to the contents herein;
(print name)

Client Signature: _____ Date: _____