Shelby Worts, BSc, ND Doctor of Naturopathic Medicine
115 Hurontario St., Suite 200 Collingwood, ON L9Y 2L9 ∞ t: 705-444-8300 f: 705-446-1777 www.shelbyworts.com

Child Intake Form

Child's name ________________ Date of birth ____________ Sex M F O

Who is filling out this form? Name ________________ Relationship ____________

How did you hear about our clinic? ◻ Friend or family Who?________________
Advertisement: ◻ PaBIA ◻ On The Bay ◻ Escarpment magazine ◻ KiDZ magazine ◻ Yellow Pages
Other: ________________________________

Contacts (in order of preference)

1. Name ________________ Phone (H) ____________
Address ________________ (W) ____________
________________ (e) ____________
Relationship to child ________________________

2. Name ________________ Phone (H) ____________
Address ________________ (W) ____________
________________ (e) ____________
Relationship to child ________________________

With whom does the child live? ________________________

Other health care providers

1. ____________
____
Phone #____________

2. ____________
____
Phone #____________

3.____________
____
Phone #____________

What are the child's health concerns, in order of importance:

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Child's Medical History

Which of the following conditions has the child had?

- ☐Rubella (German measles)
- ☐Measles
- ☐Chicken pox
- ☐Whooping cough
- ☐Roseola
- ☐Scarlet Fever
- ☐Strep throat
- ☐Mumps
- ☐Impetigo
- ☐Mononucleosis
- ☐Ear Infections
- ☐ Other:____________

Please indicate any serious conditions, illness or injuries, and any hospitalizations or emotional upsets, next to the corresponding age:

Age years	**Event**
0-12 months	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

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

Please list all CURRENT medication; prescription, over-the-counter, vitamins, herbs, homeopathics...
____
____
____
____

Please list all PAST PRESCRIPTION medications.
____
____

How many silver dental fillings were/are in the mouth of:
Child: _______ Mother: _______ Father: _________

How many times has the child been treated with ANTIBIOTICS? ________________________

Which of the following immunizations has the child had?

☐DPT(diphtheria, pertussis, tetanus) ☐Haemophius influenza ☐Hepatitis B
☐Tetanus booster: when? ________ ☐"Flu" ☐Hepatitis A
☐MMR(measles, mumps, rubella) ☐Polio ☐Chicken Pox
☐Other ________________________

Please indicate if any of the above have caused an adverse reaction:
____
____

Has the child had any screening test (i.e. blood, hearing, vision)? ☐Yes ☐No
If yes, please list:
____

Child's Diet

How was the child fed as an infant?

☐Breast-fed: how long? _________ ☐Formula: ☐Milk ☐Soy ☐Other

☐Other: ________________________

Were foods introduced before 6 months? ☐Yes ☐No

If yes, please list:

____

____

What foods were introduced between 6-12 months?

____

____

____

Did the child ever experience colic? ☐Yes ☐No

Quality of colic: ☐Mild ☐Moderate ☐Severe

Does the child have any food allergies or intolerances? ☐Yes ☐No

If yes, please list:

____

____

Does the child have any dietary restrictions (i.e. religious, vegetarian/vegan)? ☐Yes ☐No

If yes, please list:

____

____

Describe a typical day's diet for the child

Breakfast ____________________________________ Snacks _____________________________

Lunch ____________________________________ Beverage type ________________________

Dinner ____________________________________ #Beverages ________________________

Health and Development

How was the 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 the child's sleep pattern:

____

Describe the child's temperament:

____

Describe the child's behaviour and performance at school:

____

____

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 health of the mother during the pregnancy?
☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

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

What was the mother's age at the time of this child's birth? ___________

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

Did the mother experience any of the following during the pregnancy:
☐Bleeding ☐High Blood Pressure ☐Nausea ☐Vomiting
☐Diabetes ☐Thyroid Problems ☐Physical Trauma ☐Emotional trauma
☐Other:____

Did the mother use any of the following substances during the pregnancy?
☐Recreational drugs: Type? ____
☐Prescription Medications: List? ____
☐Over-the-counter Medications: List? ____
☐Supplements: List?____
☐Tobacco ☐Alcohol ☐Other: ____

Birth History
Term Length: ☐Full ☐Premature: __________wks. ☐Late: __________wks.

Length of labour: ____________________ Child's weight at birth: _________________

Was the birth: ☐Vaginal ☐C-section ☐Induced ☐Forceps ☐Anaesthesia used
Were there any complications? ☐Yes ☐No
If yes, please explain:
____
____

Did the child experience any of the following at or shortly after the birth?
☐Jaundice ☐Rashes ☐Seizures
☐Birth injuries: __________________________ ☐Birth defects: __________________________________
☐Other:________________________________

Family History

Do you know the family medical history? ☐Yes ☐No

Indicate if a close relatives (i.e. parent, sibling) has had any of the following:

Symptoms	Relationship to Child
Allergies	
Asthma	
Diabetes	
Kidney disease	

Symptoms	Relationship to Child
Birth defects	
Juvenile arthritis	
Other	

Do either of the parents have a chronic illness? ☐Yes ☐No

If yes, please describe.

____

____

Child's Environment

Is the child in: ☐School ☐Daycare ☐Home care ☐Other

What are the child's favourite activities?

____

____

Does the child exercise regularly? ☐Yes ☐No

How much? ____________________

How often? ____________________

How much television does the child watch? ____________ hours per day/week

How often does the child read, or is read to (not for school)?

☐Daily ☐Several times a week ☐Weekly ☐Less than weekly ☐Never

Does anyone in the child's household smoke? ☐Yes ☐No

Are there any animals in the home? ☐Yes ☐No

What kind? ________________________________

How is the child's home heated? ________________________________

Do you know of any toxins or hazards the child is regularly exposed to (home, school, hobbies)?

Please describe:________________________________

____

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

____

____

What else would you like to share with me about this child?

____

____

I look forward to our first meeting together.

Shelby

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DECLARATION AND CONSENT TO TREAT

This is to acknowledge that I (or parent/legal guardian) have been informed and understand that:

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. A number of different approaches are used: Diet and nutritional supplements, botanical medicine, homeopathy, Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counselling.

Shelby Worts, BSc, ND, will take a thorough case history, do a screening physical exam and if your case requires, do more specific physical examinations including breast exams, gynecological exams and genital exams. Certain laboratory assessments may also be required on a case specific basis.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those on multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform Shelby Worts, BSc, ND, of any disease process that you are suffering from or if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise Shelby Worts, BSc, ND immediately.

There is some slight health 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 or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of skin from the use of moxa.
- Muscle strains and sprains, disc injuries from spinal manipulation

As a patient of Shelby Worts, BSc, ND, I am at liberty to seek or continue medical care from a medical doctor or other care providers licensed to practice in Ontario. No employee, agent, board member, student, instructor or anyone else under the direction or control of Shelby Worts, BSc, ND, has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

The Treatment and therapies rendered or recommended by Shelby Worts, BSc, ND, may be different that those usually offered by a medical doctor or other licensed health care providers.

As a patient of Shelby Worts, BSc, ND, I understand that results are not guaranteed.

I agree to pay my full account at the time of each visit or treatment, including fee for services, cost of supplements and remedies, cost of laboratory tests and other fees unless otherwise discussed with Shelby Worts, BSc, ND. Payment can be made in cash, personal cheque, Debit Card, Visa or MasterCard.

I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during intake of my case.

I understand that a 24-hour cancellation policy is in effect. To avoid a visit charge I will notify the office of Shelby Worts, BSc., ND, 24-hours before a scheduled appointment.

I will be given a full and complete explanation of the present and future treatments and/or services that I will receive.

OVER →

Privacy of your personal information is an important part of our practice, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information. For more detailed information ask the Privacy Information Officer for a copy of our privacy policy.

In this office Shelby Worts acts as the Privacy Information Officer.

This consent form is intended to cover the entire course of treatments in this office. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Date ____

Patient's printed name ____

Parent's/legal guardian's signature ____

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PROFESSIONAL FEES FOR NATUROPATHIC SERVICES

Naturopathic services are not covered by OHIP. However, extended health care benefits on various group insurance plans do have some coverage depending on the package. Check your insurance coverage.

Fees are due at time that service is rendered.

All naturopathic services are subject to HST.

Services	Investment In Your Health
Initial visit for Consultation and Initial Examination – Adult (60min)	$165.00
Initial visit for Consultation and Initial Examination – Child (45-60min)	110.00
Follow-up Visit – Adult (30minutes)	$85.00
Follow-up Visit – Adult short (15minutes)	55.00
Follow-up Visit – Adult long (45minutes)	120.00
Follow-up Visit – Child (30minutes)	$60.00
Follow-up Visit – Child (15minutes)	35.00

The service fees for follow-up visits listed above are for in-office and phone consultations.

Forms & Reports	Investment In Your Health
Filling out Insurance forms	$25.00
Narrative reports for Legal Purposes – per page	100.00

Home Visits	Investment In Your Health
Within Collingwood – Initial visit	$225.00
Within Collingwood – Follow-up visit	165.00
Outside Collingwood; add driving time – per hour	165.00

Fee schedule is subject to change.

I have read the above and fully understand the contents

Name: ______________________________ Signed: ___________________________

Date: ___________________________

Naturopathic medical services are covered by most extended medical plans.