



# Gaia Integrative Clinic

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## Child-Patient Information and Consent Form

First Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

Suite/Apt./Unit No: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Postal Code: \_\_\_\_\_

Gender: Male Female Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Month / Day / Year

Name of Primary Caregiver: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Extension: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Other Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_

Preferred contact method: \_\_\_\_\_

May we leave a message? \_\_\_\_\_

### Family Doctor or Pediatrician:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Relationship: \_\_\_\_\_

How did you hear about Gaia Integrative Clinic?

Referral

Website

Newspaper

Yellow Pages

Advertisement

Friend/Family

Other: \_\_\_\_\_



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I, (print your name) \_\_\_\_\_, acknowledge that as the parent or guardian of (print child's name) \_\_\_\_\_, a new patient of this clinic, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. I intend this consent form to cover the entire course of treatment my child receives at Gaia Integrative Clinic. With this knowledge, I understand and acknowledge that I may ask questions regarding my child's treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement in your child's condition.

I hereby consent to the collection, use and/or disclosure of my child's personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to my child. I further understand that my child's personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

\_\_\_\_\_  
(parent/guardian's printed name)

\_\_\_\_\_  
(parent/guardian's signature)

\_\_\_\_\_  
(date)



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## Naturopathic Adolescent Intake

### HEALTH INFORMATION

What is your main health concern? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list any other health concerns (physical, emotional, or mental) in order of importance.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

How do you rate your overall health?      Poor    Fair    Good    Excellent  
 How do you rate your overall energy?    Poor    Fair    Good    Excellent

### MEDICATIONS

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/day	How long?
1.		
2.		
3.		
4.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement	Dose/day	How long?
1.		
2.		
3.		
4.		

How many courses of antibiotics have you had in the past 10 years? \_\_\_\_\_  
 Have you ever had a bad reaction to any medication? Y / N

### MEDICAL HISTORY

Please indicate if you have had any of the following childhood illnesses (circle):

Asthma	Measles	Rheumatic fever
Chickenpox	Mumps	Scarlet fever
Eczema	Polio	Whooping cough
Frequent ear infections or colds	Rubella(German measles)	Other: _____

Please briefly describe your dental history (root canals, fillings, etc)

\_\_\_\_\_  
 \_\_\_\_\_



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**Immunizations** (Check ✓)

- |           |                         |               |              |
|-----------|-------------------------|---------------|--------------|
| €DPT      | €Hemophilus influenza B | €Hepatitis A  | €Hepatitis B |
| €Flu shot | €Tetanus Booster        | €MMR          | €Polio       |
| €Smallpox | €Chicken Pox            | €Other: _____ |              |

Any adverse reactions to vaccinations? Y / N. If yes, explain. \_\_\_\_\_

Please list (with approximate dates) any medical conditions, illnesses or injuries, and any hospitalizations.

Current Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ Maximum weight and when: \_\_\_\_\_ Height: \_\_\_\_\_

**FAMILY HISTORY**

Please indicate whether any of your family members have, or have had the following:

	Relative		Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	

**LIFESTYLE FACTORS**

Please list any dietary restrictions (Vegan, vegetarian, lacto-ovo vegetarian, omnivore)

How much water do you drink a day? \_\_\_\_\_

Are you frequently exposed to animals? Y / N

Are you regularly exposed to toxins or other hazards? Y / N. If yes, explain. \_\_\_\_\_

Please list all allergies (food, environmental, or medications). \_\_\_\_\_

**WOMEN'S HEALTH**

Are you currently pregnant? Y / N

Do you get regular Pap smears? Y / N

Date of last Pap?(month/yr) \_\_\_\_\_ / \_\_\_\_\_

Have you ever had an abnormal Pap? Y / N

Age of first period? \_\_\_\_\_

Is your period regular? Y / N

Length of monthly cycle (days)? \_\_\_\_\_

Average length of period or flow (days)? \_\_\_\_\_



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Do you experience PMS? Y / N

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Have you had any of the following concerning your breasts? (circle)

Pain	Lumps	Infections	Cysts	Nipple discharge
------	-------	------------	-------	------------------

Have you been taught self-breast exams ? Y / N

Do you experience vaginal infections? Never Rarely Frequently

Do you experience bladder infections? Never Rarely Frequently

**MEN'S HEALTH**

Have you had any of the following? (circle)

Testicular pain	Hernia	STDs	Discharge	Sores
-----------------	--------	------	-----------	-------

Have you been taught testicular self-exams (TSE)? Y / N

**Confidential Adolescent Intake Form:**

This part of the form is **confidential** and the information provided is between *you and your Naturopathic Doctor*. To ensure the best possible care, you are encouraged to provide the most accurate information possible.

Please list any current health concerns that were not listed earlier:

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Are any of the following important to you?

- |   |  |
|---|--|
| <input type="checkbox"/> Weight loss/gain       | <input type="checkbox"/> Stress                    |
| <input type="checkbox"/> Skin/pimples           | <input type="checkbox"/> Emotional/physical trauma |
| <input type="checkbox"/> Safe sex/birth control | <input type="checkbox"/> Depression                |
| <input type="checkbox"/> Time management        | <input type="checkbox"/> Other _____               |

Please circle the option that best describes your social situation:

life of the party    a few good friends    one good friend    no friends

Please circle the option that best describes your feelings about school:

I really enjoy school    school is okay    I hate school

On average, how many hours of sleep do you get on a weeknight?

less than 6 hours    6-7 hours    8 hours    9 or more hours

How many times a week do you eat fast food? 0    1-3    4-6    7+



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Please circle the option that best describes how you feel about yourself:

happy with my body weight    would like to lose weight    would like to gain weight

Please describe your relationship with your family: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you have a part-time job? Y or N

If yes, how many hours per week do you work? \_\_\_\_\_

What are your goals for the next year? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please indicate if you have ever used any of the following: (include frequency and amounts)

- |  |  |
|--|--|
| <input type="checkbox"/> Cocaine _____   | <input type="checkbox"/> Diet pills _____                              |
| <input type="checkbox"/> Marijuana _____ | <input type="checkbox"/> Laxatives _____                               |
| <input type="checkbox"/> Heroin _____    | <input type="checkbox"/> Caffeine pills _____                          |
| <input type="checkbox"/> Ecstasy _____   | <input type="checkbox"/> Birth control pills/implants/injections _____ |
| <input type="checkbox"/> Tobacco _____   | _____  |
| <input type="checkbox"/> Alcohol _____   | <input type="checkbox"/> Other _____                                   |

## **Sexual history**

Are you currently sexually active? Y / N

If yes, how many partners do you have or have you had?    1-4    5-9    10+

What is your sexual preference?

heterosexual    homosexual    bisexual    not sure

Do you use protection against sexually transmitted diseases (STD's) Y or N

Please circle the option that best describes how often you use condoms:

every time    usually    once in a while    hardly ever

Do you use birth control? Y or N

If yes, what method? \_\_\_\_\_

Please circle the option that best describes how often you use birth control:

every time    usually    once in a while    hardly ever

If no, do you know where you can go to get protection against STD's and unwanted pregnancy?

Y or N

Have you discussed this with one or both parents? Y or N

If no, why not? \_\_\_\_\_



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If you have questions regarding your sexuality, do you know where you can get answers or where you can talk to someone? Y or N

Have you ever experienced physical, emotional or sexual abuse? Y or N

## **Stress**

Have you ever had suicidal thoughts? Yes No (please circle one)

Describe the emotional environment of your home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Leisure Activities**

What do you do for fun? (Specify how often): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any extra-curricular activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything important you feel has not been addressed? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your treatment goals and expectations?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of a treatment protocol specific to your healthcare needs.*