15 - 1860 appleby line burlington ontario L7L 0B7
905.332.2828 info@imbuir.ca imbuir.ca
imbuir
naturopathic medicine + iV therapy

Pediatric Intake Form

Childs Name ____________________ Age __________ Grade Level __________

Today's Date ______________________________ Date of Birth __________

Child's Height ____________________ Child's Weight ____________________

Mother's Name ____________________ Father's Name ____________________

Telephone (H) ____________________ (W) ____________________

Full Address ____

____

This record of your medical history is confidential. Information it contains will not be released to anyone unless you authorize Imbuir to do so.

Pediatrician/M.D. ____________________ M.D. Phone ____________________

Other Practitioners ____

Please list the chief health concerns of your child:

1 ____

2 ____

3 ____

Please list current and past medications or supplements.

____

____

____

Please list *all* allergies (food, environmental, prescription drug)

____

____

____

Number of courses of antibiotics has your child had in lifetime? (approx). ______

Food allergies or intolerances? Please list. ______________________________

____

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty will greatly assist my understanding of your health care needs.

Prenatal Health

What was the health of the parents at the time of conception (please circle)?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during pregnancy?

Poor Fair Good Excellent Unknown

What was the emotional state of the mother during pregnancy?

Poor Fair Good Excellent Unknown

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother experience any of the following during pregnancy?

□ Bleeding □ High blood pressure □ Nausea □ Vomiting

□ Diabetes □ Thyroid problems □ Physical or emotional trauma

□ Cigarettes/alcohol □ Other:

Birth History

Term length □ Pre-term (37 weeks or less): ____________ weeks

□ Full-term (38-42 weeks): ____________ weeks

□ Post-term (> 42 weeks): ____________ weeks

Mother's age at child's birth: __________________________ Type of birth: □ Vaginal □ C-section

Interventions during birth:

□ Induced labour □ Forceps □ Epidural/anesthesia □ Episiotomy

□ Other: ____

Length of labour: ____________ Weight of infant at birth: ______________________

Did the child experience any of the following at or shortly after birth?

□ Jaundice □ Rashes □ Seizures □ Colic

□ Birth injuries: ____

□ Infections: ____

□ Difficulties with feeding: ____

□ Birth defects: ____

□ Other: ____

Dietary History

□ Breast fed? How long? ____________ □ Formula? How long? ____________

Does your child have any food allergies or intolerances? Please list.

____

____

Describe a typical day's diet for your child.

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Beverages (include total quantity) ____

Medical History

Has your child ever experienced any of the following illnesses?

□ Rubella □ Mumps □ Pneumonia □ Measles
□ Chickenpox □ Frequent colds □ Whooping Cough □ Asthma
□ Tonsillitis □ Scarlet Fever □ Polio □ Ear Infections
□ Rheumatic Fever □ Colic □ Other: ___________________________

Has your child received any of the following vaccinations?

□ DPT □ MMR □ Polio □ TB □ Flu
□ Smallpox □ Tetanus □ Chickenpox □ Other: ______________________________________

Any adverse reactions or chronic illness following vaccination? ___________________________

Injuries/Surgeries/Hospitalizations (please list): ____
____

Any significant physical or emotional traumas? ____
____

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown
How is your child's health now? Poor Fair Good Excellent Unknown
Age began: Sitting_________ Crawling _________ Walking _________ First words________

Sleep Patterns

How is your child's sleep? ____
Does your child have nightmares? Yes No How often? _______________________________

Family History

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

Condition	Relative	Condition	Relative
□ Allergies		□ Seizures	
□ Anemia		□ Stroke	
□ Arthritis		□ Diabetes	
□ Asthma		□ Eczema	
□ Birth Defects		□ Glaucoma	
□ Bleeding Disorder		□ Kidney Disease	
□ Cancer		□ Psoriasis	
□ Hay Fever		□ Depression	
□ High Blood Pressure		□ Tuberculosis	
□ Juvenile Arthritis		□ Mental Illness	
□ Other		□ Unsure of history	

Environment

Are there any pets in the home? Yes No What type and how many?___________________

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

Toxins that the child is regularly exposed to (home, hobbies, school, etc.)? ______________
____

How would you describe the emotional climate of the home? ____________________________
____

Is there anything that you feel is important that has not been covered? ___________________

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Pediatric Consent

imbuir™ PRIVACY POLICY

At imbuir - integrative medicine + iV therapy we understand the importance of protecting your/the minor's personal information. Below is an outline of how our office is using and disclosing your/the minor's information.

The office will collect, use and disclose only necessary information about you/the minor for the following purposes:
(Please ✓ if interested)

- **To collect information for assessments conducted by our practitioners**
- **To collect fees for services and dispensary purchases**

☐ Subscription to monthly newsletters via email or mail (Optional)

☐ Emailing of continuing education, wellness, and health related topics (Optional)

☐ Seminars, workshops and surveys to promote patient education (Optional)

Your/the minor's information will be disclosed to the following individuals

- **To all health professionals employed by imbuir - integrative medicine + iV therapy**
- **To any emergency service personnel dispatched if one's life is endangered**

We will only share your/the minor's information with your consent. Storage, retention and destruction of your/the minor's personal information complies with existing legislation, and privacy protocols set out by the Board of Drugless Therapies Naturopathy (BDDT-N) and Ontario's Personal Health Information Protection Act (PHIPA).

At imbuir, we value the time we get to spend with you and strive to offer the best customer service possible, even if that is to schedule you a last minute appointment. Thus, in order to serve you better we enforce a strict 24 hour cancellation policy. If something comes up and you cannot make your appointment, please call us right away. If we do not receive a phone call or voice message, a cancellation fee of $50 will apply. We hope you will appreciate this service as your time here at imbuir is valuable.

I have reviewed the above information that explains how imbuir - integrative medicine + iV therapy will use my/the minor's personal information, and the steps that will be taken to protect my/the minor's personal information. I agree that imbuir-integrative medicine + iV therapy can collect, use, and disclose my/the minor's personal information as set out above in the privacy policy and consent to treatment.

______________________________	______________________________	______________________________
Signature of Patient or Guardian	Print Name	Date

CONSENT TO NATUROPATHIC TREATMENT/IV THERAPY

I understand and acknowledge that my attending Naturopathic Doctor or IV certified practitioner has explained verbally the nature of the naturopathic treatment or parenteral therapy I/the minor is to receive including benefits, risks, and any medical alternatives to the prescribed treatment. I hereby consent to the treatment as set out above. I may withdraw my consent to this treatment at any time.

______________________________	______________________________	______________________________
Signature of Patient or Guardian	Print Name	Date

For Office Purposes Only

☐ Verbal consent acquired and witnessed. Patient/Guardian understands and acknowledges risks and benefits to treatment explained.

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CREDIT CARD PRE-AUTHORIZATION FORM
FOR MISSED APPOINTMENTS, AND PAST DUE STATEMENTS

We require your credit card information for several reasons:

1) If you miss an appointment without calling 24 hours in advance, then we charge your card a missed appointment fee of $75.00. This fee cannot be submitted to insurance.
2) If you miss an iV/injection appointment without calling prior to 9 am on the day of the appointment, then we charge your card a missed appointment fee of $75.00 for infusions and $25 for injections. This fee cannot be submitted to insurance.
3) In the event that you have an outstanding balance past 30 days, then we will notify you in writing that your card will be charged for the outstanding balance within 15 days if you do not call our office to make partial or full arrangements for payment.

Please complete the following:

◯ I authorize imbuir – naturopathic medicine + iV therapy to keep my signature on file and to charge my Visa, Mastercard, or American Express account for an initial or recurring charge of $75.00 for any missed appointment in which I have not called 24 hours in advance to cancel and for any outstanding balances past 30 days. I realize I will only be charged for outstanding balances past 30 days if I have not made any payment arrangements with the billing department.

◯ I authorize imbuir – naturopathic medicine + iV therapy to keep my signature on file and to charge my Visa, Mastercard, or American Express for an initial or reoccurring charge of $75 for any missed iV appointments and $25 for any missed injection appointments that are NOT cancelled prior to 9 am on the date of the appointment.

◯ I understand this form is valid for one year unless I cancel the authorization in writing. I promise not to dispute charges ("charge back") for sessions I have received or that I have not cancelled 24 hours prior to a scheduled session. I further authorize imbuir – naturopathic medicine + iV therapy to disclose information about my attendance/cancellation to my credit card issuer if I dispute the charge.

____
Client Name

____
Cardholder Name

____
Cardholder Billing Address City Province Postal Code

____ __________________________________
Account Number Expiration Date

____ ___________________________
Cardholder Signature Date