CONSENT FORM AND CANCELLATION POLICY

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. Dr. Mary Sawdon ND will take a thorough case history, perform a physical examination, and prepare an individual treatment protocol. Dr. Mary Sawdon, ND is a licensed naturopathic doctor and will adhere to the standards of practice outlined by the governing bodies of the profession. Treatment protocols may include usage of any naturopathic modality, including but not limited to: botanical medicine, nutraceutical supplementation, physical medicine, homeopathy, hydrotherapy, traditional Chinese medicine and acupuncture, and diet and lifestyle counselling.

It is very important that you inform your naturopathic doctor immediately of any disease process from which you are suffering and any medications or over the counter drugs that you are currently taking. Please advise your naturopathic doctor immediately if you are pregnant, suspect you are pregnant, or if you are breast-feeding. As a patient you will receive information about your diagnosis and treatment, alternative courses of action, costs, expected benefits, risks, side effects and consequences of not having the diagnosis and/or treatment acted upon. There are some risks to treatment which include but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain or bruising from acupuncture, fainting or puncturing of an organ with acupuncture needles.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at the medical record at any time and can request a copy of it by paying the appropriate fee.

I understand that Dr. Mary Sawdon ND will answer any questions that I have to the best of her ability. Because each individual responds differently to treatment, I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I agree to pay the fees for naturopathic services. I understand that fees, herbs, and supplements are to be paid for at the time of the consultation and visit. I understand that supplements, remedies, and botanicals are not included in the visit fee. I understand that there are no refunds or exchanges on visit fees.

I understand that a fee will be charged equivalent to the cost of the visit for any missed appointments or cancellations with less than **24 hours' notice**.

I have read and understand the above stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by Dr. Mary Sawdon ND. I intend this consent to apply to all my present and future naturopathic care. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Printed name of patient: ____

Signature of patient or legal guardian: ______________________________ Date: ______________

Signature of Dr. Mary Sawdon, ND: ______________________________ Date: ______________

DR. MARY SAWDON
• NATUROPATHIC DOCTOR •

PEDIATRIC INTAKE FORM

Last Name:	First name:	Middle Name:	
Date of Birth (MM/DD/YYYY):	Age:	Sex:	Name & relation of person filling out the form:
Contact Information			
Address:	City, Province:	Postal Code:	
May we leave messages regarding your visit: Yes/ No	Phone number:	Email: Would you like to receive our newsletter?	
Emergency Contact Information			
Last Name:	First Name:	Relationship:	
Daytime phone number:	Evening phone number:		
Other Healthcare Providers			
Name: Specialty: Phone number:	Name: Specialty: Phone number:	Name: Specialty: Phone number:	
Date of last medical doctor visit:	Date of last physical exam:		

How did you hear about this clinic? If referred, please state by whom:	
Have you been treated by a Naturopathic doctor before?	If yes, by whom? Date of last visit:

GOALS
In your opinion, what are your child's most important health concerns:
1).
2).

3).

MEDICAL HISTORY

Height: Weight:	Was your child adopted? Yes/ No

Immunization Record: Check all that apply.

- DPT (Diptheria, Pertussis, Tetanus)
- MMR (Measles, Mumps, Rubella)
- Hepatitis B
- Hepatitis A
- Gardasil/ Cervarix (HPV vaccine)
- HiB (Haemophilus influenza B)
- BCG (Tuberculosis)
- Polio
- Flu vaccine
- Pneumococcal conjugate
- Meningococcal C conjugate (meningitis)
- Varivax/ Varilix (chicken pox)
- Other:

Adverse reactions to vaccine? Yes/ No
If yes, list below:

Childhood illnesses:

- Measles
- Asthma
- Polio
- Mumps
- Whooping cough
- Rubella (German measles)
- Chicken pox
- Rheumatic fever
- Scarlet fever
- Roseola

List any previously diagnosed medical conditions:	Treatment	Year of diagnosis:
1).		
2).		
3).		
4).		
5).		

Allergies (medication, food, supplements, environment)	**Reaction**
1).	
2).	
3).	
4).	

List all **prescription drugs** (antibiotics, etc), **over the counter medications**, **herbs and natural supplements** (vitamins, homeopathics, botanical tinctures etc) that the child is taking.

Medication or natural health product	Dosage/ quantity per day	Start date

Have they ever experienced any adverse effects or any allergic reactions to any of the above products/ therapies?

- No
- Yes, please specify reaction:

FAMILY MEDICAL HISTORY					
Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, seizures and other neurological conditions, dementia, hyper/hypothyroid. If deceased, please state age and cause of death.					
	Age	**Health History**		**Age**	**Health History**
Father			**Mother**		
Siblings			**Grandparents**		

PRENATAL & NEONATAL HISTORY
Was there any maternal health concerns before, during, or immediately after pregnancy? If so, please describe:

Mother's health during pregnancy: Please check all that apply & describe if needed.

Thyroid problem	Medications during pregnancy
Gestational diabetes	Supplements during pregnancy
High blood pressure (pre-eclampsia, eclampsia)	
Nausea	Age of mother at conception
Anemia	Age of father at conception
Bleeding	
Genital herpes	Other health issues during pregnancy:
Smoking	
Alcohol use	
Drug abuse	
Stress	

Child's Health at Birth:

Full term?	Premature? How many weeks?
Cesarean delivery?	Vaginal birth?
Induced labor?	Other interventions (e.g. forceps, vacuum)?
Length of labor?	Birth location (hospital, home)?
Baby's weight	Baby's length
APGAR score	Jaundice
Early infection	Anemia
Other health concerns from birth to 6 weeks of life:	

Neonatal health history (first 2 months of life)

Any early medical interventions? (Intubation, incubator etc)
Health concerns: (circle all that apply) Infections Anemia Colic Jaundice Tongue-tie Rashes Breathing problems Other?
Medications used?
How long did the baby stay in the hospital after birth?

Feeding History

Was your child breast fed?	If yes, for how long?

Was your child bottle fed? What type of formula?	If yes, for how long?
Does your child drink milk now?	If yes, what kind and how much?
At what age was food introduced? Which foods were first introduced?	

Developmental Milestones (please indicate age in months)

Roll over		Crawl		Talk		Run	
Hold head up		Stand		Firth tooth		Any issues?	
Sit up		Walk		Climb stairs			

DIET AND LIFESTYLE HABITS		
Exercise	How many times does your child exercise each week?	
	Type of exercise (sports, play etc):	
Diet	Does your child have any dietary restrictions (religious, vegetarian, vegan)?	
	Please list a typical day's diet: Breakfast:	
	Lunch:	
	Dinner:	
	Snacks and beverages:	
	How is your child's appetite? Any food cravings or aversions?	
Emotion	What is the child's mood generally? What is the child's personality? How stressful is school or other aspects of your child's life? How well does your child handle stress? What does the child fear?	
Tobacco	Is your child exposed to significant tobacco smoke?	
Toxins	Is your child exposed to toxins (school, home, hobbies)?	If yes, please describe (e.g. lead paint, asbestos, mold, etc)
Sleep	How many hours does your child sleep?	Trouble falling asleep?
	Trouble staying asleep? Night terror?	Sleep walking? Bed wetting?
Hobbies	What are your child's hobbies? Or what do they enjoy doing? Are there family pets?	

Is there anything that you feel is important that has not been addressed? Please describe.