

Full Name: _____
Birthdate: (d/m/y) _____ Sex: M F Ancestry: _____
Address: _____
City: _____ Postal Code: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Provincial Health Number: _____
Private Insurance Company: _____
Emergency Contact: _____
Relationship to Patient: _____ Phone: _____

Terms of Admission

Personal: In signing below, I voluntarily consent on behalf of my charge to treatment with the understanding that the form of medical care I will receive is based on naturopathic principles, practices and therapies. These treatments and principles may be different from those recommended by the medical establishment. Please note that there are potential risks to any treatment as well as benefits. You may inquire about risks involved in any treatment that may be prescribed. No treatment will be administered without your expressed or implied consent.

Legal:

I understand that a record will be kept of the health services provided. This record will be kept confidential and will not be released to other unless so directed by me or otherwise permitted or required by law.
I also understand that I am free to seek additional medical or health advice from any practitioner I choose.

Financial: Payments are due at time of service. If providing insurance billing information, I am responsible for all charges whether or not they are covered by my insurance. Cancellation of appointments or rescheduling must be done 48 hours prior to the appointment to avoid treatment fee charges.

I affirm that all information provided above is correct to the best of my knowledge.

Patient's Name

Guardian's Signature

Date

Print Name

- Child Intake Form -

Dr. Tanya Rampersad, ND
CNDA Member: 1640

Present Health Concerns

List present health issues in order of significance along with any diagnosis you've received:

- 1 _____
2 _____
3 _____
4 _____

Please list any treatments you are currently receiving; including prescription medication, supplements or homeopathic remedies being used. Please include dosages and brand for each.

- 1 _____ 2 _____ 3 _____
4 _____ 5 _____ 6 _____

-Personal Health Context-

Medical History

Significant prenatal or labour concerns (e.g. illness during pregnancy, difficult labour)

Serious Illnesses/Injuries of child

Date of most recent physical exam _____ Date of most recent blood test: _____

Name of child's doctor _____ Location: _____

Current weight _____

Blood type (circle): A B AB O Don't know

Baby's health after birth (circle)

Low birth weight Low APGAR scores Failure to thrive
Difficult latch Colic Jaundice Heart malformation
Gut malformation

Breast feeding/fed: Yes No; Age of weaning: _____

Age at food introduction: _____

First foods introduced: _____

Dietary restrictions of mother _____

Dietary restrictions of child _____

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Sleep Pattern (hours, regularity) _____

Exercise Patterns and/or favourite activities _____

How many times have antibiotics been used? _____ When was the last time? _____

Standard vaccinations? Y N Any adverse reactions? Y N

Pending dental work Y N Nature of the issue _____

Drug, environmental and known allergies _____

Are there any other significant events that are believed to have impacted the health?
