Dr. Greg Sikorski ND
Synergy Collaborative Health
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CHILD

CHILD INTAKE FORM

Our health is influenced by many different factors. Your child's health history is an important part and will provide valuable information for me to understand their current health. Please fill out this form and bring it with your child to the first visit.

GENERAL CONTACT INFORMATION

Name: _____ Today's Date: _____
(*Last name)* *(First name)* *(M/D/Y)*

Birthdate (M/D/Y): _____Age: _____Anatomical Sex:_____ Gender Identity:_____

Who is filling out the form (Name and Relation)? _____

Contacts (in order of preference)

Name: _____ Relationship to child: : _____

Address:_____
Street *City* *Province* *Postal Code*

Phone (H): _____ (W): _____ (C): _____

E-mail: _____Child's Alberta Health Care Number: _____

Name: _____ Relationship to child: _ _____

Address:_____
Street *City* *Province* *Postal Code*

Phone (H): _____ (W): _____ (C): _____

E-mail: _____ Alberta Health Care No. _____

May we leave you a message about your appointment: Y N Email or Cell (Please circle one or both)

With whom does the child live with? _____

How did you hear about the clinic? _____

Medical Doctor: _____ Last Visit: _____
Name *Telephone* *(M/Y)*

PERSONAL MEDICAL HISTORY

How would you describe your child's general state of health? ☐Excellent ☐ Good ☐ Fair ☐Poor

What are your child's health concerns, in order of importance?

1. _____
2. _____
3. _____
4. _____

Please list any other Healthcare Providers **your child** is currently seeing:

Name	*Phone Number*	*Reason*
Name	*Phone Number*	*Reason*
Name	*Phone Number*	*Reason*

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations along with approximate dates:

1. _____
2. _____
3. _____

Does your child have any allergies or hypersensitivities to any of the following?
Foods: _____

Medicines: _____

Environment: _____

Other: _____

Please list all prescription and over the counter medications, vitamins or other supplements your child is currently taking (including brands):****Please bring medications & supplements to your first appointment****

_____

_____

_____

_____

Please list any other Healthcare Providers **you are** currently seeing: (ie. Chiropractor/Osteopath/Acupuncturist/Specialist):

Name	*Phone Number*	*Reason*
Name	*Phone Number*	*Reason*
Name	*Phone Number*	*Reason*

Please indicate which immunizations your child has had? (Check all that apply)

☐ DPT (Diphtheria, pertussis, tetanus)
☐ Tetanus booster; when? _____
☐ MMR (Mumps, measles, Rubella)
☐ Haemophilus influenza B
☐ "Flu"
☐ Polio
☐ Hepatitis B
☐ Hepatitis A
☐ Small Pox

Other _____

Please indicate any adverse reactions: _____

_____

How many times has your child been treated with antibiotics? _____

Has your child had any of the following?

	Never	Mild	Average	Severe
Rubella (German Measles)				
Measles				
Chicken pox				
Mumps				
Roseola				
Scarlet Fever				
Whopping Cough				
Strep Throat				
Impetigo				
Mononucleosis				
Ear infections				

What screening tests has your child had (blood, hearing, vision, etc.)? When? _____

_____

_____

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

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy?

☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

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 ☐ Physical or Emotional Trauma

☐ Diabetes ☐ Thyroid Problems ☐ Vomiting

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol

☐ Recreational Drugs: _____

☐ Prescription medications: _____

☐ Over the counter medications: _____

☐ Supplements: _____

☐Other: _____

BIRTH HEALTH

Term length: ☐Full ☐ Premature: _____ weeks ☐ Late: _____ weeks

Length of labor: _____ Weight at birth: _____

Was the birth: ☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps ☐Anesthesia used

Any complications? _____

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

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Failure to thrive ☐ Respiratory distress
☐ Colic ☐ Hypoxia ☐ Surgery ☐ Difficulty Feeding ☐ Meningitis
☐ Respiratory distress ☐ Other: _____
☐ Birth defects_____ ☐ Birth injuries _____

DIET

How was your infant fed?
☐ Breastfed. How long? _____ ☐ Formula: Milk/ Soy/ Other: _____
☐ Other: _____

What foods were introduced before 6 months? (Approximately which months)
_____
_____
_____

6 – 12 months?
_____
_____
_____

Did your child ever experience colic? ☐ Yes ☐ No How Severe? ☐ Mild ☐Moderate ☐ Severe

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

Does your child have any dietary restrictions? (religious, vegetarian, vegan, etc.)
_____
_____

Describe a typical day's diet for your child:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages (and total quantity): _____

HEALTH AND DEVELOPMENT

How was your 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 your child's sleep patterns:
_____
_____

How would you describe your child's temperament?
_____
_____

How would you describe your child's behavior and performance at school?

_____

_____

FAMILY HISTORY

Please indicate if a close relative (Parent or sibling has had any of the following:

Condition	When? (Their age)	Family Member
Allergies/ Hay Fever		
Asthma		
Birth defects		
Diabetes		
Juvenile arthritis		
Kidney Disease		
Other		

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

_____

_____

ENVIRONMENT

Is your child in: ☐ School ☐ Daycare ☐ Homecare ☐ Other: _____

What are your child's favorite activities?

_____

_____

_____

Does your child exercise regularly? ☐ Yes ☐ No How much and how often?

_____

_____

_____

How much television does your child watch? _____ hours a day/week

How often does your child read (not for school), or how often does someone read to your child?

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

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

Are there animals in the home? ☐ Yes ☐ No

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

_____

_____

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

_____

_____

_____

Thank you for taking the time to complete this form. The information provided will be discussed in further detail during your child's visit. Please bring this form with you to your visit or email me a copy ahead of time to info@GregND.com

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EMAIL/PP

EMAIL CONSENT FORM

Name: _____ E-mail: _____

I hereby acknowledge that I consent to email communications about my care. It is my responsibility to inform Dr. Sikorski if my email address changes. I understand that I am exposing myself to certain risks, which include but are not limited to:

- The privacy and security of email communication cannot be guaranteed.
- Email can be intercepted, altered, forwarded, or used without authorization or detection.
- Email can be circulated, forwarded, and stored in numerous paper and electronic files.
- Backup copies of Email may exist even after sender or recipients have deleted their copy.
- Email senders can easily misaddress an Email or be received by unintended recipients
- Email is easier to falsify than handwritten or signed documents.

Dr. Sikorski will use reasonable means to protect the security and confidentiality of emails. Due to the risks above, Dr. Sikorski cannot guarantee the security and confidentiality of emails and will not be liable for improper disclosure of confidential information that is not caused by Dr. Sikorski's intentional misconduct.

Dr. Sikorski will try to read and respond promptly to emails but cannot guarantee that all Emails will be read and responded to. No one shall use Email for medical emergencies or other time-sensitive matters. It is the patient's responsibility to follow up with Dr. Sikorski if a response has not been received within a reasonable time period.

Please be advised all Emails to or from Dr. Sikorski will be made part of your medical record. It is your responsibility to inform Dr. Sikorski of any types of information you do not want sent by Email. Dr. Sikorski will not forward Emails to independent third parties without the patient's prior written consent, except as authorized or required by law.

I acknowledge that I have read and fully understood this consent. I understand the risks associated with email communications between Dr. Sikorski and myself, and consent to the conditions outlined. In addition, I agree to the instructions for communicating by Email, as well as any other instructions that Dr. Sikorski may impose to using Email.

Signature of Patient or Guardian: _____ Date: _____

PATIENT PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of providing you with quality naturopathic care. Dr. Greg Sikorski understands the importance of protecting your personal information. We are committed to collecting, using, and disclosing your personal information responsibly.

We strive to ensure that:

- Only necessary information is collected about you;
- We only share your information with your written consent;
- Storage, retention, and destruction of your personal information complies with existing privacy legislation and privacy protection protocols of our regulatory body, The College of Naturopathic Doctors of Alberta.

Information is collected, used and disclosed about you for the following purposes:

- To assess your health concerns and advise you of treatment options;
- To establish and maintain contact with you and remind you of upcoming appointments;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up for treatment, care and billing;
- To comply with legal and regulatory requirements;

I have read and understand how Dr. Greg Sikorski will use my personal information and the steps taken to protect my information. I am giving my informed consent to the collection, use and/or disclosure of my personal information as detailed above.

Signature of Patient or Guardian: _____ Date: _____

CONSENT

INFORMED CONSENT FORM

Please note that this form must be signed prior to your first appointment.

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. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history and perform a physical examination. Each patient seeking care in this clinic should understand that the practitioner is a Naturopathic Doctor, not a medical doctor.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/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/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon. Treatments used in this clinic include nutrition, botanical medicine, lifestyle counseling, homeopathy, Traditional Chinese medicine (including acupuncture), hydrotherapy, physical medicine, laboratory testing and supplement recommendations.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture or parental therapy.
- Fainting or puncturing of an organ with acupuncture needles or accidental burning of the skin from the use of moxa
- Muscle strains and sprains or disc injuries from spinal manipulation.
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened by your Naturopathic Doctor prior to manipulating the neck.

The Naturopathic Doctor is trained to handle emergencies should the need arise.

I have been informed and I understand that:

- The clinic does not guarantee treatment results.
- That my Naturopathic Doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have.
- I am free to withdraw my consent and to discontinue treatment at any time.
- I agree to pay my account in full at the time of each visit. I am aware that Alberta Health Care does not cover these fees.

Patient Name (please print): _____

Signature of Patient or Guardian: _____ Date: _____

Naturopathic Doctor: _____

SYNERGY
Collaborative Health