

Michelle Richea, BSc, ND
Naturopathic Doctor

www.ndmichellerichea.ca
info@ndmichellerichea.ca

The Clinic @ College Corner
#103-540 College Street
Toronto, ON M6G 1A6
(T) 416.923.5500
(F) 416.923.2249

Welcome to Naturopathic Medicine. A wholistic philosophy is the foundation underlying Naturopathic Medicine, and so it is from this whole-person perspective that I seek to gain a comprehensive understanding of all aspects that may be affecting your child's health. As your child's Naturopathic Doctor, it is important that I am aware of your child's current health status, his/her complete medical history, as well as what areas of his/ her health you would like to see change in the future. Please complete this form as thoroughly as possible, as your responses will greatly assist in the development of a personalized treatment plan.

***Please bring all of the completed forms in this package with you to your first visit.**

PEDIATRIC INTAKE FORM

Identifying Information

Who is filling out this form? (name, relation): _____

Child's Name: _____ Age: _____ Sex: _____ Date of Birth: _____

Height: _____ Weight: _____ Grade level: _____

Parents Names: _____ Occupation: _____

Contact Information for child's primary caregiver(s) (Who the child lives with):

Name: _____ Relation: _____

Address: _____ Email: _____

Phone Numbers: (H): _____ (W): _____

Contact Information for child's secondary caregiver(s):

Name: _____ Relation: _____

Address: _____ Email: _____

Phone Numbers: (H): _____ (W): _____

Emergency Contact:

Name: _____ Relation: _____

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

Family Doctor/ Pediatrician:

Phone Number: _____ (Fax): _____

Chief Concern #1 (Please Explain): _____

Chief Concern #2 (Please Explain): _____

Chief Concern #3 (Please Explain): _____

List of Current Medications/ Natural Health Products:

Prenatal Information

Adopted: Y / N

Previous History of Infertility: Y / N

How was pregnancy achieved? (e.g. intercourse, IVF, AI, sperm donation, other): _____

Was the pregnancy planned?: Y / N

Birth Order: _____ Siblings Names & Age: _____

Age of Mother at Conception: _____ Age of Father at Conception: _____

Number of Previous Pregnancies: _____

Number of Previous Deliveries: _____

Conditions Mom experienced during pregnancy:

(e.g. elevated blood pressure, gestational diabetes, bleeding, infections, thyroid problems, nausea, vomiting, bedrest, edema (swelling), fainting, anemia, weight gain/ loss, physical trauma):

Did the Mother use any of the following during pregnancy?:

Substance:	Yes / No	Please List (specific type, how much, how often):
Tobacco		
Alcohol		
Recreational drugs		
Caffeine		
Medications (prescribed & over-the-counter)		
Supplements		
Other		

Tests performed during pregnancy:

Please indicate any physical or emotional traumas Mom experienced during pregnancy:

Does the Mother work outside of the home?: Y / N

If Yes, please indicate at what point in the pregnancy did the mother take maternity leave: _____

How would you describe the pregnancy? _____

Birth History

Length of gestation: 9 months: _____ Early (# of weeks): _____ Late (# of weeks): _____

Location of delivery (e.g. home, hospital, birthing centre, other): _____

Length of labour: _____

Was the labour spontaneous?: Y / N If No, How was it induced?: _____

Type of Delivery: Vaginal / Cesarean Section / Breech / Emergency C-Section (Please Circle)

Interventions of Birth (e.g. anaesthesia, epidural, episiotomy, forceps, vacuum, other):

Birth injuries: Y / N, If Yes please describe: _____

Congenital defects: Y / N, If Yes please describe: _____

Caregivers involved in the birth (e.g. Obstetrician, Midwife, Doula, Family Doctor):

Birth Weight: _____ Length: _____ APGAR Score: _____

Early complications:

(e.g. failure to thrive, illness, jaundice, hypoglycemia, respiratory difficulty, meningitis, rashes, seizures):

Interventions following birth:

(e.g. medications, respirator, surgery, phototherapy, other)

Nutritional History

Breastfed: Y / NI If No, Why?: _____

Substitute Formula used: _____

If Yes, Duration: _____

Mother's diet while breastfeeding:

(e.g. foods typically enjoyed, food cravings, foods avoided, child's reactions):

Did the child experience colic? Y / N

Weaning History (e.g. when, child's response, etc.): _____

First Food(s) Introduced:

Food	When (e.g. 6, 9, 12 months)?	Reactions (if any)?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the child have any dietary restrictions? (e.g. religious, vegetarian, vegan, etc):

Food Allergies / Intolerances:

How would you describe the child's eating habits?:

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Water Intake (total quantity): _____

Other Fluids (total quantity): _____

Child's food cravings:

Medical History

How would you describe the child's general state of health?: _____

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

Please list past prescription medications:

How many times has the child been treated with antibiotics?: _____

Does the child have any allergies? (e.g. food, medicines, environmental, etc.):

What screening tests has the child had to date? (e.g. blood, hearing, vision, etc. including approx. date):

Please circle any that apply to the child

N = Never, P = In the Past, C = Currently

Skin:			Ears:			Gastrointestinal:					
Rashes	N	P	C	Infection	N	P	C	Trouble swallowing	N	P	C
Eczema	N	P	C	Hearing loss	N	P	C	Nausea & vomiting	N	P	C
Psoriasis	N	P	C	Ringling in the ears	N	P	C	Bloating	N	P	C
Vitiligo	N	P	C	Nose & Sinuses:				Abdominal pain	N	P	C
Dryness	N	P	C	Nasal stuffiness	N	P	C	Diabetes	N	P	C
Hives	N	P	C	Nose bleeds	N	P	C	Excessive gas	N	P	C
Boils	N	P	C	Infections	N	P	C	Constipation	N	P	C
Warts	N	P	C	Mouth & Throat:				Blood in stool	N	P	C
Fungal Infections	N	P	C	Thrush	N	P	C	Weight loss/ gain	N	P	C
Impetigo	N	P	C	Bad breath/ odour	N	P	C	Diarrhea	N	P	C
Mind:				Tonsillitis	N	P	C	Childhood Illnesses:			
Nervousness/ anxiety	N	P	C	Sore throat	N	P	C	Stomach flu	N	P	C
Head:				Cardiovascular:				Chicken Pox	N	P	C
Craddle cap	N	P	C	Murmurs	N	P	C	Croup	N	P	C
Hair loss	N	P	C	Rheumatic fever	N	P	C	Measles	N	P	C
Headaches	N	P	C	Respiratory:				Mumps	N	P	C
Dizziness	N	P	C	Cough	N	P	C	Rheumatic Fever	N	P	C
Dandruff	N	P	C	Wheezing	N	P	C	Meningitis	N	P	C
Lice	N	P	C	Colds	N	P	C	Pneumonia	N	P	C
Head injury	N	P	C	Asthma	N	P	C	Mononucleiosis	N	P	C
Eyes:				Bronchitis	N	P	C	Rubella	N	P	C
Redness	N	P	C	Infection	N	P	C	Strep throat	N	P	C
Discharge/ infection	N	P	C	Genitourinary:				Scarlet fever	N	P	C
Vision problems	N	P	C	Frequent urination	N	P	C	Whooping cough	N	P	C
Double vision	N	P	C	Bladder infection	N	P	C	Other:			
Blurred vision	N	P	C	Haematological:				Fever	N	P	C
Neurological:				Easy bleeding	N	P	C	Growing pains	N	P	C
Seizures	N	P	C	Past transfusions	N	P	C	Fracture	N	P	C
Tingling/ numbness	N	P	C	Anemia	N	P	C	Allergies	N	P	C
				Easy bruising	N	P	C	Fatigue	N	P	C
								Hernia	N	P	C

Other:

Immunization History:

Vaccination	Approximate Date(s)	Child's Reaction, if any (e.g. fever, rash, pain, insomnia, vomiting, swelling, mood changes, or other)
DPT (diphtheria, pertussis, tetanus)		
Tetanus Booster		
MMR (measles, mumps, rubella)		
Polio		
Small Pox		
Influenza, "Flu"		
Hepatitis B		
Hepatitis A		
Chicken Pox		

Developmental History

<u>Developmental Milestone</u>	<u>Age of Child</u>
Sitting on own	_____
Rolling over	_____
Crawling	_____
Walking	_____
Talking	_____
Eruption of Teeth	_____

Family Medical History

Relation	Significant Health Concerns	If deceased, list cause of and age at death
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings		

Sleep History

Where does the child sleep? (e.g. own bed, parent's bed, crib, with siblings): _____

Age when child first began to sleep through the night: _____

Describe the child's sleep pattern (e.g. bed time, avg. length of sleep):

Does the child experience nightmares?: Y / N or night terrors?: Y / N

Frequency: _____

Describe repetitive dreams/ nightmares/ night terrors:

Occurrence of sleepwalking: Y / N If Yes, Frequency: _____

Occurrence of Bedwetting: Y / N

Frequency: _____

How it is dealt with?: _____

Environmental Exposures

Occurrence of moving/ painting/ renovations during pregnancy: Y / N _____

How long has the child lived in this location?: _____

Age of Home: _____

What is the flooring in the house? (e.g. carpet, hardwood flooring): _____

How is the child's home heated?: _____

Does anyone in the child's household smoke?: Y / N

Indicate if there are any pets in the child's home: _____

Water source (e.g. well water/ city water/ bottled/ filtered – what kind, other):

Cleaning Products used in the home:

Do you know of any toxins or other hazards the child is regularly exposed to (e.g. home, other's work, hobbies, etc)? Please describe.

Travel history (please include destinations and date of travel):

Lifestyle

Where does the child spend his/ her time during the day? (e.g. home, daycare, school, babysitter):

How would you describe the child's temperament?: _____

How does the child interact with other people?: _____

Have you ever noticed any behavioural problems at home/ school/ daycare/ sitters?:

How is the child's performance at school?: _____

Has the child experienced any emotional trauma(s)?: _____

How does the child handle stress?: _____

What type of physical activity does the child engage in? how often?:

Child's favorite activities/ hobbies: _____

Additional comments/ Anything you would like to share that hasn't already been covered:

How did you hear about our clinic? _____

SIGNATURE

I, _____ attest that the information provided is true and accurate to the best of my knowledge.

Signature: _____

Date: _____

Additional Section for Adolescents

**This is a separate form to be filled out by the patient themselves.
The patient is to hand this form to the doctor directly.**

Name: _____ Age: _____ Gender: _____

Date of Birth: _____

Energy level (please circle): Low 1 2 3 4 5 6 7 8 9 10 High

Do you experience fatigue? Y / N

How much sleep do you get on average per night: _____

What is your ideal amount of sleep per night: _____

Do you have trouble sleeping? Y / N

Do you ever experience anxiety? Y / N

Do you ever experience depression/ low mood? Y / N

Have you ever experiencing bullying at school?: Y / N

Are you happy with your school performance?: Y / N

Have you ever felt hurt, threatened, or been harmed in a relationship?: Y / N

Are you sexually active?: Y / N If Yes, are you a consenting participant? _____

What type of sexual practices do you engage in? _____

Do you practice safer sex?: Y / N

Do you use contraception?: Y / N, if Yes, what? _____

Do you consume/ use?

Substance	What Type?	How often?
Coffee		
Caffeinated Tea		
Caffeinated Pop		
Carbonated Beverages		
Alcohol		
Recreational Drugs		
Cigarettes		

Males

Do you experience testicular pain?: Y / N

Females

Have you started menstruating? Y / N, if Yes, at what age? _____

For how long do you bleed on average? _____ days Length of time between periods? _____ days

Do you experience irregular cycles?: Y / N

On average how many pads/ tampons do you use on the heaviest day of your cycle: _____

Do you experience any of the following during menstruation? (Please Circle)

Pain/ discomfort Breast tenderness Change in mood Headaches Cravings

Have you ever had a pelvic exam, including a PAP test? Y / N

Michelle Richea, BSc, ND
Naturopathic Doctor

www.ndmichellerichea.ca
info@ndmichellerichea.ca

The Clinic @ College Corner
#103-540 College Street
Toronto, ON M6G 1A6
(T) 416.923.5500
(F) 416.923.2249

CONSENT TO SERVICES FORM

FEE SCHEDULE:

Office Visits *All Fees Include HST*:

Pediatric Initial Visit - 60 minute visit	\$139
45 minute visit	\$110
30 minute visit	\$75
15 minute visit	\$37

** Same fee schedule applies to telephone consults.*

** Please note that telephone consultations are generally intended for follow-up consultation and clarification of treatment protocols. Telephone consults are offered to new patients only after an initial visit has been conducted and a treatment plan has been initiated. It is required that you leave a credit card number on file in order to bill for a telephone consult.*

Laboratory Diagnostic Services:

Michelle Richea, ND will conduct a thorough case history, which will include an assessment of vitals and physical exam where indicated. Specific blood and/or urinary laboratory testing may be used as part of the diagnostic work-up.

Laboratory tests are Individually priced. All associated costs will be made aware to the client upon recommendation of specific laboratory services.

Herbal Dispensary & Naturopathic Medicines:

Michelle may recommend that you take certain products as part of your treatment plan. Please note that you are free to choose where you purchase the recommended products, but that certain professional product lines are only available through licensed Naturopathic Doctors.

All associated costs will be made aware to the client upon recommendation of specific health products.

Michelle Richea, ND offers an herbal dispensary for the compounding of botanical tinctures specific to the treatment protocol prescribed. Michelle also carries a limited selection of professional quality products that are not available through health food stores. OHIP does not cover the cost of these products, thus, patients are required to pay for products that they choose to purchase.

Booking Appointments:

Please schedule your appointments, including pick-up of prescribed products, in advance. Please plan to arrive for appointments on time. Visits that begin late due to a patient's late arrival will be charged the full visit fee.

Payment for Services:

Payment for services is due at the end of each visit and a receipt will be given when payment is received. Please retain this receipt for your insurance or income tax claims, if applicable. Fees may be paid by cash, cheque, direct debit, Visa, or MasterCard. A surcharge of \$40.00 will apply to all NSF cheques. Please note that refunds are not

available for medical services rendered, including lab tests performed. Extended health benefit plans often offer limited coverage for naturopathic medicine. Plans and policies differ, so please check with your provider regarding your coverage and claim procedures.

Cancelled and Missed Appointments

Please ensure to give at least 24 hrs. cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on the same day or missed appointments, a fee of \$40 will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the office manager.

Confidentiality

Everything that you communicate, directly or indirectly, to Michelle Richea, ND is confidential, unless you give written permission to disclose information to a third party. Confidentiality is respected at all times.

It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to:

1. report incidents of child abuse (physical, sexual or emotional) and neglect;
2. comply with a court ordered subpoena;
3. prevent harm to yourself or another person should such plans be disclosed;
4. report a health professional who has sexually abused a patient

In Case of Emergency

Emergency medical services are not offered by Michelle Richea, ND. In case of an emergency, patients should dial 911, or proceed to the Emergency Department of the nearest hospital.

Statement of Acknowledgment

I, _____ have read, understood and agree to the contents herein:
(print name)

Client Signature: _____ Date: _____

****Please sign and return this form to your Naturopathic Doctor on your first visit***

Michelle Richea, BSc, ND
Naturopathic Doctor

www.ndmichellerichea.ca
info@ndmichellerichea.ca

The Clinic @ College Corner
#103-540 College Street
Toronto, ON M6G 1A6
(T) 416.923.5500
(F) 416.923.2249

PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of the business practices at The Clinic @ College Corner, while at the same time providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information. The reception staff will require your name, telephone number, and address when booking your first appointment. The health file that you create with Michelle Richea, ND is completely confidential and not shared with anyone else, unless you request otherwise by signing a consent form for the release of records.

Our privacy policy outlines what Michelle Richea, ND is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols;
- Our privacy protocols comply with privacy legislation and standards of the Naturopathic Doctors' regulatory body, the Board of Directors of Drugless Therapy – Naturopathy.

HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Michelle Richea, ND understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how your information is used and disclosed. Michelle Richea, ND, will collect, use and disclose information about you for the following purposes:

- To assess your health concerns and provide appropriate health care
- To advise you of treatment options
- To establish and maintain contact with you
- To send you newsletters and other information mailings
- To 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 invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I have reviewed the above information that explains how the Michelle Richea, ND will use my personal information, and the steps that they are taking to protect my information.

I agree that Michelle Richea, ND can use and disclose personal information about

_____ as set out above in the information Michelle Richea's privacy policies.

(Patient Name)

Signature

Print name

Date

****Please sign and return this form to your Naturopathic Doctor on your first visit.***

Michelle Richea, BSc, ND
Naturopathic Doctor

www.ndmichellerichea.ca
info@ndmichellerichea.ca

The Clinic @ College Corner
#103-540 College Street
Toronto, ON M6G 1A6
(T) 416.923.5500
(F) 416.923.2249

CONSENT TO TREAT FORM

Statement of Consent

Name (please print): _____

As a patient of this practice I have read the information and understand that the form of medical care is based on Naturopathic Medical principles. I acknowledge that my Naturopathic Doctor, Michelle Richea, ND, endeavours to provide the best possible diagnosis and course of treatment, but that no warranty is made with respect to any treatment, action, or medical advice given, as many factors will be important in determining actual results. I also recognize that even the gentlest therapies potentially have their complications in certain situations and hence the information provided is complete and inclusive of all health concerns, medical history, including risk of pregnancy; and all medications, including over-the-counter drugs and supplements. The slight health risks of some naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations.

I also acknowledge that I have the ability to accept or reject this care of my own free will and choice. I give permission and consent to Michelle Richea, ND, to provide naturopathic consultation, assessment and/or treatment to me [and/or my child _____ who is my son/daughter].

Client/ Guardian Signature: _____

Date: _____

****Please sign and return this form to your Naturopathic Doctor on your first visit.***

Michelle Richea, BSc, ND
Naturopathic Doctor

www.ndmichellerichea.ca
info@ndmichellerichea.ca

The Clinic @ College Corner
#103-540 College Street
Toronto, ON M6G 1A6
(T) 416.923.5500
(F) 416.923.2249

Authorization for Release of Medical Information from Healthcare Professional

To: Dr.: _____
(please print)

Fax No#: _____

Address: _____

Telephone: _____

From: Patient: _____
(please print)

Date of Birth: _____

Address: _____

Telephone: _____

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _____

X-Rays _____

Laboratory Results _____

Other _____

On behalf of Michelle Richea, N.D., I _____ give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.

Signature of patient: _____
Date: _____

Michelle Richea, ND
Registration #1466

Signature: _____
Date: _____

Michelle Richea, BSc, ND
Naturopathic Doctor

www.ndmichellerichea.ca
info@ndmichellerichea.ca

The Clinic @ College Corner
#103-540 College Street
Toronto, ON M6G 1A6
(T) 416.923.5500
(F) 416.923.2249

The Student Preceptor Program

There are only two naturopathic medical colleges in Canada - one in British Columbia, and one situated here in Toronto. In order for a naturopathic student to complete the 4-year program, he/ she must fulfill a certain number of 'preceptor' hours. These are clinical requirements for students to witness a number of naturopathic sessions as a non-interactive observer. The students do not engage in these sessions, but simply participate as a silent observer. This is an important aspect of the naturopathic college's clinical education as this offers valuable insight into clinical practice. The students have complete understanding of the confidential nature of these sessions and uphold all requirements of full confidentiality. Your Naturopath, Michelle Richea, ND participates in this mentorship program and would like to know if you are interested in participating as well by allowing a naturopathic student to sit-in on your clinic visits. Of course, you are more than welcome to change your mind at any time, simply tell your ND or the office receptionist.

I understand the preceptor program, and:

- I would NOT like to participate
- I would like to participate by allowing a naturopathic student to sit-in on my clinic visits
(If checked, please complete below)

CONSENT TO NATUROPATHIC STUDENT PRECEPTORS

I _____ (please print name) give my informed consent to allow naturopathic students to sit-in on my naturopathic visits for educational purposes. I understand that I can change my decision at any time by notifying the clinic receptionist or Naturopathic Doctor

Signature

Date