BELMONT Naturopathic Chiropractic Massage Therapy
NATURAL HEALTH CENTRE

201-690 BELMONT AVENUE WEST
KITCHENER ON N2H 1M6
(P)519-578-7489 (F)519-578-9747
WWW.BELMONTNATURALHEALTH.COM

Tom Daly, BSc. ND
Arla Kasaj, HBSc. ND

Hello and thank you for making a commitment to your health through naturopathic medicine. Enclosed you will find an intake form, consent form, and review of systems form to be filled out before your first visit. Here are answers to some frequently asked questions:

- *Why so many forms to fill out?* An important principle of naturopathic medicine is to treat the underlying causes of a health concern. This process is comparable to the detective work in a mystery novel; it takes some time to gather all of the clues and often there are details that seem insignificant to the reader but play an important role in finally solving the mystery. This is why we ask for your patience in exploring some of the details regarding your health, and some extra diligence on your part in paying attention to the details of your symptoms and overall well-being.
- *What about supplements?* Nutritional and herbal supplements are often required for successful treatment. In designing individualized treatment plans we always try to minimize the number of items required while still gaining a therapeutic benefit for the patient. We will recommend items that we have found to be of high quality and effectiveness. Some of these are only available through health care professionals such as naturopathic doctors, and others are available at better health food stores. You are under no obligation to purchase items directly from this clinic.
- As this clinic has clients with various environmental sensitivities, we kindly ask that you refrain from wearing clothes that smell like smoke, paint or other strong odours as this can cause irritation and reactions in other allergic patients.
- *How long before I see results?* This depends on a number of factors, including the nature of the condition treated, patient compliance and the forms of treatment agreed upon. Many acute conditions such as coughs, colds and infections can be resolved very quickly. Chronic concerns such as arthritis, allergies and digestive problems usually take a number of months of commitment to treatment.
- *Are telephone consultations available?* Yes, ongoing communication is an important part of successful treatment and is therefore encouraged. Telephone inquiries are provided free of charge up to five minutes. Consultations requiring more time and discussion are billed at the regular hourly rate after five minutes. Where applicable long distance costs will also be charged.
- *Missed appointments?* Without 24 hours notice, will be billed at the hourly rate.
- *Please include a recent photograph of yourself/patient with your Intake form.*
- *In the interests of cleanliness,* please feel free to bring a quiet amusement/toy for your child during his/her appointment.

Naturopathic medicine is most effective when you are an active participant in your health care. Therefore we will do my best to explain the reasoning behind various treatment options and to answer any questions you may have regarding your care.

Thank you for taking the time to go through these materials. We look forward to meeting with you soon.

Sincerely,

Tom Daly, B.Sc., N.D. and Arla Kasaj, HBSc., N.D.

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Declaration and Consent to Treatment

Patient Name: _____ Date: _____
please print

Assessment and Treatment

Tom Daly and Arla Kasaj practice naturopathic medicine using a combination of the following forms of treatment: standard medical techniques (i.e. physical examination and lab work), nutrition, traditional Oriental medicine, homeopathic medicine, botanical medicine (i.e. herbs), physical treatments and lifestyle counselling.

After taking a thorough case history, you will receive information about your diagnosis and/or treatment, alternative courses of action, costs, expected benefits, risks, side effects, and in each case the consequences of not having the diagnosis and /or treatment acted upon. As with any form of medical intervention there can be health risks associated with treatments by naturopathic medicine. Some possible side effects could be aggravation of pre-existing symptoms, an allergic reaction to supplements or herbs, and/or pain, bruising, or fainting from acupuncture.

I understand that Tom Daly and Arla Kasaj are licensed Naturopathic Doctors (N.D.). Any treatment or advice provided to me as a patient of Tom Daly or Arla Kasaj is not exclusive from any treatment or advice that I may receive in the future from another licensed health care provider. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

I understand that in the event of a medical emergency, I am advised to seek conventional medical care at a hospital or clinic if I am unable to reach my Naturopathic Doctor.

I understand that the products available through the clinic dispensary may be available through retailers of natural health products in the community.

I understand that I have the right to ask any questions regarding the nature of my treatment, including foreseen risks and benefits. I understand that, as in any medical treatment, results are not guaranteed. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent at any time.

I welcome professional dialogue regarding my case between members of my care team at Belmont Natural Health Centre. Yes / No

Patient Fees

Adult	$148 per hour
Senior (65+) or Student/Child (17 and under)	$120 per hour

Missed appointments without 24 hours cancellation notice will be billed at hourly rate

I have read all of the above and accept that these are the terms and conditions while under the Naturopathic care of Tom Daly, B.Sc. N.D. or Arla Kasaj, HBSc. N.D.

Signature: _____ Date: _____
Patient or Parent/Guardia

Pediatric Intake Form

General Information

Child's Name:_____Birth Date Sex F ☐ M ☐

Address _____

Telephone_____ Postal Code_____

Mother's Name_____. Father's Name _____

Address (if different ~~from child~~): _____

Telephone: Home_____Work_____May leave message? Y N

Emergency Contact:_____Phone: _____

How did you hear about our clinic?_____

Would you like to receive our newsletter? Email Address _____

Primary Health Concerns

Please list health concerns order of importance to you:

Concern	When did it first occur	What makes better	What makes worse

Past/Present Medications (include supplements, antibiotics, vitamins, and homeopathics)

Name	Duration

Illnesses (Past and Present)

Mumps ☐	Ear infections ☐	Influenza ☐
Measles ☐	Frequent colds ☐	Small pox ☐
Rubella ☐	Tonsillitis ☐	Tetanus ☐
Allergies ☐	Scarlet fever ☐	Diphtheria ☐
Pneumonia ☐	Rheumatic fever ☐	Hepatitis ☐
High fevers ☐	Pertussis ☐	

Chicken pox ☐ Other:

Past Medical History (surgeries, injuries, hospitalizations)

_____

_____

Symptoms Your Child has Displayed

Frequent vomiting ☐	Easy bruising ☐		Tendency to bleed ☐
Change in appetite ☐	Nosebleeds ☐		Sore throat ☐
Body/breath odour ☐	Hearing loss ☐	Cough ☐	Bed wetting ☐
Frequent urination ☐	Hair loss ☐	Wheezing ☐	Blood in urine ☐
Cries easily ☐	Eczema ☐	Fatigue ☐	Unusual fears ☐
Night sweats ☐	Headaches ☐	Nervousness ☐	Dizzy spells ☐

Digestion

Does your child experience (please check)? Abdominal Pain ☐ Reflux ☐ Nausea ☐ Constipation ☐ Diarrhea ☐

Other: _____

Frequency of bowel movements? _____

Has this changed recently? Y ☐ N ☐

Suspected Allergies and Intolerances _____

_____

Immunizations

Measles ☐	Diphtheria ☐	Hepatitis ☐
Mumps ☐	Pertussis ☐	Influenza ☐
Rubella ☐	Tetanus ☐	Small Pox ☐
Polio ☐	Other ☐	

Any adverse reactions to any of the above? Y ☐ N ☐

If yes, explain: _____

_____

Birth and Prenatal History

Term of pregnancy: _____ Caesarean section: Y ☐ N ☐

Birth weight: _____

Interventions during birth (i.e. forceps, epidural): Y☐ N☐ ____

If yes, explain:_____

_____

Mother's age at birth: _____

Mother's health at conception (rate on scale 1 to 10): _____

Mother's health during pregnancy (rate on scale 1 to 10): _____

Symptoms or interventions during pregnancy:

Nausea	☐	Hypertension	☐	Rhogam Shot (Rh+/-)	☐
Bleeding	☐	Physical trauma	☐	Other illnesses (specify below)	☐
Thyroid problems	☐	Diabetes	☐	Emotional stress	☐
Other Illness (list)					

Medications or drugs used during pregnancy (including alcohol, tobacco, recreational drugs):

_____

_____

Was infant nursed? _____ If yes, how long? _____

If no, alternative used? _____

Food reactions or intolerances (past and present):_____

_____

_____

Symptoms which occurred at birth or during infancy:

Colic	☐	Rashes	☐	Birth injuries	☐
Seizures	☐	Jaundice	☐	Birth defects	☐

Age the following milestones were achieved:

1st tooth	Sitting	Solid foods
All teeth	Crawling	Toilet trained
First words	Walking	

Child's health in the past year (1=poor, 10=excellent):____

Any significant change from the previous year: _____

If yes, explain: _____

_____

Child's activity level (1=poor, 10=excellent): _____

Favourite activities or hobbies: _____

Child's temperament: _____

Behaviour and performance at school: _____

Communication with others (children and adults): _____

Any pets in home: _____

Urban or rural home: _____

Type of heating used in home: _____

Any smokers in the home: _____ If yes, how many? _____

How often has child moved? _____

Any recent renovations to current or recent homes: Y ☐ N ☐

If yes, specify: _____

_____

Has child had direct exposure to any potentially harmful substances or chemicals (pesticides, herbicides, insecticides, household cleaners, lead piping, poisons etc.?) Please specify:

_____

What is the current parenting situation at home (both parents at home, joint custody, single parent etc.)?

_____

Outside of school, about how many hours a week does the child spend at the following:

Physical activities (sports, play, etc.): _____

Electronic activities (TV, computer, video games): _____

Outdoor activities: _____

Creative activities (reading, schoolwork, music, etc.): _____

What is your main drinking water source? City (tap), Spring, Reverse Osmosis.

Family Health History

In the following table, please indicate which of the following ailments, have affected your child's family. Please specify any other major ailments not listed here.

Alcoholism ☐	Asthma ☐	Depression ☐	Gonorrhea ☐	Heart Disease ☐	Skin Disease ☐
Allergies ☐	Autism ☐	Diabetes ☐	Gout ☐	Paralysis ☐	Syphilis ☐
Arthritis ☐	Cancer ☐	Epilepsy ☐	Hay Fever ☐	Pneumonia ☐	Tuberculosis ☐

Please indicate relative to your child:

Relative	Age (If living)	Age at death	Ailments and Cause of Death
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles			