2019 Intake Form
Children (up to 15)

Aranka Jones
naturopathic medicine

be well
COLLINGWOOD

Child's Name:_____ Date of Birth:_____

Gender:_____ Parent/Guardian's Name:_____

Address:_____

City:_____Postal Code:_____

Phone number:_____

Email:_____

How did you hear about Dr. Jones?_____

Describe your child's general state of health: Excellent Good Fair Poor

Please list chief health concerns and goals for treatment for your child:

_____

_____

_____

_____

_____

_____

If not included in the above list, please tell me about any current or past medical conditions, serious illnesses, injuries, traumas or hospitalizations with approximate dates:

_____

_____

_____

Family physician's name:_____ City:_____

Date of last visit to physician:_____

Other practitioners treating your child:_____

List current medications (prescription and over the counter) and any natural health products:

Medication/Product	Why your child takes it	Dose	Taken since

List any drug allergies:_____

List any other allergies:_____

Is your child up to date on vaccinations? YES NO

Which of the following infectious diseases has your child experienced to date?

Measles Mumps Chickenpox (Varicella) Impetigo Strep throat

Rubella Roseola Whooping cough Mononucleosis Scarlet Fever

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

How many times has your child been treated with antibiotics in the last year?_____

Has your child ever taken a probiotic supplement?_____

Family History - please list any health conditions:

Mother	
Father	
Grandparents	
Siblings	

Prenatal Health

Describe health of both parents at conception:

Mother: Excellent Good Fair Poor

Father: Excellent Good Fair Poor

Mother's age when child was born:_____

List any health conditions/complications/traumas experienced during pregnancy:_____

_____

_____

Circle all that apply to your child:

Pregnancy length: Full term Premature Late Location of birth: Hospital Home

Type of delivery: Vaginal C-section Length of labour:_____

Did your child experience any health problems shortly after birth?_____

_____

_____

Nutritional History

Was your child breast fed? YES NO For how long?_____

If formula fed, what kind of formula?_____

When did your child begin solid foods?_____

List any food allergies:_____

_____

List your child's favourite foods:_____

_____

List your child's food dislikes:_____

_____

Describe what your child eats in a typical day:

Meal	Time of day	What and how much
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Dessert or night eating		

Lifestyle

How many hours of sleep does your child get each night?_____

Describe any sleep issues:_____

Describe any behavioural issues:_____

Note any stress at home or recent traumas:_____

How many hours of screen time does your child get each day?_____

How many hours of outdoor play does your child enjoy each day?_____

Childhood Development

At what age did your child first (1) Sit up _____ (2) Crawl _____ (3) Walk _____ (4) Talk _____

Do you have any concerns about your child's development? YES NO

Have your child's height and weight been normal for age? YES NO

Review of Body Systems - please check all that apply to your child:

- ☐ unexplained weight loss
- ☐ unexplained weight gain
- ☐ change in appetite
- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ trouble sleeping
- ☐ skin rashes
- ☐ itching/burning
- ☐ dry skin
- ☐ hair or nail changes
- ☐ head injury
- ☐ headaches
- ☐ migraines
- ☐ neck pain/stiffness
- ☐ neck lumps/masses
- ☐ eye pain
- ☐ red eyes
- ☐ eye infections
- ☐ double vision
- ☐ needs glasses
- ☐ hearing problems
- ☐ earache
- ☐ ear infections
- ☐ vertigo
- ☐ sinus congestion
- ☐ sinus pain
- ☐ nasal discharge
- ☐ nosebleeds
- ☐ hay fever
- ☐ frequent sore throat
- ☐ sore tongue
- ☐ bad breath
- ☐ thrush
- ☐ non-healing sores
- ☐ dental infections
- ☐ dental cavities
- ☐ bleeding gums
- ☐ cold sores
- ☐ heart murmur
- ☐ chest pain
- ☐ dizziness
- ☐ fainting spells
- ☐ ankle swelling
- ☐ hives
- ☐ allergies
- ☐ recurrent infections
- ☐ easy bruising
- ☐ anemia
- ☐ swollen glands
- ☐ hair loss
- ☐ heat intolerance
- ☐ cold intolerance
- ☐ excessive sweating
- ☐ excessive thirst
- ☐ cough
- ☐ shortness of breath
- ☐ asthma
- ☐ wheezing
- ☐ difficulty swallowing
- ☐ heartburn/reflux
- ☐ nausea/vomiting
- ☐ changes in bowel habits

Number of bowel movements per day:_____

- ☐ constipation
- ☐ diarrhea
- ☐ yellow eyes/skin
- ☐ abdominal pain
- ☐ bloating/gas
- ☐ black/bloody stool
- ☐ rectal bleeding

- ☐ hemorrhoids
- ☐ bowel incontinence
- ☐ pain with urination
- ☐ urinary frequency
- ☐ urinary urgency
- ☐ urinary incontinence
- ☐ bed wetting
- ☐ blood in urine
- ☐ bladder infections
- ☐ kidney infections
- ☐ kidney stones
- ☐ physical trauma
- ☐ muscle pain
- ☐ cramping
- ☐ restless legs
- ☐ joint pain
- ☐ joint stiffness
- ☐ joint swelling
- ☐ dizziness
- ☐ fainting
- ☐ seizures
- ☐ weakness
- ☐ numbness
- ☐ tingling
- ☐ tremor
- ☐ behaviour problems
- ☐ social problems
- ☐ mood swings
- ☐ nervousness
- ☐ anxiety
- ☐ worry
- ☐ depression
- ☐ psychological trauma
- ☐ grief
- ☐ suicidal behaviour
- ☐ eating disorder
- ☐ substance abuse

Females:

age of first period:_____

- ☐ irregular periods
- ☐ painful periods
- ☐ heavy bleeding
- ☐ PMS
- ☐ birth control pill use
- ☐ vaginal discharge
- ☐ vaginal itching
- ☐ yeast infections
- ☐ masses/sores
- ☐ nipple discharge

Males:

- ☐ penile discharge
- ☐ hernia
- ☐ undescended testes
- ☐ masses on genitals
- ☐ sores on genitals

Please use this space for any additional information you'd like to share:

Dr. Aranka Jones • Be Well Collingwood • 65 Fourth Street East • Collingwood ON L9Y 1T4 • 705-446-2200

What To Expect

Our work together begins with me listening attentively and with compassion to your story - usually over a cup of tea. This will feel different from interactions you've had with other doctors. I take the time to perform a thoughtful, thorough assessment of *all* your child's health concerns in the context of their lifestyle, diet and eating habits, environment, genetics and mental/emotional factors.

My diagnostic workup includes conventional blood tests as well as more sophisticated, functional medicine tests used to identify underlying problems related to your child's digestion, microbiome, immune system and environmental exposures. By taking the time to ask the right questions, perform the right tests and *really think about your child*, I gain the necessary insight to create an effective and personalized plan for their care.

Treatment is often initiated during your child's initial visit. When dependent upon the results of laboratory testing, treatment options will be discussed and implemented in their second visit.

I will recommend treatment options that are integrative, evidence based, generally safe and well tolerated. I will inform you of both the anticipated benefits as well as any known risks such as aggravation of pre-existing symptoms, known side effects and the potential for drug interactions. I will also advise you of any associated costs and alternative courses of action so that you feel confident in making an informed decision about your child's care every step of the way.

It is important that you and your child return for occasional progress visits so I may effectively monitor their response to treatment, make necessary adjustments to their care plan and support your family in maintaining their results.

Privacy Policy

1) All personal and medical information is kept strictly confidential and will not be released to anyone without your written consent. You may request a copy of your child's records in writing at any time for an administrative fee of $0.25 per page. Please allow 5-10 business days for such requests to be met.

2) Lab results will only be released once we have reviewed them together. After that time I am happy to share copies with you and members of your child's health team and there is no charge for this.

3) To ensure your child's privacy and the effective delivery of care, discussion about your child's health concerns and treatment must take place during visits. If something arises between scheduled visits please contact my office to schedule a visit so I may properly attend to your concern.

4) My office may contact you from time to time for the purpose of scheduling progress visits. Please inform us of any changes to your contact information and how you prefer to be contacted.

Financial Policy

1) **Payment**: Payment for visits is due in full at the end of each visit. You will be presented with an itemized invoice for your child's visit fee and any lab work to be performed. You can pay by debit, credit card or cash.

2) **Insurance**: I do not direct bill insurance companies at the present time; however, I will provide you with itemized official receipts which you may easily submit to your insurance provider. Please consult

your policy to learn about your child's coverage. If your child does not have coverage you may instead claim my fees as a medical expense deduction on your income tax return.

3) **Visit lengths**: Your child's *Initial Visit* will last 60 minutes. Subsequent visits vary in length depending on the complexity of your child's health concerns, what you wish to accomplish and how recently we last met. If I haven't seen your child in 3 months I'll generally ask you to book 45-60 minutes. If visits end early I will automatically reduce the fee. Likewise if your child's visit runs significantly longer than what was booked, as may be possible when my schedule permits, I will automatically increase the fee.

4) **Visit fees**:

2019 Fees for Adults		
Visit type	*Duration*	*Fee*
Initial Visit (Standard)	60 min	$150
Progress visits (in office or by phone)	30 min	$90
	45 min	$120
	60 min	$150
	75 min	$188
	90 min	$225

5) **Cancellations**: A significant amount of resources are allocated to your child's visits and the high level of care I maintain for my patients. Missed visits and last minute cancellations greatly impact my ability to sustain high overhead costs and earn a living. Please provide me with at least 24 hours notice if you need to cancel or reschedule to avoid being billed for the cost of the scheduled visit. While you and your child must attend their initial visit in person, subsequent visits can sometimes be arranged by phone depending on your child's condition and whether or not I need to examine them in person.

6) **Dispensary**: For your convenience you may purchase natural health products from my office as long as your child remains actively under my care. Please don't share or buy for other people; what is safe and effective for your child may be harmful or ineffective for someone else. Only unopened products not requiring refrigeration may be returned for credit within 30 days of purchase.

Acknowledgement

By signing below you acknowledge that you have read and understand what to expect, including my Privacy Policy and Financial Policy outlined above. You agree to inform me of all health conditions and symptoms your child is experiencing as well as any prescription and/or over the counter drugs and natural health products your child is taking. You agree to notify me if your child's condition, medication use or natural health product use change while they are under my care. You provide informed consent for your child to receive naturopathic care which you may withdraw at any time.

_____
Child's Name

_____
Guardian's Name

_____
Guardian's Signature

_____
Date signed