Dr. Jennifer Gratton, N.D.

Naturopathic Doctor

Welcome and congratulations for putting your health first. You have taken a major step towards investing in your health now and for the future. In making your appointment with us you have demonstrated that you are determined and ready to make the essential shifts in your life necessary to experience total health and wellbeing.

My goal as your Naturopathic Doctor is to find the underlying cause(s) of the presenting symptom(s) and formulate a personalized treatment plan that is specific to you. It is important to utilize preventative medicine so to enhance the body`s ability to maintain good health and empower one to make healthy lifestyle choices.

Please take the time to fill out the important form below. The information you provide will greatly assist me to understand what your goals are and what expectations you have so that we can formulate an individualized health care plan tailored to your needs. Any information that is written here or discussed during your Naturopathic visits will be held with the utmost confidentiality. As your Doctor, I am the only person who reviews these forms.

Typically, your first visit is one and a half hours long and will include a full physical examination (excluding female/ male gynecological). Once your condition is assessed you will be called in for a second visit where a treatment plan will be presented to you. Your progress will be monitored and further visits may be necessary to map out continued treatment. It is also important that if you have had any laboratory testing done within the past 6 months to bring a copy of these results with you on your first visit.

I sincerely thank you for taking this step towards the betterment of your health and I look forward to seeing you at your visit to the clinic.

In good health,
Jennifer Gratton, N.D.

Jennifer Gratton, ND
Naturopathic Medicine

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Confidential Pediatric Intake Form

Today's Date:_____

Last Name: _____ First Name: _____ MI: _____
Parent(s): Mother_____Father_____ Birthdate: _____/_____/_____ Sex: M / F
Mailing Address: _____ City: _____
Province: _____ Postal Code: _____ Home Phone: _____
Emergency Contact: _____ Relationship to Patient: _____
Contact's Phone Number: _____ Contact's Email: _____
Referred to Dr. Jennifer Gratton by: _____

Current Health Care Team:
Patient's Pediatrician: _____ Office Number: _____
Specialist Physician: _____ Specialty:_____ Office Number: _____
Specialist Physician: _____Specialty:_____ Office Number: _____
Other Health Care Team Members (Ex: massage therapist, nutritionist, acupuncturist, etc.):
Practitioner Name: _____ Office Number: _____
Practitioner Name: _____ Office Number: _____

CURRENT HEALTH CONDITION

Please list current health concerns, time of onset, and current treatment:

Condition	Onset/Duration	Treatment (if any)

PAST MEDICAL HISTORY

Pregnancy: Duration of pregnancy:_____
Any complications with pregnancy?
_____
Type of birth delivery (eg. cesarean section, vaginal) Birth Weight:____ lb, Height ____ in.

Any complications with delivery?
_____

Newborn: Any significant health concerns as newborn? (e.g. anemia, jaundice, respiratory difficulty, infection)

_____

To date, please list history of all major illnesses, hospitalizations, surgical procedures including dates.

_____
_____
_____

History of head injury or other major injury?

_____

Has this child ever been unconscious or had seizures?

_____

Immunization History (Check all that apply & list months/year of age)

- ☐ MMR
- ☐ DTP
- ☐ Haemophilus influenzae
- ☐ Hep A
- ☐ Hep B
- ☐ Influenza
- ☐ Pneumococcal
- ☐ Polio
- ☐ Tetanus
- ☐ Tetanus booster
- ☐ Smallpox
- ☐ Tuberculin
- ☐ Varicella
- ☐ Other (please list below)

MEDICAL HISTORY

Date of last Physical/Wellness Exam: _____ Date of last Blood Tests:_____

Please list any Life Threatening Allergies: _____

Other Allergies, sensitivities, or intolerances (eg. food, medication, environmental, chemical, etc.):

If currently taking any supplements please list brands and dosages of all products you are taking and the reason for taking them: _____
_____
_____

FAMILY HISTORY

Place appropriate letter(s) in blank if someone in the child's family has/had any of the following.
(F=Father, M=Mother, S=Sibling, G=Grandparent)

___ Alcoholism
___ Allergies/Eczema
___ Asthma
___ Autoimmune Disorders
___ Cancer, specify type(s):
_____
___ Crohn's Disease
___ Diabetes
___ Drug abuse
___ Epilepsy/Seizures
___ Headaches/Migraines
___ Heart Disease
___ Neurological Disorders
___ Obesity
___ Sexually Transmitted
Infections: _____
___ Thyroid Disorder
Any other condition:_____

LIFESTYLE:

Please select the following that apply to this child (write N/A if does not apply to child's age)
___ Stays at home ___ Involved in after-school activities (Ex: _____)
___ Daycare (___ days/week) ___ Socializes well with other children
___ School (grade level_____)
___ Holds attention while working on a task

Describe the child's family situation: (number of siblings, parental involvement in child's life, etc):
_____
_____
_____

Favorite Activities:
_____
Fears and Anxieties:
_____

Breast Fed and/or Bottle Fed (please indicate which one & duration):_____
Any issues with latching?_____
History of Projectile vomiting? _____

DIET (If Applicable): Please check any of the following: ___Mixed Diet (animal/vegetable)
___Vegetarian___ Organic Food

Please list any Food Restrictions (e g. dairy, gluten, soy, etc.):
_____
_____

Any additional information that is important for me to know about your child?
_____
_____
_____

I have completed this form to the best of my ability in reference to this child's health history. I have stated all known health conditions for this child and will alert the practitioner of any new condition as it arises. My signature below indicates that I agree to take full responsibility for bringing this child to naturopathic.
Signature: _____ Date: _____
Relationship to Patient:_____

Informed Consent

Naturopathic Medicine is the treatment and prevention of disease 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.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet, lifestyle counseling, clinical nutrition (primary via supplementation), botanical medicine, homeopathy, Eat Right for Your Blood and Genotype, hydrotherapy, and physical medicine. Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, increased gastrointestinal function, improved immunity, and general well-being.

Botanical medicine is a plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.
Homeopathy is a form of medicine based on the Law of Similars – that is, the use of tiny doses of the very thing that causes symptoms in health people. These minute doses of plant, animal, or mineral origins are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counseling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During you initial visits, your Naturopathic Doctor will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples or perform other laboratory testing.
Even the gentlest therapies may cause complications in certain physiological conditions this depends greatly on the individual and the extent of the illness. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease.
It is very important, therefore, that you inform your naturopathic doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

Health risks associated with Naturopathic Medicine include but are not limited to:
• Aggravation of pre-existing symptoms during the healing process.
• Allergic reactions to supplements or herbs.
• Pain, bruising or injury from acupuncture.
• Fainting or puncturing of an organ with acupuncture needles.

_____
Initials
I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

_____
Initials
I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

_____
Initials
I understand that fees and supplements are to be paid for at the time of the consultation.

_____
Initials
I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours' notice.

As the patient, you are responsible for the total charges incurred for each visit. We accept cash, or cheque at this time.

If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company – we will provide you with all of the information necessary to send your claim for reimbursement.

Your Naturopathic Doctor may prescribe supplements that can be purchased from our in-house dispensary, or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
Patient Name (please print): _____
Signature of Patient or Parent / Guardian: _____
Date: _____