ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR

Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

Pediatric New Patient Form (12 years old and younger)

Child's Name: _____Gender: _____

Birth Date (M/D/Y): _____ /_____/_____ Age: _____ Grade: _____

Who is filling out this form (Name, Relation)? _____ Today's Date (M/D/Y): _____ /____ /_____

CONTACT INFORMATION FOR PARENTS/LEGAL GUARDIANS (Who the child lives with):

Name(s): _____ Relation(s): _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

May we leave you messages regarding your clinic visits? Yes No

E-mail: _____ Would you like to join Odette Bulaong, ND's FREE e-newsletter list? Yes No

How did you hear about Dr. Odette? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____ Phone #: _____

HEALTH CARE PROVIDERS

Pediatrician: _____ Phone #: _____

Medical Doctor: _____ Phone #: _____

Specialist: _____ Phone #: _____

Other: _____ Phone #: _____

Health Concerns

Please list and briefly explain your child's main health concerns, in order of importance to you:

_____ When started: _____

_____ When started: _____

_____ When started: _____

Please list your child's past major illnesses, injuries, surgical procedures, operations, hospitalizations:

_____ When: _____

_____ When: _____

_____ When: _____

When was your child's last check-up with a pediatrician or family doctor? _____

What screening tests has your child had (e.g. blood, xray, MRI, hearing, visual, behavioural etc.)?

_____

Please describe your child's general state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR

Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

Medical History

Please list which vaccines (immunizations) your child has had and approximately how old they were at each dose:

VACCINE	AGE(S) GIVEN	ANY ADVERSE REACTIONS OR CHANGE IN HEALTH OR BEHAVIOUR
Diphtheria, Pertussis, Tetanus (DPT)		
Polio (ITP)		
Haemophilus Influenzae type B (HiB)		
Pneumococcal (Pneu-C-7)		
Measles, Mumps, Rubella (MMR)		
Meningococcal C (Men-C)		
Chickenpox/Varicella (Var)		
Hepatitis B (HB)		
Human Papillomavirus (HPV)		
DTP/ITP Booster (Tdap/IPV)		
Tetanus/Diphtheria Booster (Td)		
Influenza (Inf)		
Other(s):		

On average, how many times has your child been treated with antibiotics? _____ Approximate date of last time: _____

Please list any known or suspected allergies (medicines, food, environmental, etc.): _____

_____

_____

Please list all **CURRENT or PAST prescription and over-the-counter medications (e.g. cough syrup, antibiotics, Children's Tylenol), vitamins, mineral, herbal or homeopathic medicines** your **child** has taken by filling out the chart below. If more space is required, please attach a separate sheet.

MEDICATION	DOSAGE (AMOUNT AND # TIMES A DAY TAKEN)	APPROXIMATE DATES & LENGTH OF TIME TAKEN

Please check **(√)** which childhood illnesses your child has had and approximate dates:

	YES	WHEN		YES	WHEN		YES	WHEN
Chicken Pox			Mononucleosis			Scarlet Fever		
Croup			Mumps			Stomach Flu		
Growing Pains			Pneumonia			Strep Throat		
Measles			Rheumatic fever			Whooping Cough		
Meningitis			Rubella			Other:		

Please list any complications that arose from the above illnesses (if applicable):

_____

ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR
Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

Please list whether the child's *mother, father, siblings, maternal or paternal grandparents* have the following conditions:

	WHO?		WHO?		WHO?
Allergies		Diabetes		Liver Disease	
Anemia		Digestive Conditions		Mental Illness	
Asthma		Eczema		Migraines	
Birth Defect		Epilepsy		SIDs (sudden infant death syndrome)	
Bleeding Disorder		Heart Disease		Stroke	
Cancer (what kind?)		Kidney Disease		Tuberculosis	

Please list any other health conditions that exist in your family, and which of the above family members are affected:

_____

The following chart will provide a more complete picture of your child's overall health. Please check **(√)** column **C** if your child **CURRENTLY** has a symptom below and column **P** if they have had it in the **PAST**. If they have never had the symptom, please do not check either box.

	C	P		C	P		C	P
GENERAL			**EYES**			**CARDIOVASCULAR**		
Fatigue			Blurred vision			Heart murmurs		
Weakness			Double vision			Septal wall defects		
Significant weight loss			Redness			**RESPIRATORY**		
Significant weight gain			Itching			Cough		
SKIN			Discharge			Wheezing		
Eczema			Infection (e.g. Pink eye)			Asthma		
Psoriasis			**EARS**			Bronchitis		
Rash			Ear infection			Difficulty breathing		
Hives			Discharge			**HEMATOLOGY**		
Itching			Trouble hearing			Easy bruising		
Redness			Ringing in ears			Easy bleeding		
Dryness			**NOSE & SINUSES**			Past transfusions		
Acne			Frequent colds			Poor wound healing		
Warts			Nosebleeds			**DIGESTIVE**		
Boils			Sinus problems			Change in appetite		
Fungal infections			**MOUTH &THROAT**			Difficulty swallowing		
HEAD			Thrush			Hernia		
Headache			Sore throat			Vomiting		
Head injury			Gum problems			Nausea		
Dizziness			Dental cavities			Excessive gas		
Cradle cap			Tonsillitis			Bloating		
Lice			**URINARY**			Stomach pain		
NEUROLOGIC			Bedwetting			Diarrhea		
Seizures			Urinary/bladder infections			Constipation		
Tingling/numbness			Increased urination			Blood in stool		

Other Symptoms: _____

ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR

Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

Nutrition

Was your child breastfed? Yes No If Yes, how many months: _____

If No, reason why: _____

Substitute Formula used: _____

Please describe the mother's diet while breastfeeding by including foods typically enjoyed, food cravings, foods avoided, and any reactions the baby had to the mother eating different foods: _____

_____

_____

Did your child experience colic? Yes No

Please describe the child's weaning history including child's age when started & finished and the child's response:

_____

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

_____

How would you describe the child's eating habits?

_____

Please describe how food was introduced to your child by filling out the following chart:

FOOD INTRODUCED (EARLIEST TO MOST RECENT	*APPROXIMATE AGE (E.G. 6, 9, 12, 18 MONTHS)*	*ANY REACTIONS YOUR CHILD HAD (E.G.DIARRHEA, SKIN RASH)*

Sleep Habits

Where does this child sleep? Own room Parents' room Other: _____

Child's sleep patterns (during first year) _____

Current sleep patterns: _____

Does your child nap during the day? Yes No If yes, when is the nap taken and for how long? _____

Is there any history of bedwetting? Yes No If yes, what was your response? _____

What position does your child sleep in now? (e.g. on back, on right side) _____

As an infant what position did your child sleep in? _____

Current bed time and waking time of your child: _____

Does your child sweat a lot in bed? Yes No What parts of the body? _____

Does the sweat have an odour? Yes No What does sweat smell like? _____

ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR
Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

For the remainder of this form when given a choice of answers, please circle the answer which applies to you and your child and expand on answers where applicable in the space provided.

Perinatal History

Was your child adopted? Yes No If yes, child's age at adoption: _____

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

Was the pregnancy planned? Yes No

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

Number of Previous Pregnancies: _____ Number of Previous Deliveries: _____

Pregnancy length (weeks): _____ Labour length (hours) _____ Second/pushing stage length (hours) _____

Baby's height at birth: _____ Baby's weight at birth: _____ APGAR Scores: _____

Where was the baby birthed? Birthing Centre Home Hospital Water

Who was involved in baby's delivery? OBGYN Midwife Family Doctor Doula

How was baby delivered? Vaginal C-Section

Which pain medication was administered (if any)? _____

Who else was present for support during the delivery? _____

Please check ☑ all of the complications that occurred and procedures that were necessary during the pregnancy and labour:

☐ Placenta previa	☐ Placental abruption	☐ Breech presentation	☐ Premature birth
☐ Fetal distress	☐ Prolapsed cord	☐ Jaundice	☐ Blue baby
☐ Birth defects	☐ Multiple birth	☐ Undescended testes	☐ Meconium
☐ Episiotomy	☐ Forceps	☐ Gel induction	☐ Suction required
☐ Vacuum extraction	☐ Pitocin drip induction	☐ Oxygen required	☐ Incubator
☐ Cephalopelvic disproportion (head too big)	☐ Failure to progress/ labour stalled	☐ Premature rupture of membranes	☐ Artificial rupture of membranes
☐ Hemorrhage	☐ Other: _____		

Was Vitamin K administered? Yes No If Yes, how? By mouth By injection

Was erythromycin administered in the eyes? Yes No Was silver nitrate administered in the eyes? Yes No

Any adverse reactions:_____

Mother's emotional state at the time of birth?

_____

Mother's emotional state post-partum (after delivery)?

_____

Father's emotional state at the time of birth?

_____

ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR

Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

Please list & describe severity of any health conditions the mother experienced during pregnancy:

(e.g. high blood pressure, gestational diabetes, bleeding, infections, thyroid problems, severe nausea, anemia, trauma):

_____

_____

How would you describe the pregnancy? _____

Please list any physical or emotional traumas the mother experienced during pregnancy:

_____

If the mother used any of the following during pregnancy, please indicate ***how much, how often*** *and* ***specific type***:

Tobacco _____ Alcohol _____

Recreational drugs _____ Caffeine _____

Please list **ANY prescription, over-the-counter medications, vitamins, mineral, herbal or homeopathic medicines** the **mother** took during pregnancy by filling out the chart below. If more space is required, please attach a separate sheet.

MEDICATION	DOSAGE (AMOUNT AND # TIMES/DAY TAKEN)	APPROXIMATE DATES & LENGTH OF TIME TAKEN

Tests performed during pregnancy (e.g. ultrasound, amniocentesis):_____

If the Mom works, at how many weeks into the pregnancy did the mother take maternity leave? _____

Developmental Milestones

If applicable, at approximately what age were the following milestones reached?

Smiles	_____	Grasps an object	_____	Recognizes a face	_____
Rolls over	_____	Sat on own	_____	First tooth	_____
Crawls	_____	Walks on own	_____	First word	_____
First sentence	_____	Scribbles	_____	Plays Patty Cake	_____
Dress themselves	_____	Toiled Trained	_____	Sleeps in own room	_____

Did your child stand up: On own With help

Thank you for taking the time to complete this form.
We look forward to seeing you both at your child's first visit.

ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR

Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

Declaration of Informed Consent to Naturopathic Diagnostic and Therapeutic Procedures - Pediatric

In order for Odette Bulaong, ND to assess your child's health, identify risk factors for potential diseases and create a treatment plan for your child's existing health condition(s), the following **naturopathic diagnostic procedures** may be performed:

- A thorough Health History Intake
- Complaint-Oriented Physical Exam: body systems that may be affected by your health condition may be examined.
- Urinalysis
- Complete Screening Physical Exam: a basic examination of all major body systems.
- Laboratory Blood Work: a requisition to have your child's blood work drawn privately at LifeLabs will be provided or you may choose to have your child's blood work done through your family doctor as time permits.
- Additional In-House/Laboratory Work: salivary hormone testing, allergy testing, etc.
- Chinese tongue and pulse diagnosis: examination of the tongue and pulses to provide important information on body organs with respect to Chinese Medicine.

Naturopathic medicine is a form of primary health care that uses natural substances and treatments to support and stimulate the body's ability to heal itself. The **naturopathic therapeutic procedures** that may be used by Odette Bulaong, ND individually or in combination to address your child's health condition(s) are:

- Nutritional Counseling
- Botanical Medicine
- Acupuncture and Chinese Medicine
- Homeopathic Medicine
- Lifestyle Counseling
- Physical Medicine & Hydrotherapy
- Facial Rejuvenation Acupuncture

Although the above treatments are safe and natural, even the gentlest therapies can have complications. This is especially true in very young children. 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 Odette Bulaong, ND immediately of any disease process that your child may be suffering from.

Some complications that can occur with naturopathic treatment include but are not limited to:

- Aggravation of pre-existing or existing symptoms
- Allergic reactions (for example to supplements or herbs)
- Minor bleeding or bruising from acupuncture needles, B12 shots
- Fainting or puncturing of an organ with acupuncture needles
- Accidental burning of the skin from the use of moxa or cupping
- Muscle strains and sprains, disc injures from spinal manipulation
- The potential for stroke is a concern in neck manipulation.

I understand that the results are not guaranteed. I do not expect Odette Bulaong, ND to be able to anticipate or explain all risks and complications. I will rely on Odette Bulaong, ND to exercise judgment during the course of treatment which she feels at that time is in my child's best interests, based on the facts then known. I, the undersigned, do hereby acknowledge that I have been informed of and understand the naturopathic diagnostic and therapeutic procedure(s) and have discussed to my satisfaction this and any requests for related information with Odette Bulaong, ND.

I further acknowledge and confirm that I have been informed of, and understand the diagnostic and therapeutic procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to my child.

ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR
Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

I do hereby voluntarily give my informed consent for the naturopathic **diagnostic procedure(s)** mentioned on the previous page except (please list exceptions):

_____

I do hereby voluntarily give my informed consent for the naturopathic **therapeutic procedure(s)** mentioned on the previous page except (please list exceptions):

_____

I understand that I may change the status of my voluntary informed consent for diagnostic and therapeutic procedures at any time by informing Odette Bulaong, ND.

Patient Name: _____
First **Middle** **Last**

Parent/Guardian Name: _____
First **Last**

Parent/Guardian Signature: _____ **Date Signed:** _____
Day **Month** **Year**

Statement of Acknowledgement

In order to clarify the position of Odette Bulaong, ND and the mutual responsibilities in your child's health care, please read and sign this statement of acknowledgement.

1. I understand that I am obliged to inform Odette Bulaong, ND of any pre-existing medical conditions (especially diabetes, heart, liver or kidney disease) and procedures and/or any medications (prescribed or over the counter, conventional or natural).
2. I understand that my child will be seeing a naturopathic doctor not a medical doctor and I am aware that the methods utilized by Odette Bulaong, ND may not be accepted practice by conventional (allopathic) medicine.
3. I understand that any naturopathic treatment or advice provided to my child by Odette Bulaong, ND is not being provided in the place of or to the exclusion of any other treatment or advice that my child may now be receiving or may in the future receive from a physician, surgeon, or any other licensed health care provider.
4. I am at liberty to seek and may continue to seek treatment or advice from a physician, surgeon or any other licensed health care provider.
5. I am aware of the fee schedule for naturopathic services and understand that payment is due at the time of service.
6. I understand that I will be charged $50.00 for any missed naturopathic appointments, unless I have advised Quarry Chiropractic Clinic of cancellation no less than twenty-four (24) hours in advance of the scheduled appointment.
7. I am aware that the fees for naturopathic treatment are not covered by OHIP and that it is my responsibility to confirm whether any company that provides me with private health insurance will reimburse me for the cost of such naturopathic treatments.
8. I am not an agent of any private or government agency attempting to gather information without so stating my intentions.

Patient Name: _____
First **Middle** **Last**

Parent/Guardian Name: _____
First **Last**

Parent/Guardian Signature: _____ **Date Signed:** _____
Day **Month** **Year**

ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR
Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

Privacy Information

Privacy of your child's personal information is important to this clinic while I provide your child with quality naturopathic care. We understand the importance of protecting your child's personal information and are committed to collecting, using and disclosing your child's 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 into 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.

Collection of Personal Health Information

We collect personal health information about your child directly from you. The personal health information that we collect may include, for example, you child's name, date of birth, address, health history, records of your child's visits with Odette Bulaong, ND and the care that your child received during those visits. Occasionally, we collect personal health information about your child from other sources if we have obtained your consent to do so or if the law permits.

Uses and Disclosures of Personal Health Information

We use and disclose your child's personal health information to:

- Assess your child's health care needs;
- Develop effective treatment plans for your child;
- Provide your child with treatment, health services, and care of an acute, chronic and/or preventive nature;
- Research and inform you of additional treatment options your child may benefit from;
- Inform you of clinic services, events, updates, and health care information;
- Contact you and maintain communication with you;
- Contact you to book and confirm appointments;
- Follow up with treatment, care, health status and billing;
- Communicate with other treating health care providers, including specialists, family practitioners, referring physicians, and any other health provider involved in your child's care;
- Plan, administer and manage our internal operations;
- Conduct risk management and quality improvement activities;
- Teach, demonstrate or conduct research on an anonymous basis;
- Conduct patient satisfaction surveys;
- Compile statistics on an anonymous basis;
- Invoice, process payments and collect unpaid accounts for goods and services;
- Permit potential purchasers, practice brokers or advisors to evaluate the naturopathic practice and/or conduct an audit in preparation for a practice sale;
- Deliver your child's charts and records to the naturopathic doctor's insurance carrier to enable the insurance company to assess liability and quantify damages, if any;
- Comply with legal and regulatory requirements, and fulfill other purposes permitted or required by law;
- Comply with legal and regulatory requirements, including the delivery of patient's charts and records to The College of Naturopaths of Ontario (CONO) in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act (RHPA);
- Comply with the agreements/undertakings entered into voluntarily by the member with CONO, including the delivery and/or review of patient's charts and records to the Board in a timely fashion for regulatory and monitoring purposes;
- Prepare materials for CONO complaints committee, if necessary.

Your child's information may be accessed by regulatory authorities under the terms of the RHPA for the purpose of CONO fulfilling its mandate under the RHPA and/or for the defence of a legal issue.

You may access and correct your child's personal health records, or withdraw your consent for some of the above uses and disclosures by informing Quarry Chiropractic Clinic in writing (subject to legal exceptions). If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

ODETTE BULAONG, BSC(HONS), ND | NATUROPATHIC DOCTOR
Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

We take steps to protect your child's personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal. We conduct audits and complete investigations to monitor and manage our privacy compliance.

We take steps to ensure that everyone who performs services for us protect your privacy and only use your child's personal health information for the purposes you have consented to.

Consent to Privacy Information and the Collection, Use and Disclosure of Personal Health Information

I, _____, have reviewed Odette Bulaong, ND's written statements concerning privacy information and the collection, use and disclosure of personal health information.

I understand that Odette Bulaong, ND is seeking my consent to collect, use and/or disclose my child's personal health information from me as outlined in the written statements above.

I understand that Odette Bulaong, ND will only collect, use and disclose my child's personal health information with my consent as set out above unless a particular collection, use or disclosure is permitted or required by law without my consent.

I also understand that I can refuse to sign this consent form. I can also withdraw my consent any time by informing Odette Bulaong, ND in writing.

By signing this form, I hereby authorize Odette Bulaong, ND to collect, use and disclose my child's personal health information for the purposes that are indicated in the written statements above.

Patient Name: _____
First **Middle** **Last**

Parent/Guardian Name: _____
First **Last**

Parent/Guardian Signature: _____ **Date Signed:** _____
Day **Month** **Year**