Dr. Deirdre A.W. Jasper BSc, ND (#074)
#5-414 Westmount Drive, Winnipeg, MB R2J 1P2
T: (204) 256-2273 F: (204) 257-2449 W: www.winnipegnaturopathicdoctor.ca

For your first CHILD (Ages 0-15) patient consultation:

As requested, please find attached naturopathic intake materials and additional information. Please fill out and return all completed forms, including informed consent, to Dr. Jasper PRIOR to your first appointment. PLEASE LET US KNOW IF YOU HAVE BLUE CROSS AS WE NOW PROVIDE DIRECT-BILLING TO BLUE CROSS.

Please list, in detail, any supplements and medications that your child is currently taking, including name brands, name of supplement, dose, and how long you have been taking it.

Please indicate any special diets that your child is currently adhering to. Refer to the Diet Diary to log your diet for 3-days (at any time shortly before your initial the appointment). No need to fill out a Diet Diary if your child is exclusively breast- or bottle-fed (in this case, please indicate the name of the formula).

I am also attaching the ***"Authorization for Release of Medical Information"*** form -- this form is optional to you and may be filled out and sent back to me ASAP, at which time I can forward to your doctor(s). The purpose of this form is to release recent test results from your child's doctor(s) to your naturopathic file -- I use this information to help reach a diagnosis, and in order to better understand your health concerns. This is only done if I have your consent, and is not mandatory, but strongly encouraged.

If you have any other pertinent health information on hand please feel free to forward along as well.

The initial child patient visit is about 60-75 minutes. Be aware that part of an initial consultation may include a complaint-oriented physical exam. Please note, at this time I do not perform gynecological but can refer you to another practitioner that does.

At the conclusion of the first visit your child may be given a wellness plan (diet, lifestyle and/or supplemental recommendations) and/ or referred for further testing. Please note, I do not collect blood samples on-site.

Payment is requested at the conclusion of the visit (we take cash, cheque, debit, e-transfer, Visa and Mastercard), and you may wish to keep the receipt to forward to your extended benefits health insurance company for reimbursement of naturopathic services.

PLEASE NOTE that initial consults must be conducted face-to-face. Follow-up appointments may be provided via phone for your convenience, depending on your concern. Please read and sign the "***Consent and Waiver of Liability: Electronic Communication"*** form if you wish to communicate by e-mail with Dr. Jasper.

Thanks for your interest in naturopathic medicine and I look forward to meeting with you!
--Dr. Jasper

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Child In-take Form Form completed by whom:

Surname _____ Given Names _____

Nickname _____ Gender _____ Date of Birth _____

Guardian # 1 _____ Relationship _____

Guardian # 2 _____ Relationship _____

Country of Birth _____ Languages Spoken _____

Adopted (age?) _____

Referred by/ Heard about through: _____

Permanent Address

Address _____ City/Town _____

Province _____ Postal Code _____

Home phone no.: _____ Email / Fax _____

Guardians at this address _____

Emergency Contact

Name _____ Relationship _____

Home phone (__)_ _____ Days and Times can be reached _____

Blue Cross Information

Policy Holder's Name: _____ Policy Holder's DOB: _____

Blue Cross certificate #: _____ Blue Cross client #: _____

Please list all of the child's current health care providers (name, occupation, how long they have been treating the child, and the reason for their expertise):

Name & Title	***Length of Treatment***	***Reason for Treatment***

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Current Health Status

Please list you top 3 health concerns for this child:

1. _____
2. _____
3. _____

Please check the appropriate box below according to the letter/ rating (C/P/F/N), and comment to the right.

C currently experiencing this condition
P past history of this condition
F frequently experience this condition
N never experience this condition

Condition	Rating				Comments: (e.g. Since when, severity?)
	C	F	P	N	
Allergies					
Asthma Attacks					
Bed Wetting					
Belching / Flatulence / Hiccups					
Cavities / Fillings					
Change in Appetite (increase/ decrease)					
Cold Sores					
Common Cold					
Constipation (less than 1 BM/ day?)					
Cough (dry/ wet, when?)					
Cradle Cap or Dandruff					
Diaper Rash					
Diarrhea, loose stool					
Digestion Problems (e.g. gas, pain, etc.)					
Dizziness / Loss of Balance					
Ear Infection (how many in life?)					
Eczema (location, type)					
Eye / Vision Problems					
Fainting					
Fatigue, low motivation					
Fears / Phobias					
Fever					
Fungal Infections/ Yeast					

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Glasses / Impaired Vision					
Growing Pains					
Headaches or Migraines					
Heart Problems					
Hyperactivity, ADHD					
Itching (where?)					
Kidney / Bladder Problems (explain)					
Lice					
Mononucleosis Infection "Kissing Disease"					
Nausea / Vomiting					
Nervous Habits (explain)					
Nosebleeds					
Overweight					
Pain (list areas)					
Rashes (location, itchy?)					
Respiratory Tract Infection					
Runny Nose (colour?)					
Seizures					
Sinusitis (nose/ sinus infection)					
Skin Disorder (please name or describe)					
Sleep Difficulties (insomnia, wakes, dreams)					
Sore Throat					
Temper Tantrums, Anger, Defiance					
Thrush (white tongue/ mouth)					
Thumb-sucking					
Thyroid or Adrenal Gland Problem					
Underweight					
Urinary Tract Infection					
Warts (location)					

Psychological Assessment & Diagnosis (please attach any supportive documentation if possible)

_____

_____

_____

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Please list any other conditions the child may have that are not listed above.

_____

_____

_____

_____

_____

Prenatal, Development and Family Health History

_____	_____	_____
Birth Weight (lbs.)	**Length of Hospital Stay**	**Duration of pregnancy (weeks)**
_____	_____	
Birthplace (City & Province / State)	**Name or Birthing Facilities**	

Describe the birthing facilities and the personnel that were present? (e.g. hospital, home-birth, midwife, dula, etc):

_____

Describe the pregnancy (i.e. morning sickness, weight gain, high blood pressure, infections, etc.)

_____

_____

Was the mother exposed to chemicals, radiation, drugs, alcohol or medications during the pregnancy? If yes, please list:

_____

_____

What type of delivery was performed? (e.g. C-section, breech, etc.) _____

Were there any complications and was any special equipment / medications / procedures used?

_____

_____

Was the child breast-fed? If so, how long? _____ **If not, formula base:** _____

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List any immunizations the child has received since birth:

Type	***Date administered (mm/dd/yyyy)***	***Reaction? (Y / N)***

Family and Social Background

Describe the child's current living arrangement (i.e. how many people live at the child's permanent address and what is their relationship to the child? If there is more than one residence, please indicate the living arrangement in that household to the best of your knowledge.)

Describe the household(s) where the child lives. For example, where is the physical location (town, city, farm, apartment, etc.), does the child share a bedroom (if so, with how many other people), what kinds of pets live in and around the living space, and what type of flooring occurs throughout the house (i.e. carpet, hardwood, linoleum, etc.)

Is the child put into the care of others at any time and how much time does the child spend in their care (on average)?

Has the child ever experienced a drastic change in lifestyle? Explain. (e.g. death, illness, moving, etc.)

Does the child attend an educational institution? If so, how many hours a day?

List any extra-curricular activities, clubs, volunteering:

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How many hours are spent watching TV or sitting at the computer per week (on average)? _____

How many hours per week are spent outdoors (on average)? _____

List any hobbies / interests:

_____

_____

Briefly describe the child's personality: _____

_____

_____

List any prescription and over-the-counter medications. Include the dosing schedule and why the medication is given:

_____

_____

_____

Please list any serious accidents, injuries, or childhood illnesses, and the age of occurrence:

_____

_____

_____

Has the child ever been hospitalized? If so, for what reason(s)?

_____

_____

_____

List any health conditions, diseases or disorders that occur within the child's family and the relationship the child has with each person:

_____

_____

_____

In your opinion, has the development of this child since birth been normal (i.e. have developmental milestones such as first word, potting-training, etc.) How does their development compare with siblings / peers?

_____

_____

_____

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How many times per day does the child eat (including snacks)? _____

How many meals per week) are eaten at home? _____

List 5 foods the child likes to eat: _____

In your opinion, do you believe the child is receiving optimal nutrition? _____

_____

DAY DIET DIARY

	Day 1:	Day 2:	Day 3:
Breakfast			
Lunch			
Dinner			
Snacks			
Water 1c. = 227ml			
# Bowel Movements			
Energy (1-10)			
Exercise			
Comments			

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Informed Consent to Naturopathic Treatment

Naturopathic Doctors are trained to evaluate their patients through interview, physical exams and through various diagnostic tests. 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.

Naturopathic Doctors are regulated by the Board of Directors, of the Manitoba Naturopathic Association, and under strict adherence to the Naturopathic Act. Every Naturopathic Doctor must maintain license through their Association in order to legally practice.

Practitioners of Naturopathic Medicine may employ natural medicines and techniques such as nutritional counselling and nutritional supplements, botanical medicines, Asian medicines & acupuncture, homeopathic remedies, physical medicine (such as Bowen therapy), and lifestyle counselling.

Please check the following therapies listed below that you DO NOT wish to participate in, unless later indicated:

- ❑ ***Clinical nutrition*** is counselling on the use of special diets and nutritional supplements to address nutritional deficiencies, treat disease processes, and promote health.

- ❑ ***Botanical medicine*** is a plant-based medicine that involves the use of herbs to assist in recovery from injury and disease and to promote general well-being. Herbs may be consumed or applied topically. Some examples include consuming herbs as teas, tinctures, tablets, capsules, creams, compresses, or suppositories.

- ❑ ***Homeopathy*** is a form of medicine using highly dilute quantities of naturally occurring plants, animals, minerals and other substances to stimulate the body's healing response. Homeopathy is effective at addressing the whole person, both on a physical and mental/emotional level.

- ❑ ***Acupuncture*** refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Moxabustion and cupping are additional Eastern soft tissue techniques that can be employed.

- ❑ ***Physical medicine*** refers to the use of hands-on techniques such as soft tissue manipulation (massage, acupressure), and the use of hot or cold applications to specific areas on the body to stimulate circulation (i.e. hydrotherapy).

- ❑ ***The Bowen Technique*** is a hands-on technique that involves the gentle manipulation of soft tissues at specific points on the body for the purposes of treating musculoskeletal, neurological and systemic conditions of the individual.

- ❑ ***Lifestyle counselling*** involves discussing and reforming daily habits (such as sleep hygiene, exercise regimes, and relaxation techniques), as well as removing risk factors to one's health.

During your initial consultation your Naturopathic Doctor will guide you through a case-taking interview, may perform a physical examination, request a urine sample, and/or recommend any necessary laboratory analyses. You may be referred to an external laboratory or health care practitioner for certain diagnostic testing (e.g. blood tests, saliva testing, imaging studies, etc.)

When necessary, it is the responsibility of the Naturopathic Doctor to refer to other healthcare practitioners for confirmation of diagnosis of an illness, disease, or any physical or mental disorder. Naturopathic Doctors are not trained to dispense prescription medications, perform surgery, or provide psychiatric counselling services.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g. pregnancy, lactation, very young children, or those taking multiple prescription medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform your 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 Naturopathic Doctor immediately.

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I recognize the potential risks and benefits of these procedures as described below:

Potential risks *(not an exhaustive list)*: aggravation of pre-existing symptoms, allergic reactions to prescribed herbs and supplements, side effects of natural medicines, inconvenience of lifestyle changes, injury from injections or procedures, fainting or puncturing of an organ with acupuncture needles, or muscular/soft tissue pain from hands-on treatments.

Potential benefits (not an exhaustive list): restoration of health and the body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of illness and disease, assistance in injury and disease recovery, and the prevention of disease and its progression.

Naturopathic Physicians are in no way accountable for the outcome of treatment(s) given in adherence to the Naturopathic Act; they in no way guarantee a "cure" of any illness or disease. Naturopathic Doctors shall provide empathetic, professional, and unbiased care for all patients that request treatment. The Naturopathic Doctor and the patient reserve the right to terminate Naturopathic care/ treatment at any time, as they deem necessary.

I understand that a record will be kept of the health services provided to me. As a patient, I shall provide my Naturopathic Doctor with updated information pertaining to my health to the best of my ability. Information will be gathered solely for the purposes of treatment, and will be kept confidential and shall not be released to other parties without my consent, unless required by law. I understand that I may request any portion of my medical record by paying the appropriate fee.

I understand that all charges are to be paid at the time of the visit unless specific arrangements have been made prior to my scheduled appointment. I understand that a fee may be charged for any missed appointments or late cancellations (less than 24 hours).

With this knowledge, I voluntarily consent to Naturopathic treatments offered or recommended to me by my Naturopathic Doctor, unless omitted as indicated above. I realize my Naturopathic Doctor has made no guarantees regarding cure or improvement of my condition, nor do I expect the Doctor to anticipate and explain all potential risks and complications. I intend this consent to apply to all my present and future Naturopathic care, unless a new agreement has been reached and a new consent form has been signed.

Dated this _____day of _____, 20_____.

_____ _____

Patient's Signature Guardian's Signature (under 18 years)

_____ _____

Patient's Name (please print) Guardian's Name (please print)

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Consent and Waiver of Liability: Electronic Communication

Electronic communication is a widely accepted form of communication. While it cannot replace personal encounters between you and your health care provider, it can be a convenient way to exchange information. All electronic communication will be acknowledged in a timely fashion. However, we do not monitor emails when the office is closed for weekends, evenings, statutory holidays and vacations. Please consider our office hours when you are waiting for a reply to your electronic communication. As a general rule, we will respond to patient emails within 3 business days. If you do not receive a response within the designated time period, please assume that your email was not received and call the office to follow up.

I understand and agree that:

- Electronic communication is not an appropriate substitute for clinical examinations. I am responsible for following up on Dr. Deirdre Jasper N.D.'s (Dr. Jasper) electronic communication and for scheduling appointments where warranted;
- Electronic communication is not to be used in emergencies, or when I need information or advice urgently. In case of an emergency, go to your nearest urgent care facility or call 911;
- Electronic communication will not be used for any purpose outside the context of my direct patient-health care provider relationship;
- Electronic communication between me and Dr. Jasper will become part of my confidential patient record;
- This medical practice may use electronic communication to send me health promotion material and other educational resources;
- Electronic communication is a privilege that may be withdrawn at the discretion of Dr. Jasper;
- Electronic communication between Dr. Jasper is only for the residents of Manitoba and is governed by the laws of the Province of Manitoba;
- Electronic communication is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the electronic communication once it has been sent;
- Electronic communication can introduce viruses into a computer system and potentially damage or disrupt the computer;
- Electronic communication can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the physician or patient. Electronic communication senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients. Electronic communication is indelible. Even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or cyberspace;
- Use of electronic communication to discuss sensitive information can increase the risk of such information being disclosed to third parties;
- Emails may be forwarded or referred, as necessary, for diagnosis, treatment, or health care operations, with the permission of the patient;
- Dr. Deirdre Jasper N.D. is not responsible for information loss due to technical failures;
- I will notify the Dr. Jasper of any changes to my electronic communication address;
- I acknowledge Dr. Jasper's right to, upon provision of written or electronic communication notice, withdraw the option of communicating through email;

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I hereby authorize Dr. Deirdre Jasper, N.D. to disclose my personal health information to me via the following:

Email address (print clearly): _____

Mobile number to be used for texting (if applicable): _____

I have read and understood the "**Consent and Waiver of Liability: Electronic Communication"** form and fully acknowledge that sending personal health information via electronic communication is not secure and I fully accept the risks and responsibility involved with this. I hereby waive any and all claims against Dr. Deirdre Jasper N.D. in connection with the disclosure of my personal health information via email.

Name of Patient (print): _____

Signature of patient (or guardian/ legal representative): _____ Date: _____

Relationship to patient (if signed by guardian/ representative): _____

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PLEASE NOTE THAT THIS DOCUMENT DOES NOT INDICATE A TRANSFER OF PATIENT CARE!

Authorization for Release of Medical Information

Patient's Name: _____ Date of Birth: _____
Address: _____ City: _____
Prov/ State: _____ Postal Code/ Zip: _____
MH Reg/ Health ID #: _____ **PHIN #:** _____

Date of Request: _____ **Date Needed**: ASAP

(Practitioner's info here:)

- ❑ I authorize Dr. Jasper to ***OBTAIN*** information from:

_____
Name of Provider or Facility

_____
Address

_____
City, Prov/ State, Postal Code/ Zip

_____
HCP's Fax # (include area code) Tel #

TYPE OF RECORDS REQUESTED:

_____
_____

Signature of Patient or Representative: _____

Relationship of Representative to Patient: _____

Date: _____

PLEASE NOTE THAT THIS DOCUMENT DOES NOT INDICATE A TRANSFER OF PATIENT CARE!