Dr. Reka Laszlo, ND
19140 Centre Street – Unit B
Mount Albert, ON. L0G 1M0
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Mount Albert CHIROPRACTIC & WELLNESS CENTRE

Child Intake Form

Please take the time to fill out the following information. It provides a basis for further questions during your visit and helps provide insight into your health. All information is for office use only and is ***strictly confidential****.*

Once complete please email your forms to DrReka@EnterToBeWell.com or bring it to your initial visit.

Date of First Visit: _____

Patient Information

Full Name: _____ Date of Birth: _____ Age:_____ Gender: M___ F___

Address: _____ City: _____ Postal Code:_____

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

Parent's Email: _____ May we leave messages regarding your visits ? On what number? _____

Parents' Names: _____ Parents' Occupation: _____

Parents' Marital Status: single____ married____ common-law____ separated____ divorced____ other: _____

Number of Siblings: _____ Ages: _____ Who lives at home? _____

How did you find out about the naturopathic services at this clinic? If referred please indicate from whom.

_____

Emergency Contact

Full Name: _____

Relationship to Patient: _____

Home Phone / Cell: _____

Please List Other Health Care Providers

1._____ Speciality: _____ Phone_____

2. _____ Speciality: _____ Phone_____

3. _____ Speciality: _____ Phone_____

Current Health Concerns

What are your chief concerns regarding your child's health in order of importance?

1. _____ 2. _____

3. _____ 4. _____

When did these concerns start? _____ Is there a family history of these concerns? _____

How do you rate your child's general state of health? poor ____ fair____ good____ very good____ excellent____

Comments: _____

Medical History

Current or past diagnosed conditions (incl. year diagnosed):

_____

_____

Allergies or sensitivities (foods, drugs, environmental,

pets etc.): _____

_____

_____

How many times has your child been treated with antibiotics?

_____

Current or past illnesses, accidents or hospitalizations (incl. year):

_____

_____

Which of the following immunizations has your child had?

- ☐ DPP(diphtheria, pertussis, tetanus)
- ☐Tetanus booster
- ☐MMR (measles, mumps, rubella)
- ☐Flu ☐Polio
- ☐Haemophilus influenza
- ☐Chicken Pox
- ☐Hepatitis B
- ☐Hepatitis A

Have any caused an adverse reaction? _____

Medications and Supplements

List all CURRENT medications (prescribed, over-the-counter, vitamins, herbs, homeopathics, etc.):

_____

_____

_____

_____

List any medication your child has had an ADVERSE REACTION to in the past. Indicate name, when taken and the reaction they had:

_____

Diet & Lifestyle History

How was your infant fed? Breast-fed: how long? _____ Formula: Milk____ Soy____ Other _____

Did your child ever experience colic? No ____ Yes ____ Your child's appetite is: poor ____ fair ____ good ____ very good ____

Please list any food allergies & intolerances: _____

What solid foods were started prior to 6 months of age? _____

_____

Child's sleep patterns: _____

Does your child: ___ wake early ____ have difficulty falling asleep ____ have nightmares/terrors ____no sleep problems

How would you describe the emotional climate of the child's home? _____

_____

Indicate whether your child is exposed to or consumes the following; please describe:

Tobacco smoke: _____

Pets & animals: _____

Excess stress: _____

Chemicals: _____

Pop & Candy: _____

How many hours a day does your child:

Play on the computer or video games? _____ Exercise? _____

Read or read to (not for school)? _____ Watch television? _____

Birth History

____ Full Term ____ Premature ____ Late Mother's age at birth _____

Please indicate if any of the following interventions were applied:

Induction	Forceps	Vacuum extraction	C-section	Other _____
Episiotomy	Pitocin	Epidural	Antibiotics	

Please list all prescribed and over-the-counter medication taken during pregnancy:

_____

Were there any pregnancy or birth complications? (ie. breech. Gestational diabetes) _____

Child's weight: _____ Length: _____ Length of Labour: _____

Please indicate if any of the following occurred at birth or soon after:

Birth defects ____ Rashes ____ Birth injuries _____ Jaundice ____ Seizures ____ Other: _____

Family History- *Please indicate any health conditions that have affected members of your family:*

Relative	Age if Alive	Age at Death	Health Conditions
Mother			
Father			
Siblings			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Review of Systems

Please check box if your child has had this in the past. Circle if it is something your child has now.

- ❑ Cancer
- ❑ Heart Disease
- ❑ Schizophrenia
- ❑ Hyperactivity
- ❑ Kidney Disease
- ❑ Muscular Dystrophy
- ❑ Venereal Disease
- ❑ Multiple Sclerosis
- ❑ Stroke
- ❑ Anxiety
- ❑ Depression
- ❑ Mental Disease
- ❑ Learning Disability
- ❑ Epilepsy/ Seizures
- ❑ Allergies
- ❑ Eczema
- ❑ Psoriasis
- ❑ Hives/ Rashes
- ❑ Ear Infections
- ❑ Arthritis
- ❑ Yeast Infections/ Candidiasis
- ❑ Bed Wetting
- ❑ Diabetes
- ❑ Mononucleosis
- ❑ Chicken Pox
- ❑ Measles
- ❑ Mumps
- ❑ Rubella
- ❑ Whooping cough
- ❑ Scarlet fever
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Cold Sores
- ❑ Sinus problems
- ❑ Tonsillitis
- ❑ Frequent colds
- ❑ Coughing/wheezing
- ❑ Strep Throat
- ❑ Colitis
- ❑ Celiac Disease
- ❑ Diarrhea
- ❑ Constipation
- ❑ Stomach Ulcers
- ❑ Other _____
- ❑ Other _____
- ❑ Other _____

Dr. Reka Laszlo, ND

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 and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's healing capacity.

Naturopathic Doctors are required to obtain informed consent and to make sure you are aware of possible side effects/risks due to treatment. Dr. Reka Laszlo, ND uses the following in her practice: diet and nutritional counselling, traditional Chinese medicine and acupuncture, botanical medicine, hydrotherapy, homeopathy, and lifestyle counselling. It is important to know that any treatment or advice provided is not mutually exclusive from any treatment or advice that you may now be receiving or may in the future receive from another licensed health care provider and you are at liberty to continue medical care from a medical doctor or any other health care provider licensed to practice in Ontario.

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved gastrointestinal function, enhanced immunity, and general well-being.

Botanical medicine is 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 healthy people. These minute doses, of plant, animal, or mineral origin, 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.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

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

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

During your initial visits, Dr. Reka Laszlo, ND will take a thorough case history and perform a basic/complaint-oriented physical examination in order to obtain a complete assessment of your case.

Even the gentlest of therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those taking multiple medications. Some therapies must be used with caution in certain diseases including, but not limited to, diabetes, heart/liver/kidney disease. It is very important therefore that you inform Dr. Reka Laszlo, ND immediately if any of the above applies to you.

There are some risks to treatment by Naturopathic Medicine. These include, but are not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain/bruising/injury from acupuncture, fainting or puncturing of an organ with acupuncture needles.

_____ Initials — I understand that my child's case may be discussed for educational purposes and information from my child's medical record may be analyzed for research purposes in which my child's identity will be kept confidential. I acknowledge that I have discussed, or will have the opportunity to discuss, with Dr. Reka Laszlo, ND the nature and purpose of naturopathic treatment in general and my child's treatment in particular as well as the contents of this consent.

_____ Initials — I understand that a record will be kept of the health services provided to my child. 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 child's medical record at any time and can request a copy of it by paying the appropriate fee.

_____ Initials

I understand that Dr. Reka Laszlo, ND will answer any questions that I have to the best of her ability. Because each individual responds differently to treatment, 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 and visit.

_____ Initials

I understand that a fee will be charged (Cost of the Visit) 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. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company. Dr. Reka Laszlo, ND 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 hereby authorize and consent to naturopathic treatment and examination by Dr. Reka Laszlo, ND. I intend this consent to apply to all my child's present and future naturopathic care. 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 Parent or Guardian: _____

Date: _____

Dr. Reka Laszlo, ND

Mount Albert CHIROPRACTIC & WELLNESS CENTRE

List of Services

Fee Schedule

Initial Consultation	60 min	$180
Second Visit	45-60 min	$100
Follow-up visits	30 min	$80
Acute visit	15 min	$45
Telephone or email consultation	15 min	$45
Acupuncture (requires initial consultation)	30 min	$70

Other Services

B12 Injections	$15
Medical Letter	$25

- Fees are payable at the end of each visit.
- Prices do not include supplements, botanical tinctures, homeopathic remedies or laboratory testing.
- Payment methods include cash, cheque, Interac, Visa and Mastercard.
- Please note that fees are not covered by OHIP, however, they may be covered by your extended health care plan. Please check with your insurer to determine your coverage.
- Cancellation Policy:

  Cancellations made without 24 hours notice or missed appointments will be charged a full visit fee.

I have read, fully understand, and agree to honour the fee schedule listed above.

Parent or Guardian's Signature: _____ Date:_____