



Kinga Babicki-Farrugia BSc. (Hons), N.D
 Doctor of Naturopathic Medicine
 Holy Meadows Chiropractic Clinic

420 Essa Rd. Unit 3C
 Barrie, ON
 L4N 9J7

Tel/Fax: (705) 728 9999

Rates of Service - Child Naturopathic (rates include HST)

Initial Visit (90-120 mins)	\$ 142.38
Follow ups:	
60 mins	\$ 94.92
45 mins	\$ 71.19
30 mins	\$ 59.33
15 mins	\$ 35.60

CONFIDENTIAL CHILD INTAKE FORM (0-12)
 (please print clearly)

Today's Date: _____

Child's Name: (First) _____ (Last) _____

Mother's Name: _____ Father's Name: _____

Home Address: _____

City: _____ Province: _____ Postal Code: _____

Home phone: _____ Work/Cell phone: _____

E-mail address: _____

Please indicate how you would prefer to be contacted: _____

Age: ____ Date of birth: _____ (M/D/Y) Gender: M / F

Emergency contact: Name: _____

Phone number: _____ Relation: _____

Do you have extended medical insurance? _____

How did you hear about this clinic? _____

Referred by: _____

Other health care providers (name/title and phone number);

1. _____ Phone _____
2. _____ Phone _____
3. _____ Phone _____

CONTEXT OF CARE OVERVIEW

1. a) What expectations do you have from this visit?

2. b) What long term expectations do you have from working with me?

3. What is your/ your child's present level of commitment to address any underlying causes of your/ your child's signs and symptoms that relate to your/ your child's lifestyle? (Circle one from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviours or lifestyle habits do you/your child currently engage in regularly that you believe support his/her health? (please list)

b) What behaviours or lifestyle habits do you/ your child currently engage in regularly that you believe are self destructive lifestyle habits? (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your child's health and in adhering to the therapeutic protocols which will be shared with you and your child?

6. Who do you know that will sincerely support you/your child consistently with the beneficial lifestyle changes you/your child will be making?

7. What does your child LOVE to do?

PREGNANCY

Complications with Pregnancy: (√)

Toxemia Diabetes High blood pressure Vomiting Nausea Bleeding Thyroid Problems
 Trauma (physical or emotional) Other (Please specify): _____

Mother's & Father's Age at Conception: _____

Length of Pregnancy: (√) Full Term Premature _____ wks Late _____ wks

Number of Previous Pregnancies: _____

Any past miscarriages or abortions? When? _____

Pregnancy Care: (√) Medical doctor Doula Midwife Other (please specify): _____

Health of mother during pregnancy (physical & emotional states):

Prescription Medications/ Over the counter/ Supplements/ Herbs/ Homeopathics taken during pregnancy:

Please describe your general diet during the pregnancy. Indicate any cravings.

How much weight did you gain? _____

Labour & Delivery History

Place of Birth: (√) Hospital Home Other (please specify): _____

Birth Weight: _____ Birth Length: _____

Type of Birth: (√) Vaginal C-Section Breech Forceps Suction Induced Anaesthesia

Duration of Labour: _____

Medications used: _____

Complications experienced by child after birth (√):

Jaundice Birth defects / Injuries Rashes Seizures Respiratory problems

Other (please specify): _____

Mother's Profile:

Age: _____ Present Health Status (circle): Excellent / Good / Fair / Poor

Occupation: _____; FULL-TIME / PART-TIME (circle)

Smoker: Yes / No; During Pregnancy: Yes / No; Anyone in Household: Yes/No

Alcohol (drinks/week?): _____; During Pregnancy: Yes / No

Recreational Drugs: Yes / No; During Pregnancy: Yes / No

What is your present stress level? Please rate on a scale of 1 (least) to 10 (most). _____

Father's Profile:

Age: _____ Present Health Status (circle): Excellent / Good / Fair / Poor

Occupation: _____; FULL-TIME / PART-TIME (circle)

Smoker: Yes / No; During Pregnancy: Yes / No

What is your present stress level? Please rate on a scale of 1 (least) to 10 (most). _____

Child's Profile:

A. MEDICAL HISTORY

What are your Child’s Health Concerns? (In order of importance)

1. _____
2. _____
3. _____
4. _____

How would you describe your child’s general state of health? (circle) Excellent/Good/Fair/Poor

Date of last physical check up with Medical Doctor? _____

Has there been a trauma or sickness that your child has never fully recovered from and/or has not been well since? _____

Please indicate any serious conditions, illnesses, injuries, hospitalizations or surgeries; with approximate dates:

Check here if he/she has received all on schedule without any side effects: (√) “__” and skip filling out this chart. Otherwise please indicate the immunizations your child has had.

Vaccination	Age Received	Dates of Immunization	Reactions/Side Effects
DPT (diphtheria, pertussis, tetanus)			
Tetanus booster			
MMR (measles, mumps, rubella)			
Haemophilus influenza B			
Hepatitis A			
Hepatitis B			
Smallpox			
Polio			
Flu shots			
Chicken pox			
Other immunizations:			

Has your child had any childhood diseases such as chicken pox, measles, mumps? (please list with dates):

Current and Past Medications and Supplements (please list & indicate dose, for how long):

Does your child have any allergies to any drugs, supplements, herbs, foods, animals or other?

How many times has your child been treated with antibiotics in his/her life? _____

B. FEEDING / NUTRITIONAL HISTORY:

Breast fed for how long? _____

Formula at what age? _____ What kind (milk, soy, other): _____

Food Introduction Schedule:

Age (month & yr) of Food Introduction:				
Type of Food (fruit, veggies, meat, etc) Introduced:				

Describe your child's current appetite/including cravings:

Please describe your child's most regular foods OR yesterday's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (type and amount?) _____

Water Intake: _____ cups/day Filtered water? Yes/No

B. DEVELOPMENTAL MILESTONES (list age when child reached milestone):

Sitting _____ Crawling _____ Walking _____ Talking _____ Teething _____ Fully-toilet trained _____

D. SLEEP:

What time does your child go to bed? _____ What time does he/she wake up? _____

Does the child wake up at night? Yes / No How often? _____ Nightmares? _____

Any difficulty sleeping? Yes / No

Does your child take naps? Yes / No

E. FAMILY HISTORY (include allergies, chronic & inherited conditions, etc) :

Has a close relative (parent, child, sibling, grandparent) had any of the following: (**Indicate who with their age**)

Allergies: _____

Asthma: _____

Arthritis: _____

Cancer: _____

Diabetes: _____

Depression: _____

Drug Abuse/Alcoholism/Addiction: _____

Mental Illness: _____

Epilepsy: _____

Glaucoma: _____

High Cholesterol: _____
Heart Disease/High Blood Pressure: _____
Kidney Disease: _____
Multiple Sclerosis: _____
Stroke: _____
Thyroid problems: _____
Tuberculosis: _____
Other: _____
 (✓) I don't know my family medical history

Position of child in family (e.g. Eldest, middle, youngest): _____

Number of people living in the home where child resides: _____

F. PSYCHOSOCIAL HEALTH:

Child's Hobbies and Activities Enjoyed:

How often does your child watch TV/day or week? _____ hrs/day OR _____ hrs/week

How often does your child play video games/day or week? _____ hrs/day OR _____ hrs/week

Is your child in: (Circle) School/Daycare/Other _____ Grade: _____

How would you describe your child's performance and behaviour at school?

Is your child active or exercise regularly? Yes / No

If yes, specify type, length & frequency of activity:

What is the emotional setting of your child's environment at home?

***Thank you for taking the time to fill out this form.
I look forward to working with you on your journey toward better health and wellbeing.***



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INFORMED CONSENT

Please Read. To be signed once you have had an opportunity to discuss any questions or concerns with the Naturopath.

NATUROPATHIC MEDICINE

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths 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/support the body's inherent healing ability. A number of different approaches may be used throughout the course of treatment.

WHAT TO EXPECT

Dr. Babicki will take a thorough case history and perform a screening/complaint oriented physical exam. When indicated she may refer out for blood work and request a urine sample be taken. Kinga Babicki N.D uses the following therapeutic procedures in her practice which may be used throughout the course of your treatment: Nutritional counseling and supplementation, Botanical/Herbal medicine, Homeopathy, Traditional Chinese Medicine/Acupuncture, Hydrotherapy and Lifestyle counseling. All treatment options will be discussed and decided upon together.

TREATMENT RISKS

Even the gentlest therapies may cause complications in certain physiological conditions (e.g. pregnancy, lactation, very young children, or those taking multiple medications). Some therapies must be used with caution in certain diseases such as but not limited to: diabetes, heart, liver, or kidney disease. It is very important, therefore, that you are as honest and forthcoming as possible with Dr. Babicki. Informing her about all illnesses/diseases that you are suffering from, all allergies you may have, as well as all medications (prescription and/or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or are breast-feeding, please advise Dr. Babicki immediately.

There may be some slight health risks to treatment through Naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms.
- Allergic reactions to supplements or herbs.
- Herbs/supplements taken in doses that exceed the prescribed dose may become toxic
- Minor bleeding/bruising, minor pain/soreness and fainting from acupuncture.

More serious, though very rare, risks that have been associated with acupuncture treatment include:

- Infection, organ perforation, bent or stuck needles and seizures.

CONSENT

Please initial in spaces below

_____ 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 but will be subject to a photocopying fee. (\$0.10/page up to a maximum of \$50.00)

_____ I understand that Dr. Babicki will answer any questions that I have to the best of her abilities. I understand that results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications.

_____ As the guardian, I understand that I am responsible for the total charges incurred for each visit, including consultation and any dispensary/supplement items at the time of the visit.

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

Supplements may be recommended and can be purchased through Dr. Babicki, at various Health Food stores or elsewhere.

Most insurance companies do not cover the cost of supplements prescribed and/or dispensed.

I, the undersigned, do hereby acknowledge that I have been informed and understand the above-stated policies, information and recommended therapeutic procedure(s)/plan. I have discussed to my satisfaction any related information with the above named Naturopathic doctor. I consent to the Naturopathic treatments offered or recommended to my child by the Naturopath. I intend this consent to apply to all my 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 and must inform the above mentioned Naturopath in writing, if I choose to do so.

Patient Name: (please print): _____

Guardian’s Name: (please print): _____

Signature of Guardian: _____

Date: _____

Naturopathic Doctor: _____

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