

Initial Naturopathic Visit for your Child

Katia Bailetti is dedicated to offering you the best in natural family health care. Please print and fill out the forms below prior to your initial visit.

Naturopathic medicine is the use of safe and natural therapies to help the body heal itself. Instead of treating symptoms, naturopaths uncover and address the cause of the symptoms. Naturopathic doctors work in conjunction with other health care professionals to provide clients with the best health care possible. For additional information about naturopathic medical training or naturopathic therapies, please visit www.drbailetti.com

Initial naturopathic visit (1 hour for infants) Includes a complete health assessment (medical history, current health concerns and physical exam) and an individual treatment plan. Treatments may include herbal remedies, homeopathy, nutritional supplements and dietary modifications, acupuncture/acupressure, counseling and lifestyle coaching and mind- body medicine.

Subsequent naturopathic visits (15-60 minutes) Can include naturopathic treatments, health information or progress evaluation. Minor concerns may be addressed over the phone.

What follows is an ideal pediatric visit schedule. The timing is flexible (e.g. if your child is already 5 years old, you can still schedule a Sick Baby Care, Vaccine Consult and Brain Boost visit). This schedule does not replace your pediatric schedule with your medical doctor.

Pre-arrival	6 weeks	2 months	4 months	6 months	12 months	18 months	2 Years +
<i>Vaccine Consult* (1 hour)</i>	<i>Natural Baby Care (30 mins)</i>	<i>Initial visit* (1 hour)</i>	<i>Food Introduction (30 mins)</i>	<i>Sick Baby Care (30 mins)</i>	<i>Healthy Toddler (30 mins)</i>	<i>Brain Boost (30 mins)</i>	<i>Annual Follow-up (45 mins)</i>

*Note that the *Vaccine Consultation* and the *Initial Naturopathic Visit* can be replaced by a 2-hour Vaccine Consultation and Support visit, if Vaccines are your primary health concern.

Please indicate all additional specialty visits you may be interested in:

- Vaccination Consultation** (1 hour) Get answers to your questions and concerns regarding childhood vaccinations. Current and up to date information is provided about vaccine-preventable diseases, vaccination options, vaccination contraindications, how to minimize the adverse effects of vaccines and much more. Information is discussed in a non-judgmental way and clients are supported in making the decision that is right for their family.
- Natural Baby Care** (30 minutes) Discuss how to select safe baby care products (e.g. soaps, toothpaste, sunscreen), list of recommended products included. Discuss natural bathing, clothing and parenting strategies.
- Food Introduction in Infants** (30 minutes) Discuss how and when to introduce food into your baby’s diet, baby food making basics, food ideas for different ages and much more.

- Sick Baby Care** (45 minutes) This visit will prepare you to assess and treat your child's fever, colds and flus at home. The session includes information about how to take your baby's temperature, what different temperatures mean, how to safely lower a fever, safe and natural alternatives to cold and flu medication, when to get medical help and much more... Handouts are provided.
- Healthy Toddler** (30 minutes) Discuss transition to daycare, natural parenting strategies, extended breastfeeding, toilet learning, developmental milestones, and other health concerns in your toddler.
- Brain Boost** (45 minutes) Discuss how you can help maximize your child's learning potential naturally using activities, diet and natural health products. This visit is especially important if learning disabilities run in the family or are suspected. Handouts are included.
- Healthier Diet** (45 minutes) Drastic changes to your family's diet can be difficult to maintain. This consultation includes a diet analysis. The focus is on offering healthier food alternatives to your existing food selection as well as providing healthy food selection guidelines. Food list handouts are provided.
- Healthy Skin** (45 minutes) Learn how to perform a thorough self-skin exam, how to monitor moles and when to seek medical help from your doctor. Body chart and handout provided.

How did you hear about us? _____

Your Child's Medical History

Name:	Age:	DOB (dd/mm/yy): / /	Gender:
Home phone:() -			
Address:		City:	Postal code:
Child lives with:		Number of children in home:	
Person filling out form:		Relation:	
Emergency contact:		Relation:	
Home phone:() -	Work:() -		
Medical doctor:			
Phone:() -	Fax:() -		
Address:		City:	Postal code:
Other health care provider:			Phone:() -
Address:		City:	Postal code:

Does your child get an annual:					
physical exam	<input type="checkbox"/> yes	<input type="checkbox"/> no	dental exam	<input type="checkbox"/> yes	<input type="checkbox"/> no
urine analysis	<input type="checkbox"/> yes	<input type="checkbox"/> no	eye exam	<input type="checkbox"/> yes	<input type="checkbox"/> no
Is your child's family medical history known: <input type="checkbox"/> yes <input type="checkbox"/> no			Adopted: <input type="checkbox"/> yes <input type="checkbox"/> no		

Please complete all relevant information. Answer to the best of your knowledge and we will discuss the details together during your appointment.

Main health concerns in order of importance:

Concern	Since (mm/yy)	Cause(s)
1.		
2.		
3.		
4.		

Medical conditions your child has been diagnosed with:

Diagnosis	Date (mm/yy)	Current symptoms

Medications your child has taken in the past:

Medication	Dosage	Since (mm/yy)	Effects	Helpful	Well tolerated
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n

Medications your child is currently taking (including over the counter):

Medication	Dosage	Since (mm/yy)	Effects	Helpful	Well tolerated
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n

Any allergies or adverse reactions to medications? no yes Specify:
 Number of times your child has taken antibiotics in their life: In the past 5 years:

Supplements, remedies, herbs or other treatments your child is currently using:

Medication	Dosage	Since (mm/yy)	Effects	Helpful	Well tolerated
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n
				<input type="checkbox"/> y <input type="checkbox"/> n	<input type="checkbox"/> y <input type="checkbox"/> n

Which of the following conditions has your child had?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Parasites	<input type="checkbox"/> Strep throat
<input type="checkbox"/> Anemia	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Herpes	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Typhoid fever
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Malaria	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> Measles	<input type="checkbox"/> Rubella	<input type="checkbox"/> Yellow fever
<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Mono	<input type="checkbox"/> Scarlet fever	
		<input type="checkbox"/> Mumps	<input type="checkbox"/> Sexual abuse	

Any other conditions? :
 Any conditions your child has never completely recovered from or which have been severe?

Operations, serious injuries or hospitalizations:

Incident	Date (mm/yy)	Complications or long term effects

Which of the following vaccinations has your child received?

<input type="checkbox"/> MMR (measles, mumps, rubella)	<input type="checkbox"/> Varicella	<input type="checkbox"/> Hepatitis A
<input type="checkbox"/> DTP/DTPaP (Diphtheria, typhoid, pertussis)	<input type="checkbox"/> Pneumococcal	<input type="checkbox"/> Influenza (flu)
<input type="checkbox"/> Hib (Haemophilus influenza)	<input type="checkbox"/> Meningococcal	<input type="checkbox"/> Small pox
<input type="checkbox"/> IPV (Polio)	<input type="checkbox"/> Varicella (chicken pox)	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Typhoid

Any other vaccines or boosters?

Any symptoms following a vaccination (rash, neurological problems...)?

no yes If yes, please describe:

Typical foods you eat during the course of the day

Breakfast	Lunch	Dinner	Snacks	Beverages (include amount)

Eating habits (picky, good appetite, etc...):

What foods were introduced before 6 months (include month introduced):

What foods were introduced between 6-12 months (include month introduced):

Breast fed? yes no Until what age:

Bottle fed? yes no Starting at what age:

Formula used: yes no Type:

Any colic? yes no For how long?

When introduced:

How severe?

Any food allergies or intolerances?

no yes If yes, please describe:

Any food cravings?

Often eat on the run? yes no Eat the same foods every day yes no

Any dietary restrictions (vegetarian, vegan, religious...)?

no yes If yes, please specify:

Specify any known conditions which have affected the following relatives:

Relative	Age if alive	Age at death	Condition(s)
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Maternal Aunts/Uncles			
Paternal Aunts/Uncles			

Perinatal Information

Mother's health at conception:	During pregnancy:
Mother's nutrition during pregnancy:	Nutrition while breastfeeding:
Mother's age at child's birth:	Father's health at conception:
Any fertility issues: <input type="checkbox"/> no <input type="checkbox"/> yes	Specify:
Prenatal care by:	Location of birth:
Term length:	Length of labour:

Any of the following medical procedures used during the pregnancy or delivery:

<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Triple screen	<input type="checkbox"/> Epidural/anesthesia
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Maternal serum testing	<input type="checkbox"/> Episiotomy
<input type="checkbox"/> Chorionic villi sampling	<input type="checkbox"/> Induced labour	<input type="checkbox"/> C-section
	<input type="checkbox"/> Use of forceps	<input type="checkbox"/> Other:

Any of the following experienced during the pregnancy or shortly after birth?

<input type="checkbox"/> Bleeding during pregnancy	<input type="checkbox"/> Nausea	<input type="checkbox"/> Infection
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Difficulty breastfeeding
<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Physical or emotional trauma
<input type="checkbox"/> Swollen ankles	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Post partum depression
		<input type="checkbox"/> Other:

Any of the following medical procedures after birth?

<input type="checkbox"/> Vitamin K injection	<input type="checkbox"/> PKU test (heel prick)	<input type="checkbox"/> Eye antibiotics
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Any of the following experienced by your child after birth:

<input type="checkbox"/> Low APGAR score	<input type="checkbox"/> Birth injuries	<input type="checkbox"/> Birth defects
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Birth complications	<input type="checkbox"/> Inadequate weight gain
<input type="checkbox"/> Rashes	<input type="checkbox"/> Infections	<input type="checkbox"/> Fever
<input type="checkbox"/> Seizures	<input type="checkbox"/> Difficulties with feeding	<input type="checkbox"/> Other:

Select 'Y' (yes) for symptoms you are presently experiencing (includes last 2 months).
 Select 'P' (past) for symptoms experienced in the past. It is possible to check both 'Y' and 'P'.

GENERAL Height Weight Maximum weight Birth weight Recent weight change <input type="checkbox"/> Y <input type="checkbox"/> P Recent international travel <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		EYES Glasses or contacts <input type="checkbox"/> Y <input type="checkbox"/> P Vision deteriorating <input type="checkbox"/> Y <input type="checkbox"/> P Blurring <input type="checkbox"/> Y <input type="checkbox"/> P Blind spot <input type="checkbox"/> Y <input type="checkbox"/> P Sun irritates <input type="checkbox"/> Y <input type="checkbox"/> P Discharge <input type="checkbox"/> Y <input type="checkbox"/> P Dryness <input type="checkbox"/> Y <input type="checkbox"/> P Infections <input type="checkbox"/> Y <input type="checkbox"/> P Itching <input type="checkbox"/> Y <input type="checkbox"/> P Pain <input type="checkbox"/> Y <input type="checkbox"/> P Puffy eyes <input type="checkbox"/> Y <input type="checkbox"/> P Redness <input type="checkbox"/> Y <input type="checkbox"/> P Tearing <input type="checkbox"/> Y <input type="checkbox"/> P Styes <input type="checkbox"/> Y <input type="checkbox"/> P Dark circles <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		NECK Pain or stiffness <input type="checkbox"/> Y <input type="checkbox"/> P Lumps <input type="checkbox"/> Y <input type="checkbox"/> P Swollen glands <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P RESPIRATORY Shortness of breath <input type="checkbox"/> Y <input type="checkbox"/> P Pain on breathing <input type="checkbox"/> Y <input type="checkbox"/> P Chronic cough <input type="checkbox"/> Y <input type="checkbox"/> P Sputum <input type="checkbox"/> Y <input type="checkbox"/> P Wheezing <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P	
SKIN Acne <input type="checkbox"/> Y <input type="checkbox"/> P Bumps or lumps <input type="checkbox"/> Y <input type="checkbox"/> P Warts <input type="checkbox"/> Y <input type="checkbox"/> P Eczema <input type="checkbox"/> Y <input type="checkbox"/> P Psoriasis <input type="checkbox"/> Y <input type="checkbox"/> P Hives <input type="checkbox"/> Y <input type="checkbox"/> P Rashes <input type="checkbox"/> Y <input type="checkbox"/> P Itching <input type="checkbox"/> Y <input type="checkbox"/> P Dry skin <input type="checkbox"/> Y <input type="checkbox"/> P Slow wound healing <input type="checkbox"/> Y <input type="checkbox"/> P Perspiration at night <input type="checkbox"/> Y <input type="checkbox"/> P Odor to perspiration <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		NOSE & SINUSES Decreased smell <input type="checkbox"/> Y <input type="checkbox"/> P Stuffy or runny <input type="checkbox"/> Y <input type="checkbox"/> P Allergies <input type="checkbox"/> Y <input type="checkbox"/> P Sinus problems <input type="checkbox"/> Y <input type="checkbox"/> P Bleeding <input type="checkbox"/> Y <input type="checkbox"/> P Polyps <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		CARDIOVASCULAR Murmurs <input type="checkbox"/> Y <input type="checkbox"/> P Palpitations <input type="checkbox"/> Y <input type="checkbox"/> P Red face, flush easy <input type="checkbox"/> Y <input type="checkbox"/> P Cold hands and feet <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P	
NAILS Bend or break easily <input type="checkbox"/> Y <input type="checkbox"/> P White spots <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		MOUTH & THROAT Decreased taste <input type="checkbox"/> Y <input type="checkbox"/> P Bad breath <input type="checkbox"/> Y <input type="checkbox"/> P Mouth dryness <input type="checkbox"/> Y <input type="checkbox"/> P Canker sores <input type="checkbox"/> Y <input type="checkbox"/> P Cold sores <input type="checkbox"/> Y <input type="checkbox"/> P Toothache <input type="checkbox"/> Y <input type="checkbox"/> P Gum bleeding <input type="checkbox"/> Y <input type="checkbox"/> P Frequent sore throat <input type="checkbox"/> Y <input type="checkbox"/> P Hoarseness <input type="checkbox"/> Y <input type="checkbox"/> P Lump in throat <input type="checkbox"/> Y <input type="checkbox"/> P		BLOOD & LYMPH Frequently ill <input type="checkbox"/> Y <input type="checkbox"/> P Bleed or bruise easily <input type="checkbox"/> Y <input type="checkbox"/> P Clotting problem <input type="checkbox"/> Y <input type="checkbox"/> P Lymph node swelling <input type="checkbox"/> Y <input type="checkbox"/> P	
HEAD Dizziness <input type="checkbox"/> Y <input type="checkbox"/> P Headaches <input type="checkbox"/> Y <input type="checkbox"/> P Migraines <input type="checkbox"/> Y <input type="checkbox"/> P Injuries <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P		Number of metal fillings Other: <input type="checkbox"/> Y <input type="checkbox"/> P		MUSCULO / SKELETAL Muscle cramps <input type="checkbox"/> Y <input type="checkbox"/> P Muscle weakness <input type="checkbox"/> Y <input type="checkbox"/> P Joint pain or stiffness <input type="checkbox"/> Y <input type="checkbox"/> P Joints pop often <input type="checkbox"/> Y <input type="checkbox"/> P Joint swelling <input type="checkbox"/> Y <input type="checkbox"/> P Back pain <input type="checkbox"/> Y <input type="checkbox"/> P Broken bones <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P	
EARS Decreased hearing <input type="checkbox"/> Y <input type="checkbox"/> P Excess wax <input type="checkbox"/> Y <input type="checkbox"/> P Infections <input type="checkbox"/> Y <input type="checkbox"/> P Discharge <input type="checkbox"/> Y <input type="checkbox"/> P Itching <input type="checkbox"/> Y <input type="checkbox"/> P Pain <input type="checkbox"/> Y <input type="checkbox"/> P Other: <input type="checkbox"/> Y <input type="checkbox"/> P					

<p>NEUROLOGICAL</p> <p>Convulsions <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Fainting <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Involuntary movement <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Loss of balance <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Numbness or tingling <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Paralysis <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Speech problems <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>		<p>URINARY</p> <p>Bedwetting <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Infections <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Inability to hold urine <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Increased urination <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Pain on urination <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Blood in urine <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Cloudy urine <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Dark urine <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>		<p>MENTAL & EMOTIONAL</p> <p>Anxiety <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Depression <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Fatigue <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Difficulty concentration <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Mood swings <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Phobias <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>	
<p>GASTROINTESTINAL</p> <p>Bowel movements how often? <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Constipation <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Diarrhea <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Rectal bleeding <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Rectal itching <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Undigested food in stool <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Blood in stool <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Mucous in stool <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Change in thirst <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Change in appetite <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Low blood sugar <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Pain in abdomen <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Hernias <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Burping <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Flatulence <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Bloating <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Nausea <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Vomiting <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Difficulty swallowing <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>		<p>FEMALE ONLY</p> <p>Vaginal discharge <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Vaginal itching <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>MALE ONLY</p> <p>Undescended testicles <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Testicular mass <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Difficult urination <input type="checkbox"/>Y<input type="checkbox"/>P</p> <p>Other: <input type="checkbox"/>Y<input type="checkbox"/>P</p>			

Child Naturopathic Consent Form

I voluntarily consent to the procedures and treatments on behalf my child _____ by Naturopathic Doctor Katia Bailetti, which can include any combination of the following: medical history, physical exam, diagnostic testing, botanical medicine, homeopathy, traditional Chinese medicine, clinical nutrition, hydrotherapy, lifestyle counselling and coaching, physical therapies and mind-body medicine.

I understand the following:

- My child's medical records will be kept confidential and will not be released to anyone without my consent, unless required by law or I am at risk of harming myself or others. In order to ensure optimal care, Naturopathic Doctors may consult with other professionals about my case..
- Naturopathic medicine can be used to help prevent and treat illnesses. However, Naturopathic Doctors cannot guarantee results of treatment.
- Complications are very rare when treated by a licensed Naturopathic Doctor. Naturopathic Doctors cannot anticipate all risks and complications associated with treatment; however, they will do their best to inform me of the most common side-effects.
- I am responsible for informing the above Naturopathic Doctor if my child's condition or medications change, (especially an anticipated pregnancy), as treatments may be contraindicated in some conditions.
- I agree to pay for charges incurred during each visit by the end of the visit unless alternate arrangements have been made prior to my scheduled appointment. I will be provided with a receipt upon payment so that I can bill my insurance company. I will be charged additional fees for laboratory testing as well as supplements/homeopathic remedies/herbal medicines. I will also be charged \$50 for missed appointments, late cancellations (less than 24 hours) and overdue payments (including bounced cheques).
- The clinic will endeavor to collect and maintain accurate personal information about me and my child for the purpose of assessing my health concerns, advising me of my options, providing high quality natural and professional healthcare, maintaining contact with me and my child, facilitating practice management and complying with naturopathic regulations.

Patient's name: _____

DOB (dd/mm/yy): _____

Guardian's name: _____

Relation: _____

Guardian's signature: _____

Date (dd/mm/yy): _____

Witness signature: _____

Date (dd/mm/yy): _____