Ilana Block ND

Hello and Welcome!

I know you have choices when it comes to your child's care and I am dedicated to providing my patients with the best care possible.

Before your scheduled appointment, please carefully read and fill out this form. Please note that the diet diary on the last page will take *5 days* to complete. I know your time is valuable and bringing your completed information forms with you will maximize the amount of time we can spend discussing your child's case.

Naturopathy is a holistic and preventive approach. This means that I assess the whole person, taking into consideration the physical, mental, emotional, and spiritual aspects of the individual with the ultimate goal of identifying and eliminating the underlying causes of illness. Gentle, non-invasive techniques are used in order to stimulate the body's inherent healing capacity. These include a number of different treatment modalities such as the following:

- ***Nutritional Support*** and dietary recommendations are integral to ensuring that the body has the needed building blocks to sustain and aid healing.
- ***Lifestyle Counseling*** addresses the link between concerns of well-being, lifestyle, events, thoughts and emotions and provides recommendations such as breathing and relaxation techniques or coping strategies.
- ***Botanical Medicine*** using herbal teas, tinctures or capsules for addressing specific health concerns and aiding the body in recovering from injury or disease.
- ***Nutritional Supplementation*** to address deficiencies, assist the body in eliminating toxins, stimulate healing or address specific concerns.
- ***Homeopathy*** is an energy-based system that stimulates the healing process in the body on all levels.
- ***Hydrotherapy*** is the use of water as an accessible and effective form of stimulating healing.

Most private health insurance companies cover naturopathy; please check with your provider to determine the amount that is covered under your policy. If you have coverage, you are responsible for billing your own insurance company - We will provide you with all the information necessary to send your claim for reimbursement.

Note that my office is ***scent free*** to respect those patients with allergies or sensitivities.

If you are unable to keep your scheduled appointment time please give us a 24hour notice so that we may reschedule your visit. If not, a $50 cancellation fee will be charged.

Remember to bring copies of any recent lab work or medical records as well as any supplements or medications your child is currently taking.

I look forward to supporting your child on their journey to greater health and wellbeing

Child's Name _____ **Date of appointment** ____/____/_____
First name Last name dd / mm / yyyy

Date of birth ____/____/_____ **Age** _____ **Sex** M F
dd / mm / yyyy

Address _____
Street Apt#

_____
City Province Postal Code

Parent or guardian contact information

Name _____ **Relationship to child** _____
First name Last name

Address _____
Street Apt#

_____
City Province Postal Code

Phone _____ _____ _____
Home Work Cell phone

_____
Email

Who is filling out this form? _____

Who does the child live with? _____

How did you hear about the clinic? _____

Please list the main health concerns in order of importance, including how long they have been present

1- _____

2- _____

3- _____

4- _____

5- _____

How would you describe the child's general state of health? Excellent Good Fair Poor Very poor

CHILD'S HEALTH HISTORY

Please list any hospitalizations, surgeries, X-Rays, or imaging scans the child has received in the past.

_____

_____

Please list any injuries or traumas the child has received in the past.

_____

_____

_____

Please list all current prescription medications, over the counter medications, vitamins or other supplements the child is taking.

_____

_____

_____

Please list all past prescription medications.

_____

_____

How many times has the child received antibiotic treatments in his or her lifetime? Never 1-2 3-4 5-7 8-10 11+

When was the last time he or she received an antibiotic treatment? _____

Which of the following conditions has the child had? (Circle all that apply)

ADHD	Conjunctivitis	Head Lice	Rubella
Allergies _____	Constipation	Heart Murmur	Scarlet Fever
Anxiety	Cradle Cap	Hepatitis	Strep Throat
Appendicitis	Croup	Hernia	Sinusitis
Asthma	Diabetes	HIV+/AIDS	Teething Difficulties
Autism	Diarrhea	Hives	Thrush or Candida
Bed Wetting	Diaper Rash	Impetigo	Thyroid Disease
Behavioral Problems	Difficulty Concentrating	Irritable Bowel	Tonsillitis
Bronchitis	Difficulty Sleeping	Measles	Urinary Tract Infection
Cancer _____	Frequent Colds	Meningitis	Whooping Cough
Celiac Disease	Ear Infections	Mumps	Worms
Chicken Pox	Eczema	Parasites	
Chronic Bleeding Noses	Epilepsy	Pneumonia	
Colic	Hay Fever	Rheumatic Fever	

Other _____

Please indicate what vaccinations you have had (Circle all that apply):

Chicken Pox	Hepatitis A	Small Pox
DPT (Diptheria, Pertussis, Tetanus)	Hepatits B	Tetanus booster
Flu	MMR (Measles, Mumps, Rubella)	
Haemophilus influenza	Polio	

Other _____

Were there any reactions or complications from the vaccinations? _____

Prenatal and Birth History

How old was the mother at the time of the child's birth? _____

Number of previous pregnancies the mother carried to term _____ Not carried to term _____

How was the health of the mother at the time of conception? Excellent Good Fair Poor Unknown

How was the health of the father at the time of conception? Excellent Good Fair Poor Unknown

How was the health of the mother during the time of the pregnancy? Excellent Good Fair Poor Unknown

Did the mother use any alcohol, cigarettes or recreational drugs during the pregnancy? _____

Did the mother use any prescription medications during the pregnancy? _____

At how many weeks gestation was the child born? _____ Vaginal Birth C-Section

Were there any interventions used during the delivery (epidural, forceps)? _____

Were there any complications during the delivery? _____

How much did he/she weigh at birth? _____ How long was he/she? _____inches

Did the infant experience any of the following conditions during or following birth?

Injuries during the birth _____ Birth Defects _____

Jaundice _____ Infections _____

Developmental History

How old was the child during the following developmental milestones (if you remember):

Hold head up _____ Roll over _____ Sit up _____ Crawl _____ Stand _____ Walk _____

First Tooth _____ First Word _____ Run _____ Hop/Skip _____

FAMILY HISTORY

Which of the following have affected your family members? Which family member in relation to the child?
Include parents (M or F), siblings (S or B), grandparents (MGF, MGM, PGF, PGM), aunts (A), and uncles (U)

Acne	_____	Emphysema	_____	Mental Illness	_____
Alcoholism	_____	Epilepsy	_____	Multiple Sclerosis	_____
Allergies	_____	Gallstones	_____	Osteoporosis	_____
Alzheimer's	_____	Glaucoma	_____	Pneumonia	_____
Arthritis	_____	Gout	_____	Psoriasis	_____
Asthma	_____	Hay Fever	_____	Rheumatic Fever	_____
Bronchitis	_____	Heart Disease	_____	Sickle Cell Anemia	_____
Cancer	_____	High Blood Pressure	_____	Strep Throat	_____
Depression	_____	High Cholesterol	_____	Stroke	_____
Diabetes	_____	Hepatitis	_____	Thyroid Disease	_____
Easy Bleeding	_____	Kidney Disease	_____	Tuberculosis	_____
Eczema	_____	Liver Disease	_____	Venereal Disease	_____

Other _____ ☐ I do not know my child's family history

DIET

Was the child breast fed? Y N If yes, for how long? _____

Were there any difficulties introducing foods and what were these difficulties?

_____

_____

Does the child tend to be thirsty? Y N How much water does he/she drink each day? _____

Does the child have any food allergies or sensitivities? (Please list)

_____

_____

_____

What foods does the child crave? Does he/she have any reactions to these foods?

_____

_____

PSYCHOSOCIAL

How often does the child exercise? (if applicable) Never 1-2/month 3-4/month 1-2/week 3/week 4+/week

What type/s of exercise does he/she do? _____

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

_____

_____

What long-term goals and expectations do you have for working with me?

_____

_____

Is there anything else you would like me to know at this time?

_____

_____

_____

REVIEW OF SYSTEMS
Please check off any symptoms you child currently experiences (C) or has had in the past (P)

GENERAL
Fatigue _____
Night Sweats _____

SKIN
Rashes _____
Inflammation _____
Infection _____
Growths _____
Changes in hair/nails _____

HEAD
Headache _____
Head Injury _____

EYES
Impaired Vision _____
Eye Pain _____
Tearing or dryness _____
Double Vision _____

EARS
Impaired Hearing _____
Ringing _____
Dizziness _____

NOSE and SINUSES
Frequent Colds _____
Nose Bleeds _____
Stuffiness _____
Sinus Problems _____
Post Nasal Drip _____

MOUTH and THROAT
Frequent Sore Throat _____
Sore Tongue _____
Sores in mouth/on lips _____
Gum Problems _____
Hoarseness _____
Dental Problems _____

NECK
Swollen Glands _____
Pain or Stiffness _____

BLOOD
Anemia _____
Easy bleeding/bruising _____

HEART
Heart Disease _____
High Blood Pressure _____
Rheumatic Fever _____
Chest Pain _____
Swelling Ankles _____
Palpitations/fluttering _____

RESPIRATORY
Cough _____
Spitting up Blood _____
Wheezing _____
Difficulty Breathing _____
Pain on Breathing _____
Shortness of Breath _____
Positive TB test ever Y N

DIGESTION
Trouble Swallowing _____
Heartburn _____
Stomach Pain _____
Nausea/Vomiting _____
Bowels Move: Daily More Less
Blood in Stools _____
Belching or Gas _____
Abdominal Bloating _____
Hemorrhoids _____

URINARY
Pain on Urination _____
Increase Frequency _____
Inability to Hold Urine _____
Bladder Infections _____

CIRCULATION
Deep Leg Pain _____
Cold Hands/Feet _____
Varicose Veins _____

NEUROLOGIC
Fainting _____
Seizures _____
Paralysis _____
Muscle Weakness _____
Loss of Memory _____

EMOTIONAL ISSUES
Apathy _____
Depression _____
Sadness _____
Mood Swings _____
Anxiety or Nervousness _____
Tension _____
Fears or Phobias _____
Anger or Rage _____
Irritability _____

Other _____
_____

Name _____

DIET DIARY

The purpose of this daily record is to help you keep close watch over what your child is eating, and help you to discover which, if any, foods or beverages may be causing or contributing to his/her symptoms. Use this as a tool to become more in tune with your child's dietary habits. It is very important that the information you record in this diary be as accurate and as correct as possible. If the child is breastfeeding, please include the mother's diet as well.
The following is to be done for 5 days in a row.

1- Write down everything your child eats or drinks, including water, snacks, alcoholic beverages, soft drinks and so on.
2- List the contents found inside mixed dishes and foods. It is not enough to write down "a turkey sandwich". You should also write down the kind of bread, spread, dressing (i.e. turkey sandwich – whole wheat bread, butter, mustard).
3- Whenever you make an entry in your diary, ask yourself: "Have I given myself and my licensed Naturopath enough information about what is in this food?"

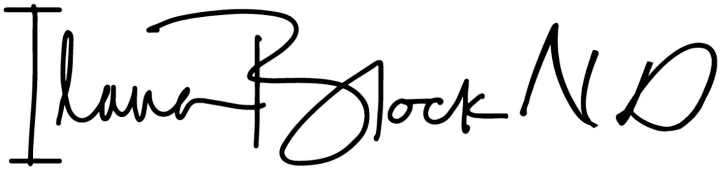
	Day 1
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	

	Day 2
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	

	Day 3
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	

	Day 4
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	

	Day 5
Breakfast	
Lunch	
Dinner	
Snack	
Digestive, urinary, skin complaints, other (i.e. Pain)	
Overall mood and energy	



INFORMED CONSENT

Statement of Acknowledgement

Printed name _____

Printed guardian's name _____

I understand that the form of care offered at this clinic is based on Naturopathic principles and practices. I recognize that even the gentlest therapies potentially have their complications and hence the information provided is complete and inclusive of all history including all prescription medications, over the counter drugs and supplements. The slight risks of some Naturopathy include, but are not limited to aggravation of pre-existing symptoms, and allergic reaction to supplements or herbs.

I also confirm that I have the ability to accept or reject this care on behalf of my child of my own free will and choice. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

Please wait for your appointment to sign this form.

_____	_____	_____
SIGNATURE	DATE	WITNESS