Naturopathic and Allergy Clinic

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Confidential child's Case History (TO BE FILLED BEFORE COMING TO YOUR APPOINTMENT)

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Dear Patient: This form was specifically designed by our **Naturopathic Doctor, the clinic director Fateh Srajeldin ND,** to help our medical team evaluate your current health condition. Please complete this health questionnaire to the best of your knowledge. Your answers will help us determine in what ways we can help restore your child's health. We will only accept your child's case if we believe that you are intending to apply our ① instructions, ② remedies, ③ therapies and ④diet as given to treat your child. Rest assured that all information will remain completely confidential. **Please make sure to answer all questions that have the mark (✳), Thank you.**

Child's information

✳Last name: _____ ✳First name: _____ Middle name: _____

✳Date of birth: MM. DD. YY. Sex: ❑ Male, ❑ Female, Height: _____ Weight: _____ Last physical date: _____

✳Child has been unwell for: _____ Yrs., Physician's name who treated my child was: _____

My child was treated by a ❑ Medical Dr., ❑ Chiropractor, ❑ Naturopath Dr., ❑ Psychiatrist, ❑ Hospital, ❑ Homeopath, ❑ Herbs.

Was treatment terminated? : ❑ Yes, ❑ No, Did treatment achieve its goal % (explain): _____

✳ My child was treated for: _____

✳ My child is currently suffering from and needs treatment for: _____

Family members who have similar conditions: ❑ Mother, ❑ Father, ❑ Brother(s), ❑ Sister(s), ❑ Daughter(s), ❑ Son(s), ❑ Adopted.

Number of older brothers: _____ Number of older sisters: _____ Child's rank in the family is: _____

Number of younger brothers: _____ Number of younger sisters: _____ Child's favorite sport is: _____

✳Child's home address: _____ Suite: _____ City: _____ Province: _____ PC code: _____

Child livs: ❑ With Both Parents, ❑ With Father, ❑ With Mother, ❑ Alternates Between Parents, ❑ With Relatives, ❑ Foster Home.

Father's Information

Last name: _____ First name: _____ Father's occupation: _____ Age: _____

Home address: ⇧ Same as above _____ Suite: _____ City: _____ Province: _____ PC code: _____

Home telephone ( ): _____ Office telephone ( ): _____ Ext. _____

Cellular number ( ): _____ email: _____ @ _____

Mother's Information

Last name: _____ First name: _____ Mother's occupation: _____ Age: _____

Home address: ⇧ Same as above _____ Suite: _____ City: _____ Province: _____ PC code: _____

Home telephone ( ): _____ Office telephone ( ): _____ Ext. _____

Cellular number ( ): _____ email: _____ @ _____

In case of an emergency who may we contact

✳First name: _____ ✳Last name: _____ ✳Relationship: _____

Telephone (H): ( ) _____ (W): ( ) _____ Ext. _____ Fax: ( ) _____

Do one or both parents have an extended health insurance at work ❑ Yes, ❑ No.? Name of Insurance company: _____

Do we have your permission to email you information and updates concerning your health plus seasonal promotions Yes ❑, No ❑

✳Who referred you to this Clinic : _____

❑ Office sign, ❑ Currently a patient, ❑ Etobicoke Guardian, ❑ Surfing the Net, ❑ Office Pamphlet, ❑ TV Interview

Dear Patient:

The following several pages contain questions concerning your child's health. There are some questions concerning both parents which pertain to your child's total health. Please take some time to answer all of the following questions as accurately as possible. The total interview and the actual examination may last approximately ninety minutes more or less. Further, You (one or both of the parents) will be informed about some food restrictions that Dr. Srajeldin wants you to observe in your child's diet. You are expected to apply the diet as given to help your child recover from the current ailment. Along with the diet, your child's daily remedies, frequency and therapies will be set too.

Please note that naturopathic examination, treatments, therapies and remedies are not covered by the Ontario Health Insurance Plan (OHIP). Naturopathic examinations, treatments and therapies for your child's coverage could be covered by your extended health insurance plan at your place of employment if you have one. You may consult with your insurance company directly.

We do not deal directly with insurance companies and we have no Information about their coverage. We do not deal directly with insurance companies and we have no Information about their coverage.

Privacy: All your child's files and information are extremely confidential, however if you have any extra information concerning more steps of privacy concerning mails, emails, phone calls or leaving phone messages, then please give us written instructions here:

_____

_____

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Parent's or Guardian's Declaration & Consent to Child Examination and Treatment

Name (please print) _____ **Date:** _____

Assessment and Treatment

I understand that the clinics Naturopath, Dr. Fateh Srajeldin, B.Sc., ND, practices with an eclectic approach to health care. Initial patients' visit to see the naturopath will include discussing your medical history from birth to date, standard physical examination, evaluation of your child's diet and prescribing remedies based on your child's medical history, physical examination, current symptoms and the results of your child's blood works (if available). Further, I understand that testing with traditional blood work and functional testing may be requested. I understand that the treatments can include Clinical Nutrition, Vitamins, Minerals, Enzymes, Co-Enzymes, Anti-Oxidants, Botanical medicine and Homeopathic medicine, Orthomolecular Supplementation, Acupuncture and Intravenous Therapy.
I understand that the clinic's mission statement is "***a Naturopathic Doctor is to provide safe and effective treatments to restore health permanently in the quickest, gentlest, least harmful way***."

I understand that Dr. Fateh Srajeldin, B.Sc., ND is a licensed Naturopathic Doctor (ND) not a Medical Doctor and his examinations and treatments are not covered by OHIP. I also understand that Naturopathic examination, treatments, therapies and remedies are not covered by the Ontario Health Insurance Plan (OHIP). I understand that my child's Naturopathic examinations, treatments and therapies could be covered by my extended health insurance plan at my place of employment (if available). I understand that it is my responsibility to consult with my insurance company directly. I understand that The Naturopathic and Allergy Clinic does not deal directly with insurance companies and have no information about my coverage.
I understand that any treatment provided to my child as a patient of Dr. Fateh Srajeldin B.Sc., ND is not mutually exclusive from any treatment or any advice that I may be receiving or may in the future be receiving from another licensed health care provider. I understand that I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario. I understand that medical therapy and naturopathic/drugless therapy, including homeopathy, are different kinds of therapies.
Dr. Fateh Srajeldin, B.Sc., ND strives to provide the best possible diagnosis and course of treatment. However, many factors will be important in determining actual results. Therefore, no representation or warranty is made with respect to any treatment, action or application of medical advice or information given.
I understand that the total interview and the actual examination may last approximately ninety minutes more or less. Further, I understand that the naturopath may spend approximately sixty minutes with me to setup my child's diet thereafter. I will apply the diet as given. Along with the diet, my child's daily remedies, frequency and therapies will be set too.

I understand that, in the event of a medical emergency, I am advised to seek conventional medical care at a hospital if I am unable to reach Naturopathic Doctor.

Fees of Examinations and services
Fees for first examination and intravenous therapy are pre-paid at time of booking the appointment by cash, Visa, Master Card, American Express and Interac. **We do not bill insurance companies.**

Choice ✓	Code	Explanation	Our fee schedule
	EX1-Child-Immunity	Discuss symptoms + Medical History + First Examination + Food caution = 1Hr. (Remedies are not included)	**$100.00** Non-Taxable
	EX-5	Subsequent Examination 30 Mins. (Remedies are not included)	**$ 065.00** Non-Taxable
	Cancellation Fees	All cancellations are not chargeable if done 48 Hrs. prior to the scheduled appointments. There is a fee for un-cancelled appointments.	**$ 050.00** Non-Taxable

I will provide a copy of my child's most recent blood work done in the past six months. Alternatively, I will arrange, bring, mail or fax all my child's medical tests, (blood, urine, x-ray, ultrasound, MRI, and surgery results), pertaining to his/her health from his/her physician's office or the hospital if he/she was treated at a hospital.

I will answer the questionnaire concerning my child's health to the best of my ability and knowledge. I will pay for all my child's examinations, treatments, therapies and intravenous therapy immediately when rendered.

I understand that remedies and laboratory blood works are not included in the examination fee. I understand that any appointment(s) cancellation requires 48 hours advanced notice for full refund otherwise there will be a $50 surcharge applied on each and every examination or therapy missed or cancelled without a notice.

Parent's Signature: _____ Date: _____

Office Witness : _____ Date: _____

Continue on page (3) please

List all the symptoms that your child is suffering from and the medication being used currently or were used.

1- Does / did your child suffer with any **IMMUNITY** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

2- Does / did you child suffer with any **FOOD ALLERGIES** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

3- Does / did you child suffer with any **MEDICATION ALLERGIES** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

4- Does / did you child suffer with any **ENVIRONMENTAL ALLERGIES** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

5- Does / did you child suffer with any **LUNGS** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

6- Does / did your child suffer with any **SKIN** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

7- Does / did your child suffer with any **MUSCLES, JOINTS, BONES** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

8- Does / did your child suffer with any **HEART** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

9- Does / did your child suffer with any **DIGESTIVE** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

10- Does / did your child suffer with any **SLEEP** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

11- Does / did your child suffer with any **MOUTH** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

12- Does / did your child suffer with any **EARS** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

13- Does / did your child suffer with any **EYES** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

14- Does / did your child suffer with any **NOSE** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

15- Does / did your child suffer with any **SCALP and HAIR** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

16- Does / did your child suffer with any **HEAD** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

17- Does / did your child suffer with any **BEHAVIOR** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

18- Does / did your child suffer with any **ENDOCRINE** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

19- Does / did your child suffer with any **URINARY** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

20- Does / did your child suffer with any **MALIGNANCY** related symptoms?:
No ❑, **Yes** ❑ **Symptom's name:**_____ **Medication used:** _____
Explanation: _____

The following section is required to list your child's medical history, sicknesses, rough times and hospitalizations, I am interested in every medication given to your child especially antibiotics, cortisone and oral contraceptive bill. You should list the starting year of diseases and the year of their cure such as tonsillitis, ears, lungs, throat, skin smoking, street drugs etc. Also list the year of admission to hospital for whatever reason.

Information should be listed from birth until today, chronologically, year after year. You may use additional sheets if needed.
You may choose to fill this sheet with your doctor before your examination.
Some important notes to consider are
1- breast feeding at birth, 2- time of food introduction during infancy, 3- smoking and 4- drugs of any kind,

Duration	Year	Age	Description of incidents		
		Birth			
		3 Months			
		6 Months			
		9 Months			
		1 Yr.			
		3 Months			
		6 Months			
		9 Months			
		2 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		3 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		4 Yrs.			
		3 Months			
		6 Months			
		9 Months			
		5 Yrs.			
		6 Yrs.			
		7 Yrs.			
		8 Yrs.			
		9 Yrs.			
		10 Yrs.			
		11 Yrs.			
		12 Yrs.			
		13 Yrs.			
		14 Yrs.			
		15 Yrs.			
		16 Yrs.			

Please add another sheet