

ODETTE BULAONG, BSC(HONS), ND
LICENSED NATUROPATHIC DOCTOR

Quarry Chiropractic Clinic | 2560 Gerrard St. E. #103 | Toronto, ON M1N 1W8 | 416.699.0368

Dear Parent/Guardian,

Thank you for choosing me to be part of your child's healthcare team. I strive to create an open, supportive and safe space that will foster your child's health. By choosing naturopathic medicine, you have made an important and conscious decision to **become an active participant in your child's health**, which is a valuable healing tool in itself.

As we work together, keep in mind that **health is a process** which requires patience. It has likely taken a number of years for your child to arrive at his/her current state of health. As a result, it can take several months for us to replenish, restore and recreate the conditions that will allow your child to return to his/her optimal state of health. If you are willing to take the time, I am determined to help your child **realize his/her unique level of physical, mental, emotional and spiritual wellness**.

Now that you have booked your child's first visit, please set aside about 30-45 minutes to read and complete this **Initial ND Visit Package**. In it you will find a **Pediatric New Patient Form** which needs to be completed before your child's first visit. The more completely and accurately you are able to fill in this form, the more thorough and effective your child's treatment plan can be. If time permits, return this form to the clinic 1 week prior to your child's first visit. You will also find **Declaration of Informed Consent to Naturopathic Diagnostic and Therapeutic Procedures, Statement of Acknowledgement, Privacy Information, and Collection, Uses and Disclosure of Information** consent forms which you will need to read thoroughly before your child's first visit. Please refrain from signing these forms until I answer any questions you may have to your satisfaction during your **Initial Naturopathic Visit**. Please refer to the **Fee Schedule** section in our website to ensure you are familiar with the clinic fees and payment policies.

In addition to **ALL OF the above forms (pg.2-10)**, here is a checklist of what else you can **bring to your first visit**, in order for us to make the most of your time in your Initial Naturopathic Visit:

- ✓ Copy of relevant blood work and imaging reports (x-rays, ultrasounds, MRI, CT), as applicable
- ✓ Health journal or health log of your child's symptoms, if you have been keeping one. For example, in certain conditions parents' monitor and keep a written record of their child's:
 - Bowel movements
 - Dietary habits
 - Energy levels
 - Illnesses or infections
 - Eczema/hive outbreaks
- ✓ A list of your top questions, so you can ask them during the visit
- ✓ Date of your first visit: _____ Time: _____

Please keep this page for your records and feel free to post it on your fridge to remind you of your child's **Initial Naturopathic Visit**.

Thank you in advance for taking the time to fully read and complete this package. I look forward to meeting you and your child and working with you both to achieve the goals in your child's health and life.

Kind Regards,
Dr. Odette ☺

Odette Bulaong, BSc(Hons), ND
Licensed Naturopathic Doctor

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Pediatric New Patient Form (12 years old and younger)

Child's Name: _____ Gender: _____

Birth Date (M/D/Y): _____ / _____ / _____ Age: _____ Grade: _____

Who is filling out this form (Name, Relation)? _____ Today's Date (M/D/Y): _____ / _____ / _____

CONTACT INFORMATION FOR PARENTS/LEGAL GUARDIANS (Who the child lives with):

Name(s): _____ Relation(s): _____

Address: _____ City: _____ Postal Code: _____

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

May we leave you messages regarding your clinic visits? Yes No E-mail: _____

How did you hear about BNC? _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____ Phone #: _____

HEALTH CARE PROVIDERS

| | | | |
|-----------------|-------|----------|-------|
| Pediatrician: | _____ | Phone #: | _____ |
| Medical Doctor: | _____ | Phone #: | _____ |
| Specialist: | _____ | Phone #: | _____ |
| Other: | _____ | Phone #: | _____ |

Health Concerns

Please list and briefly explain your child's main health concerns, in order of importance to you:

_____ When started: _____
_____ When started: _____
_____ When started: _____

Please list your child's past major illnesses, injuries, surgical procedures, operations, hospitalizations:

_____ When: _____
_____ When: _____
_____ When: _____

When was your child's last check-up with a pediatrician or family doctor? _____

What screening tests has your child had (e.g. blood, xray, MRI, hearing, visual, behavioural etc.)?

Please describe your child's general state of health: Excellent Good Fair Poor

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Medical History

Please list which vaccines (immunizations) your child has had and approximately how old they were at each dose:

| VACCINE | AGE(S) GIVEN | ANY ADVERSE REACTIONS OR CHANGE IN HEALTH OR BEHAVIOUR |
|--------------------------------------|--------------|--|
| Diphtheria, Pertussis, Tetanus (DPT) | | |
| Polio (ITP) | | |
| Haemophilus Influenzae type B (HiB) | | |
| Pneumococcal (Pneu-C-7) | | |
| Measles, Mumps, Rubella (MMR) | | |
| Meningococcal C (Men-C) | | |
| Chickenpox/Varicella (Var) | | |
| Hepatitis B (HB) | | |
| Human Papillomavirus (HPV) | | |
| DTP/ITP Booster (Tdap/IPV) | | |
| Tetanus/Diphtheria Booster (Td) | | |
| Influenza (Inf) | | |
| Other(s): | | |

On average, how many times has your child been treated with antibiotics? _____ Approximate date of last time: _____

Please list any known or suspected allergies (medicines, food, environmental, etc.): _____

Please list all **CURRENT or PAST prescription and over-the-counter medications (e.g. cough syrup, antibiotics, Children's Tylenol), vitamins, mineral, herbal or homeopathic medicines** your child has taken by filling out the chart below. If more space is required, please attach a separate sheet.

| MEDICATION | DOSAGE (AMOUNT AND # TIMES A DAY TAKEN) | APPROXIMATE DATES & LENGTH OF TIME TAKEN |
|------------|--|--|
| | | |
| | | |
| | | |
| | | |

Please check (✓) which childhood illnesses your child has had and approximate dates:

| | YES | WHEN | | YES | WHEN | | YES | WHEN |
|---------------|-----|------|-----------------|-----|------|----------------|-----|------|
| Chicken Pox | | | Mononucleosis | | | Scarlet Fever | | |
| Croup | | | Mumps | | | Stomach Flu | | |
| Growing Pains | | | Pneumonia | | | Strep Throat | | |
| Measles | | | Rheumatic fever | | | Whooping Cough | | |
| Meningitis | | | Rubella | | | Other: | | |

Please list any complications that arose from the above illnesses (if applicable): _____

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Please list whether the child's *mother, father, siblings, maternal or paternal grandparents* have the following conditions:

| | WHO? | | WHO? | | WHO? |
|---------------------|------|----------------------|------|-------------------------------------|------|
| Allergies | | Diabetes | | Liver Disease | |
| Anemia | | Digestive Conditions | | Mental Illness | |
| Asthma | | Eczema | | Migraines | |
| Birth Defect | | Epilepsy | | SIDs (sudden infant death syndrome) | |
| Bleeding Disorder | | Heart Disease | | Stroke | |
| Cancer (what kind?) | | Kidney Disease | | Tuberculosis | |

Please list any other health conditions that exist in your family, and which of the above family members are affected:

The following chart will provide a more complete picture of your child's overall health. Please check (✓) column **C** if your child **CURRENTLY** has a symptom below and column **P** if they have had it in the **PAST**. If they have never had the symptom, please do not check either box.

| | C | P | | C | P | | C | P |
|-------------------------|---|---|----------------------------|---|---|-----------------------|---|---|
| GENERAL | | | EYES | | | CARDIOVASCULAR | | |
| Fatigue | | | Blurred vision | | | Heart murmurs | | |
| Weakness | | | Double vision | | | Septal wall defects | | |
| Significant weight loss | | | Redness | | | RESPIRATORY | | |
| Significant weight gain | | | Itching | | | Cough | | |
| SKIN | | | Discharge | | | Wheezing | | |
| Eczema | | | Infection (e.g. Pink eye) | | | Asthma | | |
| Psoriasis | | | EARS | | | Bronchitis | | |
| Rash | | | Ear infection | | | Difficulty breathing | | |
| Hives | | | Discharge | | | HEMATOLOGY | | |
| Itching | | | Trouble hearing | | | Easy bruising | | |
| Redness | | | Ringing in ears | | | Easy bleeding | | |
| Dryness | | | NOSE & SINUSES | | | Past transfusions | | |
| Acne | | | Frequent colds | | | Poor wound healing | | |
| Warts | | | Nosebleeds | | | DIGESTIVE | | |
| Boils | | | Sinus problems | | | Change in appetite | | |
| Fungal infections | | | MOUTH & THROAT | | | Difficulty swallowing | | |
| HEAD | | | Thrush | | | Hernia | | |
| Headache | | | Sore throat | | | Vomiting | | |
| Head injury | | | Gum problems | | | Nausea | | |
| Dizziness | | | Dental cavities | | | Excessive gas | | |
| Cradle cap | | | Tonsillitis | | | Bloating | | |
| Lice | | | URINARY | | | Stomach pain | | |
| NEUROLOGIC | | | Bedwetting | | | Diarrhea | | |
| Seizures | | | Urinary/bladder infections | | | Constipation | | |
| Tingling/numbness | | | Increased urination | | | Blood in stool | | |

Other Symptoms: _____

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Nutrition

Was your child breastfed? Yes No If Yes, how many months: _____
If No, reason why: _____
Substitute Formula used: _____

Please describe the mother's diet while breastfeeding by including foods typically enjoyed, food cravings, foods avoided, and any reactions the baby had to the mother eating different foods: _____

Did your child experience colic? Yes No

Please describe the child's weaning history including child's age when started & finished and the child's response: _____

Does the child have any dietary restrictions? (e.g. religious, vegetarian, vegan, etc): _____

How would you describe the child's eating habits? _____

Please describe how food was introduced to your child by filling out the following chart:

| <i>FOOD INTRODUCED (EARLIEST TO MOST RECENT)</i> | <i>APPROXIMATE AGE (E.G. 6, 9, 12, 18 MONTHS)</i> | <i>ANY REACTIONS YOUR CHILD HAD (E.G. DIARRHEA, SKIN RASH)</i> |
|--|---|--|
| | | |
| | | |
| | | |
| | | |

Sleep Habits

Where does this child sleep? Own room Parents' room Other: _____

Child's sleep patterns (during first year) _____

Current sleep patterns: _____

Does your child nap during the day? Yes No If yes, when is the nap taken and for how long? _____

Is there any history of bedwetting? Yes No If yes, what was your response? _____

What position does your child sleep in now? (e.g. on back, on right side) _____

As an infant what position did your child sleep in? _____

Current bed time and waking time of your child: _____

Does your child sweat a lot in bed? Yes No What parts of the body? _____

Does the sweat have an odour? Yes No What does sweat smell like? _____

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For the remainder of this form when given a choice of answers, please circle the answer which applies to you and your child and expand on answers where applicable in the space provided.

Perinatal History

Was your child adopted? Yes No If yes, child's age at adoption: _____

How was pregnancy achieved? (e.g. intercourse, IVF, AI, sperm donation, etc.): _____

Was the pregnancy planned? Yes No

Age of Mother at Conception: _____ Age of Father at Conception: _____

Number of Previous Pregnancies: _____ Number of Previous Deliveries: _____

Pregnancy length (weeks): _____ Labour length (hours) _____ Second/pushing stage length (hours) _____

Baby's height at birth: _____ Baby's weight at birth: _____ APGAR Scores: _____

Where was the baby birthed? Birthing Centre Home Hospital Water

Who was involved in baby's delivery? OBGYN Midwife Family Doctor Doula

How was baby delivered? Vaginal C-Section

Which pain medication was administered (if any)? _____

Who else was present for support during the delivery? _____

Please check all of the complications that occurred and procedures that were necessary during the pregnancy and labour:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Placenta previa | <input type="checkbox"/> Placental abruption | <input type="checkbox"/> Breech presentation | <input type="checkbox"/> Premature birth |
| <input type="checkbox"/> Fetal distress | <input type="checkbox"/> Prolapsed cord | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Blue baby |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Multiple birth | <input type="checkbox"/> Undescended testes | <input type="checkbox"/> Meconium |
| <input type="checkbox"/> Episiotomy | <input type="checkbox"/> Forceps | <input type="checkbox"/> Gel induction | <input type="checkbox"/> Suction required |
| <input type="checkbox"/> Vacuum extraction | <input type="checkbox"/> Pitocin drip induction | <input type="checkbox"/> Oxygen required | <input type="checkbox"/> Incubator |
| <input type="checkbox"/> Cephalopelvic disproportion (head too big) | <input type="checkbox"/> Failure to progress/labour stalled | <input type="checkbox"/> Premature rupture of membranes | <input type="checkbox"/> Artificial rupture of membranes |
| <input type="checkbox"/> Hemorrhage | <input type="checkbox"/> Other: _____ | | |

Was Vitamin K administered? Yes No If Yes, how? By mouth By injection

Was erythromycin administered in the eyes? Yes No Was silver nitrate administered in the eyes? Yes No

Any adverse reactions: _____

Mother's emotional state at the time of birth?

Mother's emotional state post-partum (after delivery)?

Father's emotional state at the time of birth?

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Please list & describe severity of any health conditions the mother experienced during pregnancy:

(e.g. high blood pressure, gestational diabetes, bleeding, infections, thyroid problems, severe nausea, anemia, trauma):

How would you describe the pregnancy? _____

Please list any physical or emotional traumas the mother experienced during pregnancy:

If the mother used any of the following during pregnancy, please indicate **how much, how often and specific type**:

Tobacco _____ Alcohol _____

Recreational drugs _____ Caffeine _____

Please list **ANY prescription, over-the-counter medications, vitamins, mineral, herbal or homeopathic medicines** the mother took during pregnancy by filling out the chart below. If more space is required, please attach a separate sheet.

| MEDICATION | DOSAGE (AMOUNT AND # TIMES/DAY TAKEN) | APPROXIMATE DATES & LENGTH OF TIME TAKEN |
|------------|--|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Tests performed during pregnancy (e.g. ultrasound, amniocentesis): _____

If the Mom works, at how many weeks into the pregnancy did the mother take maternity leave? _____

Developmental Milestones

If applicable, at approximately what age were the following milestones reached?

Smiles _____ Grasps an object _____ Recognizes a face _____
Rolls over _____ Sat on own _____ First tooth _____
Crawls _____ Walks on own _____ First word _____
First sentence _____ Scribbles _____ Plays Patty Cake _____
Dress themselves _____ Toiled Trained _____ Sleeps in own room _____

Did your child stand up: On own With help

**Thank you for taking the time to complete this form.
We look forward to seeing you both at your child's first visit.**

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Declaration of Informed Consent to Naturopathic Diagnostic and Therapeutic Procedures - Pediatric

In order for Odette Bulaong, ND to assess your child's health, identify risk factors for potential diseases and create a treatment plan for your child's existing health condition(s), the following **naturopathic diagnostic procedures** may be performed:

- A thorough Health History Intake
- Complaint-Oriented Physical Exam: body systems that may be affected by your health condition may be examined.
- Urinalysis
- Complete Screening Physical Exam: a basic examination of all major body systems.
- Laboratory Blood Work: a requisition to have your child's blood work drawn privately at LifeLabs will be provided or you may choose to have your child's blood work done through your family doctor as time permits.
- Additional In-House/Laboratory Work: salivary hormone testing, allergy testing, etc.
- Chinese tongue and pulse diagnosis: examination of the tongue and pulses to provide important information on body organs with respect to Chinese Medicine.

Naturopathic medicine is a form of primary health care that uses natural substances and treatments to support and stimulate the body's ability to heal itself. The **naturopathic therapeutic procedures** that may be used by Odette Bulaong, ND individually or in combination to address your child's health condition(s) are:

- Nutritional Counseling
- Botanical Medicine
- Acupuncture and Chinese Medicine
- Homeopathic Medicine
- Lifestyle Counseling
- Physical Medicine & Hydrotherapy
- Facial Rejuvenation Acupuncture

Although the above treatments are safe and natural, even the gentlest therapies can have complications. This is especially true in very young children. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform Odette Bulaong, ND immediately of any disease process that your child may be suffering from.

Some complications that can occur with naturopathic treatment include but are not limited to:

- Aggravation of pre-existing or existing symptoms
- Allergic reactions (for example to supplements or herbs)
- Minor bleeding or bruising from acupuncture needles, B12 shots
- Fainting or puncturing of an organ with acupuncture needles
- Accidental burning of the skin from the use of moxa or cupping
- Muscle strains and sprains, disc injuries from spinal manipulation
- The potential for stroke is a concern in neck manipulation.

I understand that the results are not guaranteed. I do not expect Odette Bulaong, ND to be able to anticipate or explain all risks and complications. I will rely on Odette Bulaong, ND to exercise judgment during the course of treatment which she feels at that time is in my child's best interests, based on the facts then known. I, the undersigned, do hereby acknowledge that I have been informed of and understand the naturopathic diagnostic and therapeutic procedure(s) and have discussed to my satisfaction this and any requests for related information with Odette Bulaong, ND.

I further acknowledge and confirm that I have been informed of, and understand the diagnostic and therapeutic procedure(s) with respect to the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to my child.

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Privacy Information

Privacy of your child's personal information is important to this clinic while I provide your child with quality naturopathic care. We understand the importance of protecting your child's personal information and are committed to collecting, using and disclosing your child's personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information. All staff members who come into contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Collection of Personal Health Information

We collect personal health information about your child directly from you. The personal health information that we collect may include, for example, your child's name, date of birth, address, health history, records of your child's visits with Odette Bulaong, ND and the care that your child received during those visits. Occasionally, we collect personal health information about your child from other sources if we have obtained your consent to do so or if the law permits.

Uses and Disclosures of Personal Health Information

We use and disclose your child's personal health information to:

- Assess your child's health care needs;
- Develop effective treatment plans for your child;
- Provide your child with treatment, health services, and care of an acute, chronic and/or preventive nature;
- Research and inform you of additional treatment options your child may benefit from;
- Inform you of clinic services, events, updates, and health care information;
- Contact you and maintain communication with you;
- Contact you to book and confirm appointments;
- Follow up with treatment, care, health status and billing;
- Communicate with other treating health care providers, including specialists, family practitioners, referring physicians, and any other health provider involved in your child's care;
- Plan, administer and manage our internal operations;
- Conduct risk management and quality improvement activities;
- Teach, demonstrate or conduct research on an anonymous basis;
- Conduct patient satisfaction surveys;
- Compile statistics on an anonymous basis;
- Invoice for goods and services;
- Process credit card payments;
- Collect unpaid accounts;
- Permit potential purchasers, practice brokers or advisors to evaluate the naturopathic practice;
- Allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale;
- Deliver your child's charts and records to the naturopathic doctor's insurance carrier to enable the insurance company to assess liability and quantify damages, if any;
- Comply with legal and regulatory requirements, and fulfill other purposes permitted or required by law;
- Comply with legal and regulatory requirements, including the delivery of patient's charts and records to the Board of Directors of Drugless Therapy - Naturopathy (BDDT-N), in a timely fashion, when required, according to the provisions of the Drugless Practitioner's Act (DPA);
- Comply with the agreements/undertakings entered into voluntarily by the member with the Board of Director of Drugless Therapy - Naturopathy (BDDT-N), including the delivery and/or review of patient's charts and records to the Board in a timely fashion for regulatory and monitoring purposes;
- Prepare materials for the Board of Directors of Drugless Therapy - Naturopathy (BDDT-N) complaints committee, if necessary.

