Dr. Michael D Bastien BSc, ND
149-1233 Lynn Valley Road, North Vancouver
Office: 604-973-0210

Lynn Valley Naturopathy pediatric intake

All Information entered will remain confidential in accordance with Personal Information Protection Act. If you have any questions please ask.

Contact Information

First Last

Name:______________________________ Date: (D/M/Y)____/____/____

Age:________ Gender: M: F: Birth date: (D/M/Y)____/____/____

Mother's Name:________________ Father's Name:________________

Home Address:______________________________

City:______________ Province:__________ Postal Code:__________

Parental Contact: Phone:______________ Email:______________

Care Card Number:______________________________

Medical Doctor:______________________ Phone:__________

Other health care providers:______________________________

____

Extended Medical Coverage: Y / N MSP Premium Assistance: Y / N

Provider:______________________________

Do you have an active ICBC or WCB claim: Y / N Claim number:______________

How did you hear about Dr. Bastien:______________________________

Chief Health Concerns

Please rank concerns in order of importance to you	When did it start?
1. ______________________	______________
2. ______________________	______________
3. ______________________	______________
4. ______________________	______________
5. ______________________	______________

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Family Medical History

Please list Family members who have had any of these illnesses
(Father = F, Mother = M, Sister = S, Brother = B, Father's Father = PGF, Mothers Father = MGF, etc)

Asthma________________________________
Allergies______________________________
Eczema _______________________________
Diabetes______________________________
Arthritis______________________________
Cancer _______________________________
Thyroid disease _______________________
Kidney disease________________________
Mental illness_________________________
Addiction____________________________
Autoimmune__________________________
Liver disease_________________________
High blood pressure____________________
Heart disease_________________________
Stroke_______________________________
Other:_______________________________

Medical History

Significant illnesses: Please check any that apply and give the **age they started**

_____☐ Measles _____☐ Scarlet Fever _____☐ Rheumatic Fever _____☐ German Measles _____☐ Birth defects
_____☐ Mumps _____☐ Chicken Pox _____☐ Ear infections _____☐Throat infections _____☐ Cancer
_____☐ Diabetes _____☐ Heart disease _____☐ Hepatitis _____☐ HIV _____☐ Rashes

☐ Surgery:____
☐ Major accidents/trauma:____
☐ Other:____

Vaccinations

☐ Polio ☐ Tetanus ☐ Hepatitis ☐ HPV ☐ Rabies
☐ MMR ☐ Diptheria ☐ Pertussis ☐ Chicken Pox ☐ Other:____________________

General Health

Height________ Weight______________Has growth fluctuated between percentiles? Y N

Breast Fed? Y N How long?____________Smoke exposure at home? Y N

Bed time?____________Stays asleep for?___________________Hours of sleep per night?__________________

Pregnancy complications?____

Full term pregnancy? Y N C-section? Y N Birth Weight:_______________________

Reason if premature:____

Allergies: Drug:________________________________Food:______________________________
Foods you avoid:____

Medications and Supplements

	Dose:	Indication:
____________________	Dose:__________	Indication:______________
____________________	Dose:__________	Indication:______________
____________________	Dose:__________	Indication:______________
____________________	Dose:__________	Indication:______________
____________________	Dose:__________	Indication:______________
____________________	Dose:__________	Indication:______________

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Canopy Integrated Health

INFORMED CONSENT

I would like to take this opportunity to welcome you to Canopy Integrated Health. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. If you are working with a Naturopathic Doctor a physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

Printed name ____

As a patient of this clinic I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As Canopy Integrated Health is an integrated health clinic, I recognize that all the practitioners that are working with me may have access to my file. I also recognize that even the gentlest therapies may have risks or complications. In certain physiological conditions or in very young children or those on multiple medications the chance of these risks may be higher and hence the information provided is complete and inclusive of all health concerns and all medications. The slight health risks of some Naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries and vascular events from spinal manipulations.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that 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.

___________________________ ______/______/______ ___________________________

SIGNATURE DATE WITNESS SIGNATURE

Parental Consent

___________________________ ______/______/______

SIGNATURE OF PARENT/GUARDIAN DATE