Dr. Kathryn Harbun

Naturopathic Physician

Pediatric Intake form

Arc Integrated Medicine

personal information

PATIENT'S NAME: _____ PARENT'S NAME(S) _____

PREFERRED NAME:_____ DATE OF BIRTH: mm/dd/yr ____/____/____ AGE:_____ SEX:_____

STREET ADDRESS:_____ CITY:_____ POSTAL CODE:_____

PHONE NUMBERS:_____ EMAIL ADDRESS:_____

PREFERRED METHOD OF CONTACT (appointments, results etc): _____

PHN:_____ DO YOU HAVE EXTENDED INSURANCE?: Y / N

medical contact information

FAMILY PHYSICIAN:_____ OTHER PRACTITIONERS: _____

ADDRESS: _____ ADDRESS: _____

PHONE:_____ FAX:_____ PHONE:_____ FAX: _____

REASON FOR SEEING THEM: _____

EMERGENCY CONTACT:_____ RELATION:_____ PHONE NUMBER:_____

PLEASE LIST YOUR MAIN HEALTH CONCERNS: SEVERITY (0-10) WHEN DID IT START; HAS IT CHANGED?

1. _____ _____ _____
2. _____ _____ _____
3. _____ _____ _____

WHAT ARE 3 EXPECTATIONS YOU HAVE OF ME?

1. _____
2. _____
3. _____

LIST 3 HEALTH GOALS YOU'D LIKE TO ACHIEVE

1. _____
2. _____
3. _____

current conditions

DIAGNOSED MEDICAL CONDITIONS, INJURIES, SURGERIES, HOSPITALISATIONS	DATE	ALLERGIES	WHAT HAPPENS? *If reaction is life threatening, please circle*
1.		1.	
2.		2.	
3.		3.	

medications, supplements

please list all medications and supplements your child is currently taking (prescription and non-prescription)

MEDICATION/SUPPLEMENT/HERB	DOSE	PRESCRIBED BY	REASON FOR TAKING IT
1.			
2.			
3.			

PLEASE INDICATE THE FREQUENCY OF THE FOLLOWING MEDICATIONS (if taken in the past, mark with a P)

TYLENOL _____	FLOURIDE _____	ANTIBIOTICS (how many courses?)
IBUBROFEN _____	VITAMINS _____	_____
ASPRIN _____	MINERALS _____	(type of infection given for) _____
DECONGESTANTS _____	HERBS _____	_____

WHERE DO YOU GET YOUR INFORMATION ABOUT YOUR CHILD'S SUPPLEMENTS?

HAS YOUR CHILD HAD LAB WORK WITHIN THE LAST YEAR? Y / N

If yes, please attach a copy of the results or bring them to your appointment

past medical history

CHILDHOOD ILLNESSES			
chicken pox		ear infections/aches	
mumps		tonsillitis	
measles		strep throat	
scarlet fever		rheumatic fever	
rubella		mononucleosis	
scalded skin syndrome		croup	
fifth disease		whooping cough	
roseola		diptheria	
SYMPTOMS EXPERIENCED			
asthma		fatigue	
allergies		fever aboce 103°F	
anemia		frequent infections	
anxiety		gas	
appendicitis		hand foot & mouth	
attention issues		headaches	
bed wetting		heart murmur	
birth defects		hyperactivity	
colic/bloating/cramps		insomnia	
constipation		learning disorder	
cradle cap		mood swings	
cough/wheeze		pneumonia/bronchitis	
depression		speech disorder	
diarrhea		stuffy nose/phlegm	
dizziness		thrush	
eczema		tobacco exposure	
epilepsy/seizures		vomiting spells	
other *(please indicate)*			
IMMUNIZATIONS (include age given)			
Hepatitis B		MMR	
rotavirus		varicella (chicken pox)	
DTaP (dipth./tetan./pertus)		Hepatitis A	
Hib (*H.flu* type B)		HPV (Gardasil)	
PCV13 (pneumococcus)		influenza	
polio		other	
BIRTH HISTORY (during pregnancy)			
age during pregnancy		high blood pressure	
alcohol use		high stress	
anemia		medications	
anxiety		mental illness	
asthma		nausea/vomiting	
bleeding		recreational drugs	
cigarette smoking		thyroid issues	
eczema/psoriasis		trauma/injury	
gestational diabetes		yeast infection/UTI	
other infection/illness			

WHAT IS YOUR CHILD'S DISPOSITION?

_____

_____

past medical history cont'd

CHILD'S BIRTH HISTORY			
full term		induced	
premature (#weeks)		anesthesia	
late by (# days)		labour length *(hours)*	
vaginal		baby's birth weight	
C-section		complications, or problems after birth:	
forceps			
DEVELOPMENTAL MILESTONES (age, if applicable)			
sitting		walking	
crawling		talking	

family history

please indicate any conditions a family member has experienced

allergies		hearing loss	
asthma		diabetes/hypoglycemia	
eczema		high blood pressure	
autoimmune disease		heart disease	
mental illness		bleeding disorder	
epilepsy		anemia	
ear infections		cancer	
other			

WHAT IS YOUR ETHNIC HERITAGE? _____

lifestyle

sleep (hrs/night)		sleeps through the night	
exercise (hrs/day)		outside time (hrs/day)	
screen time (hrs/day)		energy level (1-10)	
has friends		emotional traumas	
dietary habits			
breast fed (how long)		dairy/cow's milk	
formula fed (how long)		vegetables (#servings)	
age solid foods began		fruits (# servings)	
which foods?		refined sugar (per day)	
any reactions?		processed food (per day)	
any foods you avoid (why)?			

living situation

WHAT TYPE OF HOME DO YOU LIVE IN?_____

URBAN OR RURAL AREA? _____

DO YOU LIVE WITH ANYONE? _____

DO YOU HAVE ANY PETS?_____

social history

PARENTS: MARRIED / SEPARATED

FULL TIME JOB: MOM / DAD SCHOOL (hrs/day) _____

DAYCARE (hrs/day) _____ (days/week)_____

OTHER GUARDIANS_____

ANYTHING WE'VE MISSED? _____

_____

INFORMED CONSENT TO TREATMENT
TERMS & CONDITIONS

Thank you for your interest in Dr. Kathryn Harbun, ND, and Arc Integrated Medicine as your naturopathic health care provider, and guide towards living a healthier, more vibrant life.

Throughout this letter agreement the terms "you", "I", "me" and "my" shall refer to you the undersigned individual or your child (as applicable), specified at the end of this letter agreement.

DISCLOSURE OF QUALIFICATIONS

I understand and acknowledge that Dr. Kathryn Harbun is a fully licenses naturopathic physician who has completed both a bachelor's degree, and a four-year diploma in naturopathic medicine. She is fully licenses by the CNPBC, and holds multiple college-approved certifications for additional therapies. As a member of the college, Dr. Harbun is governed by the Health Professions Act, as are all other licensed health care professionals.

TREATMENTS AND TESTING

I understand that naturopathic physicians may employ a variety of testing measures and treatment options including but not limited to:

- General diagnostic procedures which may include blood work, urine and stool testing, physical exams, radiography, testing through both public and private laboratories etc)
- Intravenous therapies, which may include injecting vitamins, amino acids, antioxidants, chelating agents, etc
- Nutritional interventions including dietary advice and therapeutic nutrition
- Lifestyle recommendations and psychological counselling
- Supplement or pharmaceutical prescription: Prescribing therapeutic substances which may include plants/herbs, minerals, vitamins, animal materials or pharmaceuticals. Medicine may be suggested in various forms (teas, pills, tinctures containing alcohol, creams, washes, suppositories etc)
- Traditional Chinese medicine and acupuncture: The use of the principles of Chinese medicine to approach a treatment protocol, and the sue of acupuncture to support a comprehensive treatment plan.

No testing or treatment will be administered without my (the patient's) knowledge and consent. I also understand that not all therapies or testing will be covered by the BC medical services plan, and unless my extended insurance agrees to reimburse me for these tests/treatments I am responsible for covering the cost. I understand that naturopathic physicians are currently unable to refer for imaging studies, or to specialists in BC.

I hereby acknowledge and agree that the Treatment may lead to certain unforeseen complications, including but not limited to: aggravation of pre-existing symptoms; allergic reactions to pharmaceuticals, supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations. I also acknowledge that I have the right to accept or reject this medical care of my own free will and choice.

PATIENT EXPECTATIONS

I understand that it is very important for me to inform my naturopathic doctor of any condition I currently have and if I am taking any medication or over-the-counter drugs. If I am pregnant, suspect pregnancy or am breast-feeding, I will advise my ND immediately, as some therapies may present a risk to the baby.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time with proper notification. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees of results have been given to me by Dr. Kathryn Harbun.

I understand that I am expected to be honest with Dr. Harbun about my health history, and what I can and cannot do as part of a treatment protocol. I agree to keep an open mind and hear/try all treatment recommendations and their reasoning before declining a therapy. I understand that if I do not adhere to treatments as recommended, they may be less effective, and therefore my results will not be as substantial. I will always do the best I can, and I understand that Dr. Harbun is available to help me with struggles along the way.

ATTENDANCE AND CALCELLATION

I will arrive early or on time to my appointments to the best of my ability, and if I need to cancel my appointment I will notify Arc Integrated Medicine front desk staff at least 24 hours in advance. If I fail to cancel my appointment sooner than 24 hours prior, or I no show without explanation, I will be charged the full fee for my visit.

I further agree and acknowledge that Dr. Harbun has the right to stop providing treatment to me at any time effective immediately, without any compensation to me whatsoever. This agreement will cover the entire course of my treatment and I am free to withdraw my consent and to discontinue participation in my treatment at any time.

CONFIDENTIALITY

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of my health history and the health services provided to me. This record will be kept confidential and will not be released to others unless I give consent or unless required by law. I understand that all staff and NDs at Arc Integrated Medicine are legally obligated to override confidentiality agreements if they become aware of any current child abuse, neglect, threats to harm any individual, or serious threats of suicide relating to my case. I understand that I may view my medical records at any time and I may request a copy of it by paying the appropriate fees.

I, (please print) _____ hereby agree to the terms and conditions set fourth in this agreement, and I certify that I have read all terms and conditions. I consent to the treatments as described above which will be provided by Dr. Harbun, or another doctor at Arc Integrated Medicine so long as I am made aware of the change in physician.

Signature _____ Date _____

(patient or legal guardian if under 18)