DR. TERESA AMBRA, ND

1047 Gerrard Street East
Toronto, ON
M4M 1Z7
(647)-725-7733
www.movementmedicine.ca

Today's Date: _____

Pediatric Patient Information		
Name: _____ (First) (Middle) (Last)		
Preferred Name (if different): _____		
Age:	DOB: ____/____/_____ M D Y	Sex: ☐ M ☐ F Other:
Marital Status:	Occupation:	
Contact Information		
Home Address:		
City:		Postal Code:
Home Phone(s):	Cell Phone(s):	Work Phone(s):
May we leave voicemails at the above phone numbers? If so, please select which ones. No confidential information is left on voicemails. ☐ Home ☐ Cell ☐ Work		
E-mail Address:		
Would you like to receive our newsletter for news, events and special offers (sent out quarterly) ☐ Yes ☐ No	Preferred method of contact: ☐ Phone ☐ E-mail	
Emergency Contact Information		
Primary Contact:		
Relationship:		
Phone number(s) for emergency contact:		
Other Healthcare Providers		
Medical Doctor:	Location:	Date of last visit:
Specialist:	Location:	Date of last visit:
Specialist:	Location:	Date of last visit:

MOVEMENT MEDICINE
NATUROPATHIC SPORTS MEDICINE CLINIC

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Clinic Information

How did you hear about Dr. Teresa Ambra, ND?

If you were referred by another patient of the ND, who referred you?

If you found out about the clinic on the Internet, how did you find it? (Specific search terms, websites etc.)

Context of Care Review

As a naturopathic doctor, I believe comprehensive and effective healthcare is only possible when a doctor has a complete understanding of the patient on a physical, mental and emotional level. The responses you provide to the following questions will assist me in understanding your health care needs and goals. Your time, thoughtfulness and honesty in completing this form is appreciated, and will provide me with great insight in order to help you feel better, sooner!

Have you been to a naturopathic doctor before? ☐ Yes ☐ No

Health Concerns

What are your child's most important health concerns? Please list as many as they have in order of importance.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Does your child have any known contagious diseases at this time? ☐ Yes ☐ No
If yes, what?

Please list any previous diagnoses your child has received (presently or in the past), who diagnosed the condition and relevant dates.

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What 3 expectations do you have from *this* visit?

1. _____
2. _____
3. _____

What *long-term* expectation do you have for working with a naturopathic doctor?

Medication & Supplements (C = Current, P = Past)

Can your child swallow pills/capsules? ☐ Yes ☐ No

___ Aspirin
___ Tylenol
___ Ibuprofen (Advil)
___ Antibiotics
# of Antibiotic Rx _____

Medications (including dose & frequency) _____ _____

Supplements (including dose & frequency) _____ _____

Allergies & Sensitivities (Please List)

_____ _____ _____

_____ _____ _____

Please indicate whether your child has experienced any of the following:
(C = Current, P = Past)

___ Constipation	___ Frequent Colds/Flus	___ Sleep Problems	___ Chronic Rash
___ Diarrhea	___ High Fevers	___ Nightmares	___ Nose Bleeds
___ Vomiting	___ Sore Throat	___ Night Sweats	___ Anemia
___ Stomach Aches	___ Easy Bruising/ Bleeding	___ Fears	___ Heart Murmur
___ No Appetite	___ Excessive urination	___ Nervousness	___ Hearing Loss
___ Excessive Thirst	___ Eczema	___ Cries Easily	___ Excessive Fatigue
___ Cough	___ Light sensitivity	___ Excessive Energy	___ Hives
___ Joint Pain	___ Wheezing	___ Sound sensitivity	___ Seizures

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Immunizations (check all that apply):

☐ MMR	☐ Small Pox	☐ Rotavirus	☐ Hepatitis A
☐ DPT	☐ H. influenza	(Rot-1)	☐ Hepatitis B
☐ Chicken Pox	(Hib)	☐ Pneumococcal	☐ Other:
(Var)	☐ The Flu Shot	☐ Meningococcal	

Did your child experience any adverse reaction to any of the above immunizations? If so, please specify.

Medical History

___ Chicken Pox	___ Rubella	___Tonsillitis; # of times _____
___ Measles	___ Scarlet Fever	___ Ear infections; # of times _____
___ Mumps	___ Pneumonia	___ Strep Throat; # of times _____

Has your child ever had any of the following? Please indicate dates, locations, and results.

Electroencephalogram (EEG): ☐ Yes ☐ No

Sleep Study: ☐ Yes ☐ No

Psychological Evaluation: ☐ Yes ☐ No

Hearing Tests: ☐ Yes ☐ No

Speech/Language Evaluation: ☐ Yes ☐ No

Vision Tests: ☐ Yes ☐ No

Injuries, surgeries or hospitalizations (please list and specify below): ☐ Yes ☐ No

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Family History

Do you or anyone in your family have a history of any of the following? Please check and indicate who.
M = Mother, F = Father, GM = Grandmother, GF = Grandfather, S = Sister, B = Brother, C = Child

☐ Anemia
☐ Arthritis
☐ Asthma
☐ Autoimmune Disease
☐ Cancer
☐ Diabetes
☐ Eczema
☐ Epilepsy
☐ Glaucoma
☐ Hay Fever
☐ Heart Disease
☐ High Blood Pressure
☐ Hives
☐ Kidney Disease
☐ Mental Illness
☐ Psoriasis
☐ Stroke
☐ Substance Abuse
☐ Other: _____

What is your family heritage?

Prenatal History

Previous pregnancies by birth mother, miscarriages or complications? ☐ Yes ☐ No

Mother's health during pregnancy:

___ Bleeding
___ Illnesses
___ Medications
___ Nausea
___ Hypertension
___ Diabetes
___ Physical or Emotional Trauma
___ Cigarettes, alcohol, or drug consumption

Other:

Birth History

___ Full Term
___ Premature
___ Late

___ Vaginal Delivery
___ C-Section

Complications during birth: _____
_____
_____
_____
_____
_____

Length of labour:
Weight at birth:
Mother's age at birth:

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Did your child have any of the following problems shortly after birth?

___ Rashes	___ Birth Defects	Other: _____
___ Jaundice	___ Seizures	_____
___ Colic	___ Fever	_____
___ Birth Injuries	___ Blue Baby	_____

Please describe your child's typical daily diet:

Breakfast:	Lunch:	Dinner:	Snacks:

Athletic History

Please list all sports and activities your child was and/or is involved in (including # of years played and level of competitiveness and if they are still involved in this activity)

Bone Breaks (location, type, sidedness, approximate year)

Concussions (# and approximate year)

Other Injuries (location, type, sidedness, approximate year)

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Consent to Treatment of Naturopathic Medicine

This form must be signed prior to your first appointment

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Dr. Teresa Ambra, ND will take a thorough case history, perform a focused physical examination and complete laboratory testing, if necessary.

It is very important that you inform Dr. Teresa Ambra, ND immediately of any disease process that you are suffering from and any medications/over-the-counter medications that you are taking. Please advise Dr. Teresa Ambra, ND immediately if: you are pregnant, suspect you are pregnant, are trying to get pregnant, or if you are breast-feeding.

There are some slight health risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reaction to supplements or herbs
- Pain, bruising or injury from venipuncture, acupuncture or parenteral therapy
- Fainting or puncturing of an organ with acupuncture needles
- Muscles strains and sprains, disc injuries from spinal manipulation
- There is a very small potential for stroke in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.

I understand:

- An electronic medical record will be kept of the health services provided to me. This record will be kept in strictest confidentiality and will not be released to others unless law requires it or I give my written consent. I realize in rare instances courts may subpoena my medical records, which means that my records will have to be released.
- Dr. Teresa Ambra, ND will have to report me in the following instances: when I am in imminent danger of harming myself or others, when there is reasonable suspicion that I am neglecting and/or emotionally, physically or sexually abusing a minor, and if I engage in sexual relations with any of my healthcare providers.
- I may access my medical records at any time and can request a copy by paying the appropriate fee.
- Dr. Teresa Ambra, ND does not guarantee treatment results. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and potential complications. I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list, if any):

_____

I recognize that this consent form covers the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I have read this statement and agree to work within its guidelines, including the limits of confidentiality.

Patient Name (please print): _____

Signature of Patient or Patient's Guardian: _____ Date: _____

Signature of Dr. Teresa Ambra, ND: _____ Date: _____

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Patient Consent for Collection, Use and Disclosure of Personal Information

Privacy and protecting your personal information is an important part and consideration of my practice as a naturopathic doctor. This privacy policy outlines what I do to ensure that:

- Only necessary information is collected about you;
- I only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols (this includes cloud-based electronic medical records that are housed within Canada and are compliant with such legislation and privacy protocols);
- Privacy protocols comply with privacy legislation and standards of naturopathic doctor's regulatory body

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To assess your health concerns, provide health care and advise you of treatment options;
- To establish and maintain contact with you;
- To remind you of upcoming appointments;
- To efficiently follow-up with you for treatment;
- To complete claims for insurance purposes;
- To invoice for goods and services;
- To process credit card payments;
- To collect unpaid accounts and follow-up on billing, as required;
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable disease and individuals who may be an imminent threat to harm themselves or others;
- To be used for educational and research purposes (this includes case summaries and reports, photographs, lab results and other pertinent medical information). Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances.

Patient Consent

I, _____ have reviewed the above information that explains how Dr. Teresa Ambra, Naturopathic Doctor, will use my personal information and the steps that are taken to protect my information.

I agree that Dr. Teresa Ambra, Naturopathic Doctor, can collect, use and disclose personal information about my case as set out above regarding privacy policies.

Patient/Child Name: _____

Guardian Signature: _____

Date: _____