Simmonds McMurrer Naturopathic Medicine

Dr.Kali Simmonds,N.D. Dr.Lana McMurrer,N.D. Dr.Nara Simmonds,N.D.
34 Queen Street, 2nd Floor Charlottetown, PE C1A 4A3
Tel.902.894.3868 Fax.902.894.4054
www.simmondsmcmurre.com

Child's Name: _____ Date of Birth: _____

Health Card #:_____

Parent's Name: _____ Email: _____

Address: _____

Phone (home): _____ (work):_____ (cell):_____

How did you hear about us? _____

Who is your child's pediatrician and/or Medical Doctor? _____

What is your primary concern regarding your child's health? _____

_____

What else would you like to see changed in his/her health? _____

_____

Who diagnosed your child's with condition(s) your child has? _____

Please list any specialists consulted: _____

What medication(s) is your child presently on?

Medication	Reason	How long

What supplements or vitamins does your child take on a regular basis?

Supplement (including dose)	Supplement (including dose)

What was the level of health of both parents prior to conception?

Father: Poor _____ Fair _____ Good _____ Excellent _____

Mother: Poor _____ Fair _____ Good _____ Excellent _____

What was the level of health of the mother during pregnancy?

Poor _____ Fair _____ Good _____ Excellent _____

Comments: _____

What supplements did you take during pregnancy?

Supplement	Dose

Did you smoke during pregnancy? Yes _____ No _____ If yes how many per day? _____

Did you drink during pregnancy? Yes _____ No _____ If yes how many per day? _____

What medications were you on during pregnancy?

Prescribed	Over the counter

Would you say your diet during pregnancy was?

Poor _____ Fair _____ Good _____ Excellent _____

How was the birth of the child? Indicate if there were any complications: _____

_____

Was the baby nursed? Yes _____ No _____ If yes, how long was the baby nursed? _____

What was the first liquid, apart from being nursed or water? _____

What solid foods were started prior to 6 months of age?

Food	Age

What additional foods were introduced from 6 months to 9 months?

Food	Age

What level of health did the baby have within the first 6 months?

Poor _____ Fair _____ Good _____ Excellent _____

Did he/she have colic?

Never: _____ Occasionally: _____ Often: _____ Never: _____

What vaccinations has your child had?

Vaccination	Age	Adverse reaction

What was your child's first illness that was given medical attention?

Illness	Age	Treatment

What childhood diseases has your child had? Indicate severity, mild/average/severe.

Disease	Yes/No	Age	Severity
Roseola			
Rubella (German measles)			
Rubeola (Measles)			
Chicken Pox			
Mumps			
Scarlet Fever			
Pertussis (Whooping Cough)			
Strep Throat			
Impetigo			
Mononucleosis			

How many times has your child been treated by antibiotics? _____

List all the medications your child has taken in the past?

Illness	Age	Medication	Adverse reaction

Please give a brief history of the present health concern, giving the age of onset, first symptoms and present symptoms.

_____

_____

_____

_____

What are your observations about your child's temperament?

_____

_____

Was was your child's physical development:

Slower than average _____ Average _____ Faster than average _____

Was your child's emotional/mental development:

Slower than average _____ Average _____ Faster than average _____

How was your child's behavior and performance in school?

_____

_____

Are the child's natural parents:

Married _____ Common law _____ Separated _____ Divorced _____ Remarried _____

Does any member of the household smoke? Yes _____ No _____

Are there brothers and/or sisters?

Name	Age	State of health

What was the mother's emotional state during pregnancy?

Excellent _____ Stable _____ Stressed _____ Very stressed _____

What form of heating do you presently have?

Electrical _____ Gas _____ Oil _____

What is the emotional state of the child's home presently?

Very stable _____ Stable _____ Stressful _____ Very stressful _____

Family History

Please indicate the age of all relatives living and indicate the age at which any family member became deceased.

Family member	Age living	Age deceased
Maternal grandmother		
Maternal grandfather		
Paternal grandmother		
Paternal grandfather		
Father		
Mother		
Brother(s)		
Sister(s)		

Indicate if there have been any of the following diseases in grandparents, parents, brothers or sisters.

Disease	Yes	No	Disease	Yes	No
Diabetes			**Allergies**		
Cancer			**Goiter**		
Heart disease			**Rheumatism**		
Mental illness			**Kidney disease**		
Alzheimer's disease			**Stomach disorders**		
Tuberculosis			**Arthritis**		
Hypertension			**Other**		

Does either the child's mother or father have a chronic illness? What is their general state of health?

Mother_____

_____

_____

_____

Father_____

_____

_____

_____

Thank you for taking the time to fill out the requested information. It will help greatly in our study of your child's present health and will assist us in choosing an appropriate direction for his/her restoration to health.

NATUROPATHIC DECLARATION AND CONSENT TO TREATMENT

This is to acknowledge that I have been informed and understand:

1. Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider.

2. I understand that Naturopathic Medicine is a comprehensive approach to health and illness and focuses on prevention and the use of natural substances and treatments including: Clinical Nutrition, Lifestyle Counseling, Homeopathy, Chinese Medicine, Acupuncture, Botanical Medicine, Physical Medicine and Hydrotherapy.

3. I am at liberty to seek and/or continue medical care from a medical doctor or other qualified health care provider.

4. I am aware that no part of my treatment or testing is covered by P.E.I. Medicare and that I am solely responsible for payment.

5. Payment is to be made in full at the time of my treatment.

I HEREBY AUTHORIZE AND CONSENT TO NATUROPATHIC TREATMENT BY:

Dr. Kali Simmonds, N.D. _____
Dr. Lana McMurrer, N.D. _____
Dr. Nara Simmonds, N.D. _____

Patient's Full Name (please print): _____
First Middle Last

Date of Consent: _____
Day /Month/Year

Signature: _____
Patient or legal guardian

How did you hear about us?
Advertisement ____ Word of mouth ____Walk by ____ Referral ____ Other ____
Would you like to subscribe to our newsletter? Yes ____ No ____

AGREEMENT TO TREATMENT

It is my pleasure to provide you with effective, economical and quality health care. In order to do this, please understand the following policies and procedures:

If you cannot make a scheduled appointment, please **call 24 hours in advance to reschedule**. Patients will be charged the full fee for a missed appointment.

Payment for appointments is due in full at the time of service. We will provide you with a receipt for submission to your insurance company when services are rendered.

FEE SCHEDULE

New patient appointments:	
New patient consultation (1 hour and 15 minutes)	$ 150.00
Follow up visits:	
15 minutes	$ 40.00
30 minutes	$ 75.00
45 minutes	$ 100.00
1 hour	$ 120.00
Acupuncture:	
45 minutes (Existing patient)	$ 100.00
Letters:	$ 40.00
Sauna (Infrared)	
Session	$ 25.00
Package (10)	$ 200.00
Telephone Consultation / follow up:	
Follow the same fee schedule as an in office appointment and are based on the length of the consultation.	
*** Other Fees: Returned Cheque**	$ 10.00

Signature: _____ Date: _____

Food Diary

This form gives your naturopathic doctor important information about your health. Please DO NOT change your eating habits, eat exactly as you normally would (e.g. if you don't eat breakfast, then simply record that on the form). It is not necessary to "eat healthy". The purpose is to see what you eat most days, as this will help to determine if your diet may be contributing to specific health concerns.

NAME: _____

START DATE: _____

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			
Snacks (please indicate time of day)			
Energy 1-10			
Water intake			
Other liquids			
# Bowel Movements			
Comments**			

**Include symptoms experienced that day, such as headaches, stomach upset, sleeplessness, etc.