



2917 Lake Shore Blvd, West.
Toronto, Ontario. M8V 1J3
647-748-2917 | PHYSIOINTHESIX.COM

All information will be held in strict confidence.

Last Name First Name Initial
Date of Birth Age Sex (circle) M / F
Address City Postal Code
Email of Parent
Home Phone Work Phone Cell Phone
Height Weight Blood Type Handedness (circle) R / L
Weight at Birth lbs / kgs Weight at 1 year lbs / kgs
Height at Birth cm Height at 1 year cm
Parent's Names: Marital Status of Parents:
Child lives with:

Direct Billing Information: Insurance Company

Policy Holder Last Name Policy No.

Policy Holder First Name ID/Certificate No.

Family Physician

How did you hear about us?

Name Doctor Friend Media Walk-In
Address Insurance Company Family Member Other
Phone Referral Source's Name (Optional)
Fax

Contact in case of Emergency

Name Relationship (mom/dad/other)

Home Phone Work Phone

Table with 2 columns: SERVICE, TOTAL FEE. Rows include Naturopathic Assessment (\$180.00), Naturopathic Treatment per unit (\$90.00), Naturopathic Re-assessment (\$150.00).

N.B. Fees are subject to change.

01/09/2018

Our cancellation policy requires 24 hours notice or you will be charged 100% of the fee

This signed form and photocopies of this signed form will serve as authorization to the Physio In The Six Inc. Clinic to obtain/release medical information pertaining to myself from/to my family physician and to other Physio In The Six Inc. Clinic practitioners. It also serves as an agreement to provide payment to Physio In The Six Inc. Clinic, at the time of each visit, and later claim through any extended health benefits plan, as appropriate. The undersigned has read and understands the cancellation policy.

Signature

Date (dd/mm/yyyy)



Physio In The Six Inc.
Health Profile and Medical History (Part 1)

Child's Current Medical Conditions

- 1) _____
- 2) _____
- 3) _____

Major Surgical Operations *(If possible please provide location & date)*

- 1) _____
- 2) _____
- 3) _____

Medications *(List all prescription, over the counter and supplements you are currently taking)*

Medication/Supplement /Vitamins/Health Foods	Strength (i.e. 400 mg)	Amount Per Day (i.e. one)	Time (AM/PM)	Since how long? (i.e. starting 1 yr ago)

Allergies:

Drugs: _____ _____ _____	Food: _____ _____ _____	Environmental: _____ _____ _____
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****Patient's Name:** _____
****Date of Birth:** (dd/mm/yyyy) ____/____/____



Physio In The Six Inc.
Health Profile and Medical History (Part 2)

What are you most concerned about regarding your child's health?

How did you hear about naturopathic medicine?

Birth History

Term length: _____ Please circle: Full / Premature

If Premature: _____ weeks If Late: _____ weeks

Length of Labour: _____ Complications? _____

Describe Birth Experience (i.e. vaginal, induced, joyous, anesthesia, etc.)

Prenatal Health

Mother's diet during pregnancy (circle): Poor / Fair / Good / Excellent / Unknown

Did mother experience any of the following during pregnancy (circle):

- | | | |
|----------|---------|-----------------|
| Bleeding | High BP | Nausea/vomiting |
| Diabetes | Thyroid | Trauma |

Mother's age at child's birth _____ Hospital Birth or Home Birth? _____

Birth was attended by (circle): OBGYN / MD / Midwife

**Patient's Name: _____

**Date of Birth: (dd/mm/yyyy) ____/____/____



Physio In The Six Inc.
Health Profile and Medical History (Part 3)

Family History (Please complete to the best of your ability)

Relation	Age (if alive)	State of Health	Age at Death & Cause	Check and Designate if They Had
Mother				<input type="checkbox"/> Tuberculosis <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Migraine <input type="checkbox"/> Strokes <input type="checkbox"/> Cancer <input type="checkbox"/> Allergies/Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Nervous Troubles
Father				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				
Sibling (M / F)				
Sibling (M / F)				
Sibling (M / F)				
Sibling (M / F)				

If your child has or has had any of the following, please complete by checking the boxes that apply to you

- | | | | | | |
|----------------------|--------------------------|-------------------------|--------------------------|-------------------------|--------------------------|
| Scarlet Fever | <input type="checkbox"/> | Hearing Loss/Ringing | <input type="checkbox"/> | Trouble Swallowing | <input type="checkbox"/> |
| Measles | <input type="checkbox"/> | Sinusitis | <input type="checkbox"/> | Abdominal Pain | <input type="checkbox"/> |
| Rubella | <input type="checkbox"/> | Tonsillitis | <input type="checkbox"/> | Diarrhea | <input type="checkbox"/> |
| Mumps | <input type="checkbox"/> | Eye Infections | <input type="checkbox"/> | Constipation | <input type="checkbox"/> |
| Chicken Pox/Shingles | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | Bladder/Kidney Problem | <input type="checkbox"/> |
| Infectious Mono | <input type="checkbox"/> | Shortness of Breath | <input type="checkbox"/> | Anemia/Blood Disease | <input type="checkbox"/> |
| Whooping Cough | <input type="checkbox"/> | Chest Pain/Pressure | <input type="checkbox"/> | Moles | <input type="checkbox"/> |
| Colic | <input type="checkbox"/> | Excess Sweating | <input type="checkbox"/> | Warts | <input type="checkbox"/> |
| Psoriasis | <input type="checkbox"/> | Goiter/Thyroid Diseases | <input type="checkbox"/> | Athlete's Foot | <input type="checkbox"/> |
| Eczema | <input type="checkbox"/> | Cough or Sputum | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> |
| Rash | <input type="checkbox"/> | Asthma or Wheezing | <input type="checkbox"/> | Jaundice | <input type="checkbox"/> |
| Swollen Glands | <input type="checkbox"/> | Pneumonia or Pleurisy | <input type="checkbox"/> | Hepatitis | <input type="checkbox"/> |
| Night Sweats/Fevers | <input type="checkbox"/> | Blood in Sputum | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> |
| Frequent Colds/Flus | <input type="checkbox"/> | Hoarseness | <input type="checkbox"/> | Sports Injury | <input type="checkbox"/> |
| Ear Infections | <input type="checkbox"/> | Indigestion | <input type="checkbox"/> | Car Accident | <input type="checkbox"/> |
| Knee Trouble | <input type="checkbox"/> | Joint Disease | <input type="checkbox"/> | Headache | <input type="checkbox"/> |
| Numbness/Tingling | <input type="checkbox"/> | Tremors | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> |
| Nightmares | <input type="checkbox"/> | Worries/Stress | <input type="checkbox"/> | Problems Concentrating | <input type="checkbox"/> |
| Depression | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> | Phobia(s) | <input type="checkbox"/> |
| Acting Out | <input type="checkbox"/> | Temper Tantrums | <input type="checkbox"/> | Heart Problems | <input type="checkbox"/> |
| Nasal Congestion | <input type="checkbox"/> | Other Nasal Problems | <input type="checkbox"/> | Weight Loss-unexplained | <input type="checkbox"/> |

**Patient's Name: _____

**Date of Birth: (dd/mm/yyyy) ____/____/____



Physio In The Six Inc.
Health Profile and Medical History (Part 4)

Dietary Assessment

How was your infant fed (circle)? Breastfed / Formula

If breastfed, how long? _____ If Formula please indicate (circle) Milk / Soy / Other _____

What foods were introduced before 6 months? (please list approximately at what month)

What foods were introduced between 6-12 months?

Is your child sensitive to any foods (circle)? YES / NO If yes, please indicate:

How many times does your family eat at fast food restaurants, per week? _____

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Liquids (list quantity) _____

**Patient's Name: _____

**Date of Birth: (dd/mm/yyyy) ____/____/____



Physio In The Six Inc. Health Profile and Medical History (Part 5)

Health and Development

How was your child's health in the first year (circle)? Poor / Fair / Good / Excellent / Unknown
At what age did your child begin to:

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's mood and behavior at home:

How is your child's behavior and performance at school?

Is your child in (circle):

School / Daycare / Homecare / Other _____

What are you child's favourite activities?

Does your child exercise regularly (circle)? YES / NO

How much, how often?

How much television does your child watch? _____ hours a (circle) DAY / WEEK

How much computer time? _____ hours a (circle) DAY / WEEK

Does anyone in the child's household smoke (circle)? YES / NO

Are there animals in the house (circle)? YES / NO

How is the family home heated? _____

Do you know of any toxins or other hazards the child is regularly exposed to (home, hobbies, school etc.)? Please describe.

Describe the emotional climate of the child's home:

Anything else of importance you would like to add?

**Patient's Name:

**Date of Birth: (dd/mm/yyyy) ____/____/____

Physio In The Six Inc.
Naturopathic Medicine – Consent To Treatment and Privacy Policy

Naturopathic medicine is the treatment and prevention of diseases 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 capacity/

I hereby consent to the assessment and treatment performed by the Registered Naturopathic Doctor named below.

I understand that treatment may include treatments for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purposes. Treatment modalities include dietary modification and nutritional supplementation, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counseling. Bowen therapy may also be used, as well as bio-identical hormones.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or in those with multiple medications. 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 your Naturopath immediately of any disease process that you are suffering from or if you are on any medication or over-the-counter drugs. If you are pregnant, suspect that you are pregnant or are breast-feeding, please advise your Naturopath immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These can include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture

Supplements may be prescribed by your Naturopathic Doctor, these can be purchased at the clinic or at other local health stores. Please note: extended health insurance companies may not cover the supplements prescribed to you.

I understand that I may rescind or amend this consent in writing.

I further understand that the clinical, psychological and any other information which is gathered during the course of my treatment is confidential, but may be shared with my insuring agents, third party payers and/or physician(s) upon request.

Privacy and protecting your personal information is something we take very seriously. All personal information gathered adheres to the privacy legislation and standards of the College of Naturopaths of Ontario(CONO).

I have read the above consent, and I have had the opportunity to ask questions about its content. This consent will cover the naturopathic assessment and entire course of treatment.

Patient's Name *(Please print)*

MARY GALIC
Doctor's Name *(Please print)*

Date of Birth: *(dd/mm/yyyy)* ____/____/____

Signature of Patient

**The Health Information Custodian of this chart is
Physio In The Six Inc.**

Date Signed

Physio In The Six Inc.
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