



PYATT HEALTH CENTRE
NATUROPATHIC FAMILY MEDICINE & ONCOLOGY CARE

PATIENT INFORMATION - CHILD

Name _____ Date of Birth ____ / ____ / ____ Age ____
DD MMM YY

PARENT/GUARDIAN INFORMATION

Name(s) _____

Address _____
STREET NAME & # CITY, PROV POSTAL CODE

Phone # () - _____ Alt phone # () - _____
HOME WORK CELL HOME WORK CELL

Email address _____

How did you hear about our clinic? _____

PATIENT MEDICAL INFORMATION

Family Doctor _____ () - _____
NAME PHONE #

Year of last physical exam _____ Vaccinations: ___ up to date ___ not vaccinated ___ partially vaccinated

Hospitalizations & surgeries _____

Prescribed medications _____

Over the counter medications and supplements _____

Allergies _____

Dietary restrictions _____

Patient name _____

HEALTH INFORMATION

Reason for visit _____

Diagnosed conditions _____

Current treatments (other than medications & supplements) _____

Significant family health history _____

Issues at birth _____

Breastfed: Y / N / for a short time

C-section: Y / N

Antibiotics given: Y / N

Please rate the following where 1 = very poor and 10 = ideal state:

Overall health ____ / 10

Energy ____ / 10

Sleep ____ / 10

Stress tolerance ____ /10

REVIEW OF SYSTEMS

Please state any health issues in the following categories that are not already mentioned above, including any significant past issues as well, indicated by a (P) after the condition:

SKIN, HAIR, NAILS _____

DIGESTIVE _____

RESPIRATORY _____

EYES, EARS, NOSE, THROAT _____

IMMUNE SYSTEM _____

WEIGHT _____

URINARY _____

MUSCULOSKELETAL _____

MENTAL EMOTIONAL _____

FOODS _____

OTHER _____



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CONSENT TO TREAT & PATIENT RESPONSIBILITY

The Undersigned patient and/or responsible relative or person hereby consents to the following:

I authorize Pyatt Health Centre naturopathic doctors and medical personnel to administer and perform medical examinations, investigations, and medical treatments during the course of my care that are deemed advisable or necessary.

I consent to Pyatt Health Centre contacting me by telephone if needed regarding appointments and follow-up needs.

I am responsible for making my own appointments and notifying Pyatt Health Centre with sufficient notice (one business day prior to my appointment) should I be unable to attend a scheduled appointment. Appointments missed or rescheduled without sufficient notice may carry a financial penalty.

I understand that should I be later than half the length of my appointment I will likely need to reschedule. Though every attempt will be made to accommodate late clients, Pyatt Health Centre is unable to make guarantees in this regard.

I realize that I am responsible for all costs associated with my care at Pyatt Health Centre. This includes, but is not limited to, consultations, treatments, evaluations & labs, supplementation, professional letters/ correspondences and courier & shipping costs. I also know that I will be duly informed by a member of Pyatt Health Centre of any cost prior to my incurring them.

I understand that it is my responsibility to follow-up with my care provider at Pyatt Health Centre via a phone or clinic consult, should phone messages or email not be answered in a timely fashion. Inquiries regarding changes or continuation of my treatment plan will require a follow-up appointment. Email may be used to clarify existing treatment plans and general questions or or notify practitioners of adverse reactions.

I will familiarize myself with all instructions or guidance for testing or visits provided by Pyatt Health Centre prior to the scheduled appointment.

Out of respect for the healing environment at Pyatt Health Centre I will refrain from wearing any toiletries and cosmetics that are heavily scented.

Parent/Guardian Signature

Date