<u>PEDIATRIC REGISTRATION</u> (Birth to 5 years)

Name ____ Date of First Visit _________________

Age __________ Date of Birth (M/D/Y) _______________ Gender: female ____ male ____

Parent/Guardian Name(s): ____

Address_____________________________________ City___________ Postal Code________

Home Phone _______________________ Work/Cell Phone ____________________________

Parent/Guardian's Email ____

May we contact you via email: Yes ___ No ___; email updates/newsletters: Yes ___ No ___

Parent/Guardian's Occupation ______________________________ Hours per week _______

Extended Health Plan Carrier ____

Has any other family member already been a patient at the clinic? _____________________

Emergency Contact Person ____________________ Relationship to Patient ______________

Home Phone ______________________ Work/Cell Phone ____________________________

How did you hear about Ray Clinic? ____

<u>HEALTH OVERVIEW</u>

Name of child's current GP (Medical Doctor) or Pediatrician _________________________

MD's contact information ____

Child's last MD visit __________________ Reason __________________________________

Name(s) of other health care professional(s) _______________________________________

What is the main reason for your child's visit today? ________________________________

What are your child's current health concerns? Please list in order of importance.

____

____

Medical History: Please circle any of the following that applies to your child's health.

Chickenpox	Measles	Mumps
Rubella	Scarlet Fever	Polio
Roseola	Strep Throat	Ear Infections
Whooping Cough	Rheumatic Fever	Pneumonia
Bronchitis	Asthma	Skin Infections:

Other:

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Family History: Please circle any of the following that applies in your child's family history.

Cancer : type	Diabetes	Heart Disease
High Blood Pressure	Birth Abnormality	Celiac Disease
Epilepsy	Mental Illness	Asthma
Hay Fever/Hives/Allergies	Anemia	Kidney Disease
Glaucoma	Tuberculosis/TB	Arthritis

Other:

Immunizations: Please check any of the following immunizations your child has received.

	Polio		Pertussis
	Tetanus		Diphtheria
	Measles/Mumps/Rubella (MMR)		Pneumococcal
	Hepatitis B		Meningococcal
	Hemophilus influenza B		Influenza ('flu shots')
	Travel Related:		Other:

Please list any injuries, hospitalizations, surgeries, and other procedures.

__________________________ year:_____ __________________________ year:_____

__________________________ year:_____ __________________________ year:_____

Please list any hypersensitivity or allergy to medications, chemicals, foods, or environment:

____

Please list all medications, vitamins, and supplements the child is taking:

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Birth Mother's Prenatal History:

Mother's age at child's birth: _________ Mother's health during pregnancy: ________________
Please check any of the following if experienced during pregnancy:

__ Bleeding __ Cigarette use/exposure __ Alcohol/drug consumption
__ Nausea/Vomiting __ Medications __ Gestational diabetes
__ Illnesses __ High Blood Pressure __ Pain: _________________
__ Physical or Emotional Trauma __ Thyroid Problems __ Other: _________________

Child's Birth History:

__ Full Term __ Premature@_____ weeks __ Late@ _____weeks Weight at Birth: _______
Length of Labour: ___________________ Any Complications? _________________________
Birth (please check √): __ vaginal __ cesarean __ induced __ forceps __ anesthesia

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Were there any of the following present after birth?

__ Birth Abnormality	__ Jaundice	__ Seizures
__ Birth Injuries	__ Rashes	__ Colic
__ Blue Baby	__ Fever	__ Cerebral Palsy
__ Other: ____________________________		

Breastfed? Y N how long?_________ Formula? Y N if yes, type: (cow's, soy, rice, other)
How is your child's sleep pattern? ____
How is your child's mood and temperament? ____
Any diet restrictions (religious, vegetarian, vegan)? ___________________________________
Age began solids _________ Order of foods? ____
Age began: Sitting _______ Crawling _______ Walking ______ Talking ______

Please mark any of the following if applicable ('C' *current* and 'P' *past*):

__ Hives	__ Eczema	__ Excessive fatigue	__ Nervous
__ Nosebleeds	__ Stomachaches	__ Vomiting spells	__ Cries easily
__ Bleeding gums	__ Diarrhea	__ Dizzy spells	__ Night sweats
__ Wheezing	__ Constipation	__ Anemia	__ Nightmares
__ Cough	__ Gas	__ Easy bruising	__ Motion/Car sick
__ Frequent colds	__ Frequent urine	__ Joint pain	__ Bad breath
__ Headaches	__ Burning urine	__ Bloody urine	__ Unusual fears
__ Canker sores	__ Hair loss	__ No appetite	__ Other: __________

PRIVACY NOTICE

Privacy of personal information is of utmost importance while providing quality naturopathic medical care. The clinicians and staff at Ray Clinic understand the importance of protecting personal information and are committed to collecting, using, and disclosing personal information responsibly.

FEE SCHEDULE

Initial Consultation (1 hour): $180	IV Therapy (Push): $90	Lab Tests: Varies
Follow-up Visit (30 min): $90	IV Therapy (Drip): $145	Supplements: Varies
Extended Follow-up (45min):$135	IM Injection (B12): $30	Missed Appt Fee: $55

CONSENT & AGREEMENT

As the parent/guardian, I hereby request and consent to receive treatment from the physicians at Ray Clinic for my child. I understand that this consent is voluntary and may be withdrawn at any time in written or verbal format. I understand the fee schedule, including the cancellation policy – I am responsible for paying the missed appointment fee if I do not give 24 hrs notice of change or cancellation. I accept responsibility for prompt payment at the time of each visit or treatment. I give permission for the clinic to leave messages regarding appointments at the contact information I have provided above.

Patient Name (Please Print) ____

Parent/Guardian Signature ____________________________________ Date ____________________

***Scent-Free Environment: Patients in our clinic may have sensitivity and/or allergic reactions to various fragrant products. We ask that you avoid personal products that are perceptible to others when visiting the clinic. Your understanding and support is greatly appreciated. Thank you.**

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