ray clinic

PEDIATRIC REGISTRATION (Birth to 5 years)

Name _____ Date of First Visit _____

Age _____ Date of Birth (M/D/Y) _____ Gender: _____

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? _____

HEALTH OVERVIEW

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

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
__ Nosebleeds
__ Bleeding gums
__ Wheezing
__ Cough
__ Frequent colds
__ Headaches
__ Canker sores
__ Eczema
__ Stomachaches
__ Diarrhea
__ Constipation
__ Gas
__ Frequent urine
__ Burning urine
__ Hair loss
__ Excessive fatigue
__ Vomiting spells
__ Dizzy spells
__ Anemia
__ Easy bruising
__ Joint pain
__ Bloody urine
__ No appetite
__ Nervous
__ Cries easily
__ Night sweats
__ Nightmares
__ Motion/Car sick
__ Bad breath
__ Unusual fears
__ 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
Follow-up Visit (30 min): $90
Extended Follow-up (45min):$135
IV Therapy (Push): $90
IV Therapy (Drip): $145
IM Injection (B12): $30
Lab Tests: Varies
Supplements: Varies
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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