Context of Care
Overview

What expectations do you have from working with Dr. Kulwinder Sraw ?

Short Term:____

Long Term:____

What do you know about Dr. Sraw's approach?

What is your current level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? *Rate from 0-10 (10 = 100% commitment)*

What behaviors & lifestyle habits do you currently engage in regularly that you believe support your health?

What potential obstacles do you foresee in addressing lifestyle factors that are determining your health and in adhering to the therapeutic protocols which will be shared with you?

Who do you know that will sincerely support you consistently with the beneficial therapeutic and lifestyle changes you will be making?

What do you love to do?

Confidential Patient Health Record
PEDIATRIC / ADOLESCENT

Personal Information

Full Name: ________________________ Age: _____ Sex: ____ Birthdate: _________ (mm / dd / yyyy)

Name preferred to be called:________________________ Parent's Names: ________________________

Address: ________________________City: ______________ Postal Code: __________

Home Phone: ________________ Parent's Work Phone: ______________ (Mother, Father, Other)
Parent's Cell Phone: ____________ (Mother, Father, Other) Email: ________________________

Emergency Contact: ________________________ Phone: ________________

Other Health Care Providers (Family Physician, Specialists, Complementary and Alternative Therapy):
Name: ________________ Name: ________________ Name: ________________
Phone: ________________ Phone: ________________ Phone: ________________

How were you referred to this office (Dr. Kulwinder Sraw, ND)? • friend • newspaper • referral • other ________________________
Would you like to subscribe to the quarterly Newsletter, via email? • Sure • No, Thank you.

What are the main health concerns you would like addressed?
1. ____
2. ____
3. ____
4. ____
5. ____

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

	Type / Reason / Cause	*Year*
Injuries / Accidents:	________________________	__________
Major Illnesses:	________________________	__________
Hospitalizations:	________________________	__________
Surgeries:	________________________	__________

Do you have allergies (medications, environmental, etc)?
____

Please indicate which immunizations you have had:
- DPT (diphtheria, pertussis, tetanus)
- Tetanus booster, when? __________
- MMR (measles, mumps, rubella)
- Haemophilus Influenza B
- Hepatitis A
- Hepatitis B
- Polio
- "Flu"
- Smallpox

Other: ________________________

Please indicate if any of the above caused adverse reactions? ________________________

Childhood Illnesses
- Chicken Pox
- Measles
- Mumps
- Rubella
- Scarlet Fever
- Rheumatic fever
- Strep Throat
- Pneumonia
- Mononucleosis
- Ear Infections
- Tonsillitis
- Other: _______

Please list all MEDICATIONS you are taking, including dosages, duration and why you are taking them:			
Medication	**Dosage**	**Duration**	**Condition Treating**

Please list all NATURAL HEALTH PRODUCTS (vitamins, minerals, herbs) you are taking, including dosages, duration and why you are taking them:			
Natural Health Product	**Dosage**	**Duration**	**Condition Treating**

How frequently have you been treated with antibiotics? ______________________________

Please indicate if you use the following:

- Aspirin
- Tyelenol
- Antacids
- Laxatives
- Antibiotics
- Decongestants
- Diet Pills
- Birth Control Pills
- Fluoride
- Other: ____________________

Caffeine — form and amount per day or week? ____________________________________

Alcohol — how much per day or week? ____________________________________

Tobacco — form and amount per day or week? ____________________________________

Recreational Drugs — type and how often? ____________________________________

Please indicate if you have had the following:

	currently	*past*
Acne	______	______
Allergies	______	______
Anemia	______	______
Asthma	______	______
Bed wetting	______	______
Birth defects	______	______
Colic	______	______
Constipation	______	______
Cough / Wheeze	______	______
Cradle cap	______	______
Depression	______	______
Diarrhea	______	______
Dizzy spells	______	______
Earaches	______	______
Eczema	______	______
Epilepsy / Seizures	______	______
Fatigue	______	______
Frequent infections	______	______
Headaches	______	______
Heart murmur	______	______
High fever	______	______
Hyperactivity	______	______
Insomnia	______	______
Jaundice	______	______
Learning disorder	______	______
Moodiness	______	______
Stuffy nose	______	______
Thrush	______	______
Vomiting spells	______	______
Other: ____________	______	______

How would you describe your own disposition?

____

Prenatal, Antenatal, Postnatal and Feeding History

Mother's health during pregnancy with this patient:

_____ Age _____ Trauma / Injury _____ Alcohol Consumption _____ Diabetes
_____ Bleeding _____ Stress _____ Drugs Other: ____________
_____ Nausea _____ High Blood Pressure _____ Smoking Medications: ________
_____ Illness _____ X-Rays _____ Toxemia ____________________

Pregnancy Term

_____ Premature. If yes, how many weeks / days early? _________
_____ Full Term

Birth Weight: ________________

How would the pregnancy be described?

_____ Easy _____ Difficult _____ C-Section

Feeding of Infant

_____ Breast Fed. How long? ______________ Milk? What type? How long?__________________
_____ Formula Fed How long? ______________ Type of formula? ____________________________

_____ Age solid foods were begun

What foods? ____

Were any food allergies or intolerances noted? ________ Which foods?__________________________

Do you have any food restrictions (religious, vegetarian, vegan, etc?) ______________________________

Daily Diet Sample (choose a typical day including food and liquid):

Breakfast:

Lunch:

Dinner:

Snacks:

Please comment on previous pregnancies by natural mother, including complications:

____
____
____
____

Family History

Father (age): _____ Mother (age): _____ Brothers (ages): _________ Sisters (ages): __________

******If deceased, please list age at death and circle.*

Please identify all family members who have had any of the following (F - father, M - mother, B1, B2, S1, S2, etc)

______ Alcoholism ______ Bleeding Disorder ______ Heart Disease ______ Obesity
______ Allergies ______ Cancer of ___________ ______ Hearing Loss ______ Stomach Ulcers
______ Anemia ______ Colitis ______ High Blood Pressure ______ Stroke
______ Arthritis ______ Diabetes ______ Hypoglycemia ______ Thyroid Disorder
______ Asthma ______ Eczema ______ Kidney Disease ______ Tuberculosis
______ Birth Defects ______ Epilepsy ______ Mental Illness Other: __________

Do you have any of the above? ________ If yes, which one(s)? ____________________________

Social History

Child's Parents: ______ Married ______ Separated ______ Divorced
Mother's Occupation: ________________________________ ______ Full time ______ Part time
Father's Occupation: ________________________________ ______ Full time ______ Part time
Other Guardian: ______________________________ Relationship: ________________________
Other's residing at home: ____________________________ Relationship: ________________________
Interaction with relatives: Whom? ___________________________ How often? ________________________

Do you attend daycare, preschool or school? If yes, how many hours per day? ________ # days per week? _____

New Patient Policy and Fee Explanation

Dear Patient,

The services of Naturopathic Physicians are covered by many extended health care providers, but are currently not covered under the Medical Services Plan (MSP). Please take note of the following clinic policies:

1. The cost of initial consultation is $165.00, 10% off for children, seniors & students.
2. Subsequent visits are $85.00 and are booked in 30 minute increments; any time over this will be billed accordingly, 10% off for children, seniors & students.
3. If you receive Assisted Premiums with the Medical Services Plan, please let us know before drawing up the bill (and provide us with your MSP card number).
4. Payment is due when services rendered. Credit cannot be extended without prior approval.
5. **Appointments not cancelled with sufficient notice (greater than 24 hours) are charged a fee of $65.00 for single appointment, and $80.00 on a extended appointments.**
6. There is a $30.00 charge on NSF cheques.
7. Additional services (such as prolotherapy injections, chelation therapy, other injection therapies, supplements, assisted treatments, blood tests, acupuncture, etc) will incur separate or additional fees.

Yours - In Sincerest of Health,

Dr. Kulwinder Sraw, N.D.

Signature:____________________________ Witness:________________________

Date: ______________________________

Informed Consent for Treatment

I,________________________, hereby authorize Dr. Kulwinder Sraw, ND to perform the following procedures to facilitate my diagnosis and treatment:

Common Diagnostic Procedures: venipuncture, laboratory, physical exam
Medicinal Use of Nutrition: therapeutic nutrition, nutritional supplements, intra-muscular, subcutaneous, intracutaneous and intravenous vitamin/mineral injections.
Physical Medicine: microcurrent / electrical frequency, manipulative therapy, soft tissue therapy, injection therapies (prolotherapy, neural prolotherapy, neural therapy, chelation therapy, platelet rich plasma therapy), trigger point therapy.
Acupuncture: insertion of acupuncture needles into the dermis and subcutaneous layers of the skin.
Botanical Medicine: herbs prescribed as teas, alcoholic tinctures, capsules, tablets, creams, or plasters.
Homeopathic Medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to stimulate the body's healing capabilities.
Lifestyle Counseling and Hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.

I recognize the potential risks and benefits of these procedures as described below:
Potential Risks – allergic reaction and adverse effect to prescribed herbs, supplements and medications, inconvenience of lifestyle changes, injury from injections or venipuncture, acupuncture, manipulation or other procedures.
Potential Benefits – restoration of health and the body's maximum functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease and its progression.

Notice to Women: all female patients must inform the doctor if they know or suspect pregnancy, as some of the therapies used could present a risk to the pregnancy – mother and fetus.

With this knowledge and understanding, I voluntarily consent to the above procedures. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
I understand that Dr. Kulwinder Sraw, ND will keep a record of the health services provided to me. This record will be kept in confidential and will not be released to others unless directed by myself or my representative in writing or unless is required by law. I understand that I may look at my medical record and can request a copy. I understand that my medical records will not be kept for more than seven (7) years after the day of my last appointment. I understand that any questions concerning this form may be asked of the naturopathic physician.

___________________________________ ____________________
Signature of Patient Date

___________________________________ ____________________
Signature of Patient's Representative or Guardian Date

___________________________________ ____________________
Witness Date