

Hello and welcome to the Daziran Integrative Health. We are privileged to be a part of your healing team. For most people, the naturopathic experience will be quite different than the conventional medical system to which they are accustomed. Your initial visit will include a consultation, detailed history, relevant physical exam, screening diagnostics and naturopathic assessments. Other lab work may be requested depending upon your specific presentation and concerns.

Your second visit, usually two weeks later, will include a detailed report of findings and your individualized treatment plan will be discussed. Also, any remaining portion of the relevant physical exam will be completed on this visit. Treatment plans may include dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy, or hydrotherapy.

Subsequent visits are typically every 4 to 6 weeks, though may be more frequent if your child's case requires active treatments or close follow-up. As your child starts to experience greater health and wellness, an office visit every three months is recommended for general health maintenance and disease prevention. Please note that for infants, well child visits are recommended at 1, 2, 3, 6, 9, 12 and 18 months. If ever an acute, non-emergency condition occurs, please call the office as naturopathic treatments may be indicated.

At Daziran, we attempt to treat the whole person with an emphasis on the cause of their concerns, not just the symptoms. Our treatment plans are gentle and non-invasive, working with the body's inherent ability to heal itself. Client education is strongly emphasized as it encourages our patients to become invested in their health and therefore increases the likelihood of a successful outcome.

Contrary to what you might think, naturopathic care does not need to be practiced in isolation. Many of our clients with pre-existing medical concerns and subsequent treatment seek out our services to best ensure that all their health needs are met. We look forward to continued professional relations with the medical community so that our patients get the best of what both approaches have to offer. An integrative approach to health is an essential part of building happy and healthy communities.

With all this in mind, please take a few minutes to answer the following health questionnaire openly and honestly. Our ability to treat you with the best that naturopathic care has to offer depends on it. Additionally, please include a copy of your child's most recent lab work or imaging studies as these will help direct the course of your individualized treatment. Looking forward to meeting you and your family,

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Dr. Marika Geis, BSc, ND  
Daziran Integrative Health

**Patient Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ M/F  
(First) (Middle) (Last) (dd/mm/yy)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Address: \_\_\_\_\_  
(Box Number) (House Number) (Street) (Suite/Apt#)

\_\_\_\_\_ (City) (Province) (Postal Code)

Legal Guardian: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Guardian's Home Phone Number: \_\_\_\_\_ Guardian's Cell Phone Number: \_\_\_\_\_

Guardian's Work Phone Number: \_\_\_\_\_ Guardian's email address: \_\_\_\_\_

Where is the most convenient place to reach you (Guardian)? \_\_\_\_\_

Guardian's Marital Status: \_\_\_\_\_ Number of Siblings: \_\_\_\_\_

Guardian's occupation: \_\_\_\_\_

Referred by: \_\_\_\_\_

**In Case of Emergency, Contact:**

Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_

**Primary Health Concerns:**

(Please list in order of importance)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Medical History:**

Does your child currently see a family physician? Y/N

Name of family doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Have there been any recent lab tests or imaging studies? Y/N

If so what were the results?

\_\_\_\_\_

Current/Past Illnesses, Conditions, Hospitalizations or Injuries with approximate dates:

List medications or supplements used currently (include dose and brand name):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies/Sensitivities (food, drug, seasonal, pets, etc) with brief description of reaction:

List any medications/supplements used in the past:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Vaccinations received to date, check all that apply:

DPT	___	HiB	___	Hep A	___	Meningococcal	___
Tetanus Booster	___	Flu	___	Hep B	___	Chicken Pox	___
MMR	___	Polio	___	Pneumococcal	___	HPV	___

Did your child experience any adverse reactions to the immunizations (eg: fever, rash, ear ache, behavioral disturbances etc), either immediately or up to a month following vaccinations? If yes, please explain.

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How frequently has your child been prescribed antibiotics? When was the last date of use? For what purpose?

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What was the date of your child's last physical exam? \_\_\_\_\_

What was the date of your child's last eye exam? \_\_\_\_\_

What was the date of your child's last hearing assessment? \_\_\_\_\_

**Illnesses/ Review of Systems**

*(Please check all that apply)*

Condition/Symptom	Present	Past	Never	Condition/Symptom	Present	Past	Never
<b>Childhood Diseases</b>				<b>Head, Ears, Eyes, Nose</b>			
Chicken Pox				Headaches			
Diphtheria				Dizziness			
Rubella (german/3day)				Severe head injury			
Measles (2 wk)				Vision Problems			
Mumps				Itchy, watery eyes			
Polio				Recurring Ear Infections			
Whooping Cough				Earaches			
Mononucleosis				Frequent Runny Nose			
Roseola				Congestion			
Rheumatic Fever				<b>Digestive Health</b>			
Scarlet Fever				Constipation			
<b>Throat and Lungs</b>				Diarrhea			
Strep Throat				Indigestion/ Gas			
Tonsillitis				Colitis			
Asthma				Vomiting			
Bronchitis				Jaundice			
Coughing/ Wheezing				Mucus/blood in stool			
Croup				<b>Urinary Health</b>			
Pneumonia				Bed wetting			
Pleurisy				Bladder infections			

<b>Cardiovascular Health</b>				<b>Neurological Health</b>			
Heart murmur				Meningitis			
High Blood Pressure				Encephalitis			
<b>Immunology</b>				Cerebral Palsy			
Frequent infections				Paralysis			
Influenza				MS			
Fevers				Seizures			
<b>Skin</b>				<b>Blood Disorders</b>			
Acne				Anemia			
Ulcers				Leukemia			
Hives/ Rashes				<b>Hormonal Health</b>			
Herpes (oral)				Diabetes			
Eczema				Hyperthyroid			
Cradle Cap				<b>Mental/Emotional Health</b>			
Poor wound healing				Anxiety			
				Fears			

***Perinatal/Neonatal history***

Length of pregnancy (weeks): \_\_\_\_\_

Mother's age at birth: \_\_\_\_\_

Were there any complications during pregnancy (eg: nausea, vomiting, bleeding, high blood pressure, pre-eclampsia, gestational diabetes, positive GBS, physical /emotional trauma)? Y/N

If yes, please describe:

\_\_\_\_\_

Were there any complications during delivery (eg: induction, cesarean, vacuum/forcep extraction, pre-term labor etc)? Y/N

If yes, please describe:

\_\_\_\_\_

Describe any complications for mom or baby after the birth:

\_\_\_\_\_

If available, please indicate:

Baby's birth weight: \_\_\_\_\_ APGAR Scores \_\_\_\_\_

Baby's birth length: \_\_\_\_\_ Head circumference \_\_\_\_\_

***Prenatal History, Mom's health:***

Has the mother ever miscarried? Y/N

If so, please indicate the date and at what point during the pregnancy the miscarriage occurred.

\_\_\_\_\_

Did the couple experience any difficulty conceiving (eg: ectopic pregnancies or infertility)? Y/N

If so, what interventions were used to conceive (if any)?

\_\_\_\_\_

What was the total weight gain during pregnancy? \_\_\_\_\_

Was the mother previously over/underweight? Y/N

Briefly describe mom's diet during pregnancy, any food cravings?

\_\_\_\_\_

\_\_\_\_\_

What medications/supplements did the mother take during pregnancy?

\_\_\_\_\_

Was mom physically active during pregnancy?

\_\_\_\_\_

Did the mom smoke while pregnant? Y/N

If so, indicate quantity and frequency: \_\_\_\_\_

Did the mother smoke before conception? Y/N

If so, indicate quantity and frequency: \_\_\_\_\_

Did the mom use drugs or alcohol? Y/N

If so, indicate type, amount and frequency: \_\_\_\_\_

***Prenatal History, Dad's Health:***

Dad's age at birth: \_\_\_\_\_

Did the father smoke prior to conception? Y/N

If so, indicate quantity and frequency: \_\_\_\_\_

Was mom exposed to second hand smoke during pregnancy? Y/N

Did the father use drugs or alcohol prior to conception? Y/N

If so, indicate type, amount and frequency: \_\_\_\_\_

***Feeding and Diet History:***

Was your child breastfed? Y/N                      Until what age? \_\_\_\_\_

Approximate feeding schedule: \_\_\_\_\_

Were there any difficulties with breastfeeding? If so, please describe:

\_\_\_\_\_

If formula fed, for how long? \_\_\_\_\_

Type of formula (eg: dairy or soy based, other?): \_\_\_\_\_

Combined with breast milk? Y/N

Any adverse reactions (eg: diarrhea, constipation, rash, behavioral changes)? If so, please describe:

\_\_\_\_\_

When were solids first introduced? \_\_\_\_\_

Can you briefly describe the order in which foods were introduced?

\_\_\_\_\_

\_\_\_\_\_

Please indicate if there were any adverse reactions to any newly introduced foods:

<i>Food Introduced</i>	Colic	Bloating	Gas	Change in bowel mvmt's (diarrhea /constipation)	Nausea/Vomiting	Rashes
1.						
2.						
3.						

Please indicate what your child has consumed in the last 24 hours:

Breakfast: \_\_\_\_\_ How many glasses of water per day?

Lunch: \_\_\_\_\_ How many carbonated drinks per day?

Dinner: \_\_\_\_\_ How many glasses of milk per day?

Snacks: \_\_\_\_\_ How many glasses of juice per day?

Is this typical? If not, please describe:

\_\_\_\_\_

Has your child lost or gained significant amounts of weight at any time? Y/N

If so, please describe: \_\_\_\_\_

In general, how is your child's appetite? \_\_\_\_\_

Is your child a picky eater? Y/N

### ***Developmental History:***

Please indicate at which ages the following behaviors took place:

First held head erect \_\_\_\_\_ Said their first words with meaning \_\_\_\_\_

Rolled over \_\_\_\_\_ Spoke in sentences \_\_\_\_\_

Sat without support \_\_\_\_\_ Was toilet trained \_\_\_\_\_

Crawled \_\_\_\_\_ Tied their first shoes \_\_\_\_\_

Took first steps \_\_\_\_\_ Dressed without help \_\_\_\_\_

Cut their first tooth \_\_\_\_\_

### ***Sleep History:***

How many hours does your child sleep per night? \_\_\_\_\_

How many hours does your child sleep during the day? \_\_\_\_\_

Does your child wake up refreshed? Y/N

Is your child a restless sleeper or does he/she sleep throughout the night?

**Environment:**

Please indicate if your child is in:

Home care \_\_\_\_\_ Daycare \_\_\_\_\_ School \_\_\_\_\_ Other \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

How much time does your child spend inside? \_\_\_\_\_ Hours in front of TV or computer? \_\_\_\_\_

How much time does your child spend outside? \_\_\_\_\_ What type of activities? \_\_\_\_\_

Does anyone smoke at home?

Are there animals at home?

To your knowledge has your child ever been exposed to hazardous chemicals?

Are there any sources of stress in your child's life?

**Family Health History:**

Please indicate whether a close family relative (Mother (M), Father, (F) siblings (S), Grandparents (G)) has had any of the following:

Allergies \_\_\_\_\_ Cancer \_\_\_\_\_

Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_

Heart disease \_\_\_\_\_ Depression \_\_\_\_\_

Stroke \_\_\_\_\_ Substance abuse \_\_\_\_\_

Epilepsy \_\_\_\_\_ Other mental illness \_\_\_\_\_

Kidney disease \_\_\_\_\_ Genetic defect \_\_\_\_\_

Thyroid problems \_\_\_\_\_ Multiple sclerosis \_\_\_\_\_

Other: \_\_\_\_\_ Blood disorders \_\_\_\_\_

Please use this space to add any information you feel is relevant to your child's history that has not been covered:

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***Fee Schedule***

Pediatric Initial Appointment (Under 12 years of age)	75 minutes	\$125
Pediatric Follow up	30 minutes	\$50

*Prices do not include GST*

- Phone consultations are available only after the first appointment at the cost of a regular follow-up visit.
- Laboratory tests are priced on an individual basis.
- Full fees apply to missed/cancelled appointments with less than 24 hours notice.

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**INFORMED CONSENT  
FOR NATUROPATHIC DIAGNOSTIC & TREATMENT PROCEDURES**

**Your signature is required before any treatment is rendered. Your signature acknowledges the following:**

1. You are ultimately responsible for your own health.
2. It is your responsibility to inform your Naturopathic Doctor of: any medical conditions or allergies that you are suffering from; any medications/supplements that you are currently taking; and if you are pregnant, may be pregnant, or if you are breast-feeding.
3. While changes in habits are not a prerequisite for treatment, failure to follow the recommended nutritional and lifestyle programs could undermine the expected results.
4. You understand that that it takes time to feel better when using naturopathic medicine. You accept that positive changes will occur more rapidly with increased compliance.
5. You are accepting or rejecting this naturopathic medical care of your own free will and choice. You are free to withdraw your consent and to discontinue treatment at any time.
6. You accept full responsibility for any fees incurred during care and treatment and agree that payment is due when services are rendered. You acknowledge that canceling or rescheduling appointments must be done 24 hours in advance.
7. If you have any questions regarding your treatment program, it is your responsibility to clarify these issues with your Naturopathic Doctor.
8. Naturopathic Doctors (ND) are not Medical Doctors (MD). Therefore, if standard medical treatment (drugs, surgery, etc.) is necessary, it must be obtained from a Medical Doctor.
9. You are not an agent of any private, local, county, provincial or federal agency attempting to gather information without stating your intention to do so.
10. There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to: pain, bruising, or injury from acupuncture or injections; allergic reactions to certain supplements and herbs; and aggravation of pre-existing symptoms.

I, \_\_\_\_\_ (please print), have read, understood, and acknowledge the above statements.

**Patient or Lawful Representative Signature** \_\_\_\_\_

**Date Signed** \_\_\_\_\_ **Witness** \_\_\_\_\_

**Consent to Treat a Minor**

I authorize Marika Geis, Doctor of Naturopathic Medicine, who has been engaged by me as she may select or approve, to examine and administer Naturopathic care and treatment to \_\_\_\_\_ whose relationship to me is as a \_\_\_\_\_.

I have been given an explanation of and understand the nature of naturopathic medical care and treatment.

I authorize Marika Geis to take whatever measures she considers necessary or desirable in connection with such naturopathic care and treatment.

**Dated in the province of British Columbia, this \_\_\_\_ day of \_\_\_\_\_(month), \_\_\_\_\_(year).**

\_\_\_\_\_  
**Parent or legal guardian of minor (Please print)**

\_\_\_\_\_  
**(Signature)**

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## Release of Medical Records

Instructions:

1. Please read and sign the following document.
2. When completed, we will fax your general practitioner. (Note: Any reports done by specialists will have been sent to your GP).
3. Please give your GP a courtesy call to confirm document was received and will be sent to our office. (Note: There may be a fee for the release of records, the records will not be sent until this fee is paid).

Please send or fax copies of:

\_\_\_\_\_

D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

**LAB REPORTS ONLY** to our office:

\_\_\_\_\_ All Previous Lab Reports.

\_\_\_\_\_ Lab Reports only in the past \_\_\_\_\_ years/months.

Doctor's Name: \_\_\_\_\_

Doctor's Address: \_\_\_\_\_

\_\_\_\_\_

City	Province	Postal Code
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Telephone: \_\_\_\_\_

Fax: \_\_\_\_\_

Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Requested By:

Dr. Marika Geis, ND (#438)                       Faxed      By: \_\_\_\_\_

Received: By: \_\_\_\_\_