



Dr. Jennifer Bunzenmeyer ND Doctor of Naturopathic Medicine

12427 Bonaventure Drive SE Suite 201 Calgary, AB T2J 3N8 www.DrJennBND.com
(587) 471-5377 Fax (403) 255-2997 info@drjennbnd.com

Welcome to my Naturopathic Office

I want you and your child to enjoy and benefit from your visits with me.

Your child's first visit will consist of **consultation, detailed history, a general physical exam and a more specific naturopathic examination.** Based on this information, initial recommendations for your child's treatment protocol will be made on their first visit. If I feel it is necessary for a more complete analysis of health status, your child may be asked to have further laboratory tests through your medical doctor, or additional testing through my office lab facilities. Through this healthcare assessment, we are able to establish a baseline measure of health that we can then use to monitor progress.

On your second visit, **a detailed report of findings and an in-depth treatment plan** will be explained to you. Programs often include **dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy and traditional Chinese medicine.** Your child's program will also involve lifestyle recommendations that are logical and sensible. (I encourage your child to have a support team as you make these changes. Often having someone else, be it family member or friend who is undergoing naturopathic care at the same time will help to ease you both toward better health.) This return visit is also a good time to ask any questions that you may have had after your child's initial visit. If you need immediate clarification on remedies, dietary recommendations or have a concern over any unfamiliar symptoms that may arise, please call my office.

On your following visits, your child's progress will be monitored and treatments will be modified accordingly. The second visit is usually three to five weeks after their initial visit. As your child starts to experience a new level of wellness, we suggest an office visit every three to four months for general disease prevention and health maintenance. If an acute, non-emergency condition occurs, please give us a call as we may be able to help with a naturopathic treatment.

Many of my patients and staff have allergies and are environmentally sensitive. We ask that on the day of your visit to our office, you do not wear any scented products (perfumes, shaving lotions, hairsprays, etc.).

We request that if you are unable to keep a scheduled appointment, you give our office 2 business days notice. We are then able to provide that appointment time to someone on our waiting list. If we do not receive sufficient notice, you will be charged for the missed visit and you will be asked for your credit card information to pay for the missed visit.

Naturopathic coverage is available through many extended healthcare plans; please inquire with your HR department. Payments for visits are due at the time of the appointment.

Effective Jan. 1, 2017, Teen's Appointment Fees (no GST on visits) are:

Initial teen visit	75 minutes	\$ 250
2 nd teen visit	45 minutes	\$ 185
Regular visit	45 minutes	\$ 165

I utilize an Online Dispensary (**Fullscript**) of professional quality supplements, botanicals and homeopathics for the treatment of my patients. Most supplements I recommend for your child will be available through this online ordering system.

I accept the following methods of payment:

Visa, Mastercard, Debit Card.

If you have any concerns, please contact my front desk staff and they will be happy to pass your message on to Dr Jenn.

Please fill out the following forms and bring to your child's first appointment.



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Patient Intake Form for Teen

Our professional regulatory college (CNDA) requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission.

First Name _____ Last Name _____

Address _____

City _____ Province _____ Postal Code _____

Parent/Guardian's Names _____

Telephone (H) _____ (W) _____ (F) _____

E-mail _____ Cell _____

By signing below, you give **Dr. Jennifer Bunzenmeyer ND** permission to send you email regarding upcoming visits, online dispensary through Fullscript, newsletters and notices on events. Your email will not be distributed for any other use.

(Print Parent Name)

(Parent Signature)

(Dated)

Type of school & / or child care _____

Performance (circle one): **Academics:** Excellent/Moderate/**Weak** **Concentration:** Excellent/Moderate/Weak

Social interaction: Excellent / Moderate / Weak **Overall Health:** Excellent / Moderate / Weak

Date of Birth _____ Age _____ Sex M F Parent's Marital Status _____

Other Siblings & their ages _____

Blood Type _____ Height _____ Weight _____ Ideal Weight _____

Religion or personal philosophy _____

Name of Medical Doctor _____ Date of last physical _____

Phone (____) _____ Fax (____) _____ Date last lab tests _____

Has your child been treated by a Naturopathic Doctor? _____ Other health practitioners? _____

Name _____ Name _____

When? _____ When? _____

Please tell us how you heard of our Clinic? Family ___ Friend ___ Co-Worker ___ Ad ___ Facebook ___

Internet ___ Health Professional ___ Who recommended our clinic to you? _____

Please list (in order of importance) the primary health concerns / reasons for this visit for your child.	Please indicate any treatments that you have tried previously to address your child's health issues and how effective you found these treatments.

Please list all **pharmaceutical medications, herbals, vitamins and supplements** (& dosages, if known)

Now	In the Past

Please list any **allergies** your child has and what kind of **reaction** occurs.

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Please list all **hospitalizations, fractures or major illnesses** that your child has had.

Type of illness, operation / procedure	Date	Any ongoing concerns?

How would you rate your child's **energy level**? ____ (from 1-10, **10 being highest**) Do they wake-up feeling refreshed? Y___ N___ What time do they go to sleep from and wake up at? _____

How many glasses of **water / day** does your child? Please indicate numbers & type below.

Tap_____ Filtered_____ Spring _____ Reverse Osmosis_____ Distilled_____

How many **cups / day** does your child drink of each of the following?

Juice ____ Pop ____ Milk _ __ Chocolate milk ____ Rice /soy/almond milk ____ / ____ / ____

Is your child exposed to cigarette **smoke**? N __ Y ____ How many years? ____ In the past? Y ____

Does your child **exercise**? N__ Y___ Hours per week _____ Type of exercise _____

Does your child watch **TV**? N__ Y___ # of hours / week _____ Use computer? N __ Y __ # of hours / week

Please check **childhood illnesses** your child has had.

- | | | | | |
|----------------------------------|--------------------------------------|---|--|------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rubella | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Polio | <input type="checkbox"/> Asthma |

Please check any **vaccinations** your child has had.

- | | | | | | | |
|--------------------------------|--------------------------------------|------------------------------|-----------------------------------|------------------------------|--------------------------------|---|
| <input type="checkbox"/> Hep B | <input type="checkbox"/> DtaP or DTP | <input type="checkbox"/> MMR | <input type="checkbox"/> Gardasil | <input type="checkbox"/> Hib | <input type="checkbox"/> Polio | <input type="checkbox"/> Varicella (Chickenpox) |
|--------------------------------|--------------------------------------|------------------------------|-----------------------------------|------------------------------|--------------------------------|---|

Did they have any **adverse reactions** (eg. rash, flu, extreme upset, vomiting, neurological)?

What vaccines have they had recently? _____

Please check all of the following **conditions** that are applicable to **your child & their family** and note who.

<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	Gout	<input type="checkbox"/>
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Heart murmurs	<input type="checkbox"/>
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
<input type="checkbox"/>	Auto Immune	<input type="checkbox"/>	Hypo / hyper thyroid	<input type="checkbox"/>
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Irritable bowel	<input type="checkbox"/>
<input type="checkbox"/>	Crohn's or Colitis	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>
<input type="checkbox"/>	Depression	<input type="checkbox"/>		<input type="checkbox"/>
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>
<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
<input type="checkbox"/>	Gallbladder	<input type="checkbox"/>	Stroke or aneurysm	<input type="checkbox"/>
<input type="checkbox"/>	GERD/hiatal hernia	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>
<input type="checkbox"/>	Glaucoma / Cataracts	<input type="checkbox"/>	Other	<input type="checkbox"/>

On a separate sheet of paper, please record everything that your child ate yesterday for breakfast, lunch, dinner, snacks and beverages in as much detail as possible.



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INFORMED CONSENT (MINOR)

Naturopathic doctors assess the whole person, taking into consideration the physical, mental, emotional and energetic aspects of an individual. Your naturopathic doctor will conduct a thorough case history, physical exam and may request specific laboratory tests and reports to be used as part of the treatment work-up.

It is very important that you inform your naturopathic doctor immediately of all disease processes that your child may be experiencing, and of any medication, over-the-counter drugs or supplements s/he is taking.

Statement of Acknowledgement

As the guardian of a patient of this office who is below the age of majority, I have read the information and understand that the health care to be provided is based on naturopathic and other supportive principles and practices. I hereby confirm that I am the legal guardian of this child and have the legal authority to provide consent for her/him.

I understand that a record will be kept of the health services provided to my child. This record will be kept confidential and will not be released to anyone other than Dr. Bunzenmeyer unless so directed by myself or law requires it. Please note Dr. Bunzenmeyer is mandated to break confidentiality in the following cases:

- Your child discloses to her they have a plan to harm themselves or another person.
- Any suspicion of child abuse.
- She is subpoenaed by law to give a copy of your file.

By signing below, I acknowledge the above regarding confidentiality and understand what provisions Dr. Bunzenmeyer needs to follow regarding confidentiality. I will inform Dr. Bunzenmeyer if this is a concern to me.

I will inform Dr. Bunzenmeyer if I have any concerns about these methods of enhancing my child's care. I understand that I may look at my child's medical records at any time and can request a copy of these by paying the appropriate fee.

I also recognize that even the gentlest therapies can have complications in certain physiological conditions, in very young children, or for those on multiple medications. The information I have provided about my child is complete and inclusive of all health concerns including possibility of pregnancy, and all medications including prescription drugs, over-the-counter drugs and supplements/remedies.

The slight health risks of some naturopathic treatments include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from intramuscular vitamin injections
- muscle strains and sprains from physical treatments & muscle testing.

I understand that results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications of treatment. With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above for my child.

I intend this consent form to cover the entire course of my child's naturopathic treatment at this office. I also confirm that my child and I have the ability to accept or reject this care of our own free will and choice, and to discontinue participation in these procedures at any time.

I also understand since my child is under the age of 18 that a legal guardian/parent needs to accompany him/her to all their naturopathic visits with Dr Bunzenmeyer.

I accept full responsibility for all fees incurred during care and treatment and acknowledge that payment is required on the day of service.

NAME of PATIENT (Please Print) _____

NAME of GUARDIAN (Please Print) _____

SIGNATURE of GUARDIAN _____ DATE _____