



PEDIATRIC REGISTRATION (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? _____

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:



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.

<input type="checkbox"/> Polio	<input type="checkbox"/> Pertussis
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Measles/Mumps/Rubella (MMR)	<input type="checkbox"/> Pneumococcal
<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Meningococcal
<input type="checkbox"/> Hemophilus influenza B	<input type="checkbox"/> Influenza ('flu shots')
<input type="checkbox"/> Travel Related:	<input type="checkbox"/> 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



Were there any of the following present after birth?

- | | | |
|--|-----------------------------------|---|
| <input type="checkbox"/> Birth Abnormality | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Birth Injuries | <input type="checkbox"/> Rashes | <input type="checkbox"/> Colic |
| <input type="checkbox"/> Blue Baby | <input type="checkbox"/> Fever | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> 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):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Eczema | <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Stomachaches | <input type="checkbox"/> Vomiting spells | <input type="checkbox"/> Cries easily |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Constipation | <input type="checkbox"/> Anemia | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Gas | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Motion/Car sick |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Frequent urine | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Bad breath |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Burning urine | <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Canker sores | <input type="checkbox"/> Hair loss | <input type="checkbox"/> No appetite | <input type="checkbox"/> 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): \$175+hst	IV Therapy (Push): \$90+hst	Lab Tests: Varies
Follow-up Visit (30 min): \$85+hst	IV Therapy (Drip): \$140+hst	Supplements: Varies
Extended Follow-up (45min): \$130+hst	IM Injection (B12): \$25+hst	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 _____

Thank you. We look forward to helping your child in any way we can.