



## **PEDIATRIC INTAKE FORM**

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

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

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

Parent's Email: \_\_\_\_\_

Male  Female  Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child lives with: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

Would you like to receive our newsletter by email? Yes

### **HEALTH CONCERNS**

Please, list your health concerns in order of importance.

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_

### **Vitamins and Supplements**

List all vitamins/minerals/herbal supplements your child is currently taking:

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## Medications

List all prescription and non-prescription medications your child is currently taking: \_\_\_\_\_

## Medical History

List any major illness, injuries and/or surgeries that your child has had and when:

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Has your child ever experienced any of the following?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Rubella         | <input type="checkbox"/> Diaper rash    | <input type="checkbox"/> Stomach aches  |
| <input type="checkbox"/> Mumps           | <input type="checkbox"/> Cradle cap     | <input type="checkbox"/> Headaches      |
| <input type="checkbox"/> Measles         | <input type="checkbox"/> Diarrhea       | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Chickenpox      | <input type="checkbox"/> Constipation   | <input type="checkbox"/> Hives          |
| <input type="checkbox"/> Whooping cough  | <input type="checkbox"/> High fever     | <input type="checkbox"/> Rashes         |
| <input type="checkbox"/> Scarlet fever   | <input type="checkbox"/> Bedwetting     | <input type="checkbox"/> Eczema         |
| <input type="checkbox"/> Polio           | <input type="checkbox"/> Strep throat   | <input type="checkbox"/> Other          |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Frequent colds | illness/diseases:                       |
| <input type="checkbox"/> Colic           | <input type="checkbox"/> Sleep problems | _____                                   |
|  |   | _____                                   |

## Vaccinations (Please check)

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> Flu Shot     |
| <input type="checkbox"/> MMR (Measles, Mumps, Rubella)        | <input type="checkbox"/> Hepatitis A  |
| <input type="checkbox"/> Chicken Pox                          | <input type="checkbox"/> Hepatitis B  |
| <input type="checkbox"/> Polio                                | <input type="checkbox"/> Other: _____ |

Did your child experience any adverse effects from vaccinations? If yes, please explain:

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Did the mother use any of the following during pregnancy?

Tobacco                       Alcohol                       Recreational drugs

Prescription medications: \_\_\_\_\_

Over the counter medications: \_\_\_\_\_

Vitamins and/or supplements: \_\_\_\_\_

### Birth History

Term length

Pre-term (less than 37 weeks)     Full term (38-42 weeks)     Post-term (43+ weeks)

\_\_\_\_\_ Wks                      \_\_\_\_\_ Wks                      \_\_\_\_\_ Wks

Type of birth:     Vaginal                       C-section

Interventions:

Induction                       Epidural/anesthesia                       Other:

Use of forceps                       Episiotomy

Were there any complications during delivery (e.g. Breech)? \_\_\_\_\_

Length of labour \_\_\_\_\_ hrs                      Weight of infant at birth: \_\_\_\_\_ kg/lbs

Did the child experience any of the following at or shortly after birth?

Jaundice                       Infections: \_\_\_\_\_

Rashes                       Birth Injuries: \_\_\_\_\_

Seizures                       Birth defects: \_\_\_\_\_

Difficulties with feeding: \_\_\_\_\_

### Health and Development

At what age did your child first:

Sit up \_\_\_\_\_    Crawl \_\_\_\_\_    Walk \_\_\_\_\_    Talk \_\_\_\_\_

At what age did your child start teething? \_\_\_\_\_

**Nutritional History**

How was your infant fed?  Breastfed  Formula: Cow's milk/Soy/Other

For how long? \_\_\_\_\_

Did your infant experience any reactions to the breast milk or formula?

If yes, please explain: \_\_\_\_\_

What foods were introduced before 6 months? Please list the approximate month and any reactions: \_\_\_\_\_

What foods were introduced between 6 and 12 months? Please list the approximate month and any reactions: \_\_\_\_\_

**Typical Food Intake**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To Drink: \_\_\_\_\_

**Signature**

I attest that the information provided is true and accurate to the best of my knowledge.

Signature of Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**DECLARATION AND CONSENT TO TREATMENT**

Naturopathic Doctors minimize the risk of harmful side effects, by supporting the body's own capacity to heal and by using the least invasive procedures for diagnosis and treatment whenever possible. However, even the gentlest therapies have potential for complications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, or in specific patient populations such as pregnant or lactating women, very young children, or patients taking multiple medications. It is very important that you inform your Naturopathic doctor immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture or blood draws
- Fainting or puncturing of an organ with acupuncture needles

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known.

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

If I am unable to make my appointment I must provide advance notification within 48 hours in which case no charge will be applied.

**THIS IS TO ACKNOWLEDGE** that I have been informed and I understand that:

I. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving from another licensed health care provider, or may receive in the future;

II. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Alberta;

III. No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

IV. The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

**I DECLARE** that I have received a full and complete explanation of the treatment or services that I may receive and hereby authorize and consent to treatment.

**I AGREE** to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, as well as other applicable fees. I understand that there is a fee for completing insurance forms, letter writing, and telephone consultations greater than 10 minutes and emails that take greater than 10 minutes to answer. Notice of 48 hours is required for appointment cancellation, otherwise you will be charged an administrative fee of \$35.00.

Patient's Full Name: \_\_\_\_\_ Date of Consent: \_\_\_\_\_

Signature of Guardian: \_\_\_\_\_