

NATUROPATHIC CHILD INTAKE FORM

Child's name _____ Date of birth _____

Sex: M F

Parent or guardian _____

Address _____ Postal Code _____

Phone number: Home _____ Cell _____

Email _____ Would you like to receive e-news? Yes No

How did you hear about us? _____

Other health care providers:

Name _____ Title _____

Address _____

Phone _____

Name _____ Title _____

Address _____

Phone _____

Please list your child's health concerns in order of importance

1. _____

2. _____

3. _____

4. _____

Current height _____ Weight _____

Ethnicity _____

Religion _____

MEDICAL HISTORY

Please indicate which of the following illnesses your child has had:

- | | | |
|---|----------------------------------|--|
| <input type="checkbox"/> rubella (german measles) | <input type="checkbox"/> measles | <input type="checkbox"/> mononucleosis |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> mumps | <input type="checkbox"/> impetigo |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> roseola | <input type="checkbox"/> strep throat |
| <input type="checkbox"/> whooping cough | | |

How many times per year does your child get:

1. Ear infections never rarely once 2-3 times more than 3x

2. Colds never rarely once 2-3 times more than 3x

3. Flu never rarely once 2-3 times more than 3x

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Please list any other illnesses, severe injuries, or any hospitalizations your child has had. Include approximate dates:

Does your child have any allergies (medications, environmental, etc)?

Please list all current medications (prescription, over the counter, supplements, etc.)

How many times has your child been treated with antibiotics? _____

Vaccinations: Please fill out OR provide a copy of your child's immunization record

At what age did your child receive his/her first vaccination? _____

Please indicate what vaccinations your child has had and date received if possible:

	Date received		Date received
<input type="checkbox"/> DPT (diphtheria, pertussis, tetanus)	_____	<input type="checkbox"/> Tetanus booster	_____
<input type="checkbox"/> MMR (measles, mumps, rubella)	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Haemophilus influenza	_____	<input type="checkbox"/> Flu	_____
<input type="checkbox"/> Meningococcal	_____	<input type="checkbox"/> Pneumococcal	_____
<input type="checkbox"/> Varicella (chicken pox)	_____	<input type="checkbox"/> Hepatitis A	_____
<input type="checkbox"/> Hepatitis B	_____		

Please indicate if any caused adverse reaction

Do you have concerns about your child's hearing? Yes No
Has your child's hearing been tested? Yes No
Do you have concerns about your child's vision? Yes No
Has your child's vision been tested? Yes No

Comments: _____

PRENATAL HISTORY

Health status of parents at time of conception

Mother poor fair good excellent unknown

Father poor fair good excellent unknown

Were any measures taken to conceive?

fertility drugs in vitro fertilization other _____

Health status of mother during pregnancy

poor fair good excellent unknown

Age of mother at child's birth _____

Mother's diet during pregnancy

poor fair good excellent unknown

Any food cravings experienced during pregnancy?

How much weight gain during pregnancy? _____

Did the mother experience any of the following health concerns during pregnancy?

Bleeding High blood pressure Nausea Vomiting

Diabetes Thyroid problems Seizures

Flu Physical or emotional trauma

Other: _____

Did the mother use any of the following during pregnancy?

Tobacco, If yes how much? _____ Alcohol, If yes how much? _____

Recreational drugs, If yes how much? _____

Prescription medications: _____

Over the counter medications: _____

Vitamins and supplements: _____

Other: _____

BIRTH HISTORY

What was the term length of the pregnancy? _____

How long did the labour last? _____

Who delivered the child? _____

Was the delivery: in hospital in a birthing centre at home other _____

Any labour complications? _____

Was the birth: vaginal c-section induced

Were any interventions used? forceps vacuum anaesthesia antibiotics

other _____

Child's weight at birth _____ length at birth _____

Head circumference at birth _____ APGAR Score _____

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

jaundice rashes seizures birth injuries _____

birth defects _____

other _____

ENVIRONMENT

Does your child live in: apartment house other _____

What is the approximate age of the building? _____

Recent renovations? _____

How is the house heated? furnace electric heat other _____

Please indicate if your child is regularly exposed to any toxins or hazards that you are aware of:

Exposure to household smoke:

always often sometimes rarely never

Does your household have any pets?

LIFESTYLE

Does your child live with

mother father both guardian _____

How many siblings? _____

Age/sex of each one _____

Who is responsible for childcare?

Is your child in: daycare elementary school high school home-schooled

What are the child's favourite activities? _____

How much time is spent watching TV / playing videogames per day?

> 3 hours 1-3 hours < 1 hour none

How much time is spent in physical activity per day?

> 3 hours 1-3 hours < 1 hour none

How long is an average night's sleep?

< 7 hours 7-8 hours 9-10 hours > 10 hours

Please indicate if any of the following apply:

sleepwalking talking in sleep wake frequently bed-wetting

nightmares other _____

DIET

How was your child fed as an infant?

formula, what kind? _____

breast-milk, for how long? _____

Food introduction (approximate):

At 6 months: _____

At 9 months: _____

At 12 months: _____

At 15 months: _____

Typical foods consumed now:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Drinks _____

How much water does the child consume? _____

Food sensitivities?

Dairy Wheat Corn Peanuts Other _____

Dietary restrictions (eg. religious, vegetarian, etc.)? _____

Appetite: Large Moderate Small

Thirst: Large Moderate Small

FAMILY HEALTH HISTORY

Identify any family members (eg. mother, father's mother, brother) who have each of the following diseases/conditions:

Juvenile Arthritis _____

Heart Disease _____

Cancer _____

Allergies _____

Asthma _____

Eczema _____

Kidney Disease _____

Mental Illness _____

Sickle cell anemia _____

Other genetic condition _____

Do either of the parents have a chronic illness? Please describe _____

HEALTH & DEVELOPMENT

Age (in months):

sit up _____ first tooth _____ crawling _____ walk _____ talk _____

How would you describe your child's temperament?

How would you describe your child's behaviour at school?

POLICIES AND PROCEDURES

Please note the following pricing policy:

Type of Visit	Duration	Cost
First visit	60 minutes	\$135.00
Follow up visits	15 minutes	\$ 40.00
	30 minutes	\$ 75.00
	45 minutes	\$ 95.00
Missed appointment fee		\$ 40.00

We offer direct billing for most insurance providers, please ask for more details.

Otherwise payment is due at time of service, payable by Debit, Mastercard, Visa or cash.

Lab Services

Lab tests are available as part of your health assessment. Cost is dependent on the test and may be covered by your insurance provider. These include:

- Food sensitivity test
- Microbiology test (including Candida)
- Comprehensive stool analysis
- Heavy metal test (hair and urine tests)
- Organic Acid test
- Blood tests

Please note we cannot bill directly to insurance companies for laboratory expenses.

Professional Supplements

Supplements may be prescribed at some of your child's visits. For your convenience we carry a variety of professional grade supplements. You may purchase them in office, or you may purchase your supplements from a health food store of your choice.

Cancellations

If you need to cancel your appointment, please call us as soon as possible.
Failure to give 24 hours notice will result in a missed appointment charge.

INFORMED CONSENT

The principles and practices of Naturopathic Medicine and other supportive therapies will be practiced to assist the body's own ability to heal and to improve the quality of life and health through natural means. Your ND will conduct a thorough case history and a physical exam. She may also request additional blood and/or urinary laboratory or functional tests as part of your naturopathic work-up.

It is important to recognize that even the gentlest therapies come with some health risk. These risks include:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from acupuncture or intramuscular injection

Although generally safe, some treatments have the potential for complications in certain physiological conditions. Thus, it is important to provide a complete health history and advise the ND of:

- all current medications (including over the counter drugs and supplements) and any changes in these medications
- pregnancy or breastfeeding status

PRIVACY POLICY

Protecting your personal information is of vital importance to us. Our privacy policy is as follows:

- only necessary information is collected about you
- only with your consent do we share information with others outside the clinic
- storage, retention and destruction of your information complies with existing law
- our policy conforms to privacy legislation and standards of the College of Naturopaths of Ontario

We collect personal information in order to:

- assess your health and provide treatment
- establish and maintain contact with you for appointments, billing and follow-up care
- facilitate your insurance claims
- comply with regulatory requirements and laws under the College of Naturopaths of Ontario

I have read the Naturopathic Pricing Policy posted, and I understand that I am fully responsible for any fees relating to any services rendered or products sold to me.

I have read the cancellation policy and understand that 24 hours notice is required to avoid charges. I have also read and understood the consent form and privacy policy.

Date: _____

Patient Name: _____

Parent or Guardian Signature: _____

Naturopathic Doctor's Signature: _____