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PEDIATRIC INTAKE FORM

Please complete this form and return it on your first visit

Name:_______________________________ Date: __________

Address: ____

____

Telephone numbers: (h)______________ (w)________________

May we leave messages for you at these numbers?____YES ____NO

E-mail: ____

Referred by: ____

Family Medical Doctor _______________________________

Other Primary Care Givers_____________________________

Emergency Contact ______________________________________

____

THE FOLLOWING INFORMATION IS CONFIDENTIAL AND WILL NOT BE RELEASED WITHOUT YOUR WRITTEN PERMISSION

Child's name ___________________________________ Date of birth ____________ Sex M F

Date ____________ Who is filling out this form (name and relation)?____________________________

Whom does the child live with(all family members)____

What are your child's health concerns, in order of importance:

1. ____
2. ____
3. ____
4. ____
5. ____

Medical history

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

____
____
____
____

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

n m a s	rubella (german measles)	n m a s	roseola	n m a s	impetigo
n m a s	measles	n m a s	scarlet fever	n m a s	mononucleosis
n m a s	chicken pox	n m a s	whooping cough	n m a s	ear infections
n m a s	mumps	n m a s	strep throat		

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

____

____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, etc.)

____
____
____
____

Please list past prescription medications.

____
____
____

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

Please indicate what immunizations your child has had

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis B
☐ Tetanus booster; when? _____________ ☐ "Flu"shot ☐ Hepatitis A
☐ MMR (measles, mumps, rubella) ☐ Polio
Other ____

Please indicate if any caused adverse reactions

____
____

What screening tests has your child had (blood, hearing, vision, etc.)__________________________
____

Prenatal health

What was the health of the parents at conception?

Mother Poor Fair Good Excellent Unknown
Father Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? ________

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting
☐ Diabetes ☐ Thyroid problems ☐ Physical or emotional trauma
Other ____
____

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: ____________________________________

☐ Prescription medications:

____

☐ Over-the-counter medications:

____

☐ Supplements:

____

☐ Other:

____

Birth history

Term length: ☐ Full ☐ Premature: ________ wks ☐ Late: ________ wks

Length of labour: ________________ Weight at birth _____________

Any complications?

____

Was the birth: Vaginal/C-section Induced Forceps Anesthesia used

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

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth trauma

☐ Birth defects

____

☐ Other

____

Diet

How was your infant fed?

☐ Breast fed. How long? ____________ ☐ Formula. Milk/Soy/Other: ____________

☐ Other: ____

What foods were introduced before 6 months? (Please list approximate month as well.)

____

____

____

6–12 months?

____

____

____

____

Did your child ever experience colic? Y N How severe? mild moderate severe

Does your child have any food allergies or intolerances? Please list.

____

____

____

____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____

____

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first

Sit up ____________ Crawl ____________ Walk ____________ Talk ____________

Describe your child's sleep pattern ____

____

____

How would you describe your child's temperament? ____

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

____

____

Environment

Is the child in school daycare home care other ____

What are your child's favorite activities? ____

____

Does the child exercise regularly? Y N How much, how often?

____

____

How much television does your child watch? ________ hrs a day/week

How often does your child read (not for school), or How often does someone read to your child?

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

How would you describe the emotional climate of the child's home?

____

____

Is there anything that you feel is important that has not been covered?

____

____

____

Naturopathic Medicine is the art and science of diagnosis, treatment, and prevention of disease using natural therapies with a focus on optimizing health and well-being through individualized patient care and public education.

PRINCIPLES OF NATUROPATHIC MEDICINE

- ***Primum non nocere*** – First do no harm. The most effective health care with the least possible risk.
- ***Vis medicatrix naturae*** – The healing power of nature respects and promotes self-healing.
- ***Tolle causum*** -Treat the cause, identify and remove obstacles to health while avoiding suppression of symptoms.
- ***Docere*** - Doctor as teacher. Educate patients, inspire and encourage self-responsibility.
- ***Treat the whole person*** – Acknowledge the individual and treat using a holistic paradigm.
- ***Health promotion is the best prevention*** - The focus of Naturopathic Medicine is as much on wellness as it is on treating disease.

NATUROPATHIC MEDICAL THERAPIES

- ***Acupuncture and Oriental Medicine*** –Combines the use of acupuncture, diet and traditional botanical formulas to treat a variety of health conditions.
- ***Botanical Medicine*** – The use of plants individually and in synergistic combinations.
- ***Clinical Nutrition*** –Diet and the appropriate use of supplements to promote health and manage disease.
- ***Homeopathic Medicine*** – Based on the principle of "like cures like", uses minute doses of plant, animal and mineral substances for treatment and prevention of many health conditions.
- ***Hydrotherapy*** – There are various applications that can use the healing power of water. Can be used acutely and constitutionally.
-
- ***Prevention and Lifestyle Modification*** - Assessment of risk factors, including personal and family history as well as lifestyle factors. The emphasis is on patient education, helping patients help themselves.

OFFICE POLICIES AND PROCEDURES

- The fees for Naturopathic Services are as follows: ***Includes HST***

Adult New Patient Visit (75 mins)	$140
Student/Child New Patient Visit (60 mins	$115
Adult Follow-up (30-45 mins)	$87.75
Student/Child Follow-up (30-45 mins)	$77.75
Acupuncture (30 minutes)	$60.00
Acute Visit (15 minutes)	$30
Telephone Consultation (15 mins)	$30
Letters - Medical/Legal	$40
Chart Photocopying	$25

- Please note that all fees are due at the time of service. Methods of payment include cash, cheque, debit, Visa and MasterCard.

- As a courtesy to other patients, a 24-hour cancellation policy exists. A $40 cancellation fee will apply to cancellations made with less than 24-hours notice.

- Itemized receipts will be issued to you at the time of payment. Please keep all receipts for insurance purposes.

- If you have any questions regarding Naturopathic Medicine and/or the office policies, please don't hesitate to ask.

Thank You