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. We work with you to get to the root cause of illness with a focus on prevention and wellness.

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.

BEFORE YOUR FIRST APPOINTMENT

Please fill out the intake form and complete the 4-day diet diary. Bring this to your first appointment.

If you've had any recent bloodwork or other testing done, please try to obtain a copy to bring with you. If this isn't possible, we can send a request to your MD for this information.

If you have questions about our fees, location and parking in downtown Dartmouth please refer to our website: www.pillarsofhealth.ca

If you have any questions about your appointment, or need to reschedule please call 902.444.3303 or email reception@pillarsofhealth.ca. Please note that we have a 24-hour cancellation policy in effect.

We look forward to meeting you and helping you achieve your best health!

Dr. Jennifer Salib Huber, B.Sc (Hons),P.Dt., N.D
Dr. Samanda Verdun, B.Sc., N.D.
10 Portland Street – Suite 101
Dartmouth, NS B2Y 1G9
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www.pillarsofhealth.ca

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

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?

_____

_____

Diet Diary and Food Frequency Questionnaire

Please record all foods eaten over a 4-day period, including 1 weekend day. If any symptoms occur after eating a food or meal, please make note in the space below

Breakfast	Lunch	Supper	Snack

Notes:_____
_____
_____
_____

Does your child have any food allergies or food sensitivities?

Are there any foods that your child avoids because they make you feel sick or unwell?

Does your child follow any specific type of diet – ie. Vegetarian, Diabetic, Grain-Free?