CHILDREN'S **INTAKE FORM**

Child's Last name:_____________________________ **First name**:______________________ Middle:_______________

Date of birth:_______________________ Age:_______Sex: M F, Height:________ Weight:_________

Parents'/Custodians' names:____

Child has been treated by a □Medical Dr □Chiropractor □Naturopath □Psychiatrist □Hospital □Homeopath □Herbalist treated for____

Did treatment achieve its goal: (explain)____
____

Family doctor/pediatrician______________________________________

Address____ Phone:______________________________

Other health care providers____Phone:___________________

What are your child's health concerns, in order of importance, and the age at which they began

1.____Age:__________________

2.____Age:__________________

3.____Age:__________________

4.____Age:__________________

5.____Age:__________________

Members of child's family who have similar conditions:___________ _______________________________________

Address:____ City___________________ Postal Code______________

Home phone:(   )______________________ Work phone:(   )_______________________ Ext:________________

Cellular/Pager:(   )____________________________

In Case of Emergency who may we contact

Last name:___________________________ First name:_________________________ Relationship:________________

Home phone: (   )________________________ Work phone: (   )_____________________ Ext:_______________

Referred to ND by:

Dear parent: Please take some time to answer the questions on the next few pages as accurately as possible. The total interview and examination may last approximately 60 minutes.

Before your child's appointment date, please arrange and bring, mail or fax all medical test results (blood, urine, x-ray, ultrasound, MRI, surgery results) pertaining to your child's health from you doctor's office or hospital.

Naturopathic examination, treatments and remedies are not covered by OHIP, but could be covered by extended health plans at your place of employment. You should check with your insurance company directly. We do not deal with insurance companies and have no information about their coverage.

VACCINATIONS

Please circle: Hepatitis Diphtheria Tetanus Pertussis Haemophilus influenza

Poliovirus Measles-Mumps-Rubella Varicellavirus/Chickenpox Flu shot

MEDICAL HISTORY

1. Was your child ever hospitalized?____
2. Any fractures?____
3. Other traumas (physical/emotional)?____

4. Past illnesses: (please circle and indicate treatment if any)

   Diaper rash______________ Cradle cap____________High fever_______Diarrhea________________

   Constipation__________Chicken pox_____________Measles______________Mumps__________

   Ear infections (how many?)____

   How many courses of antibiotics has your child taken?_________________

BIRTH HISTORY (please circle)

1. Type of birth: C-section Vaginal Forceps Epidural Induced Anesthesia Length of labour __________________

   Birthweight__________________Any complications?____

2. Term length: Full Premature _________wks
3. Location of birth: Home Hospital Other
4. Did your child experience any of the following at or shortly after birth?

   Jaundice (Mild or Severe?) Rashes Seizures Birth injuries____

   Infections____________________________________Birth defects ______________________________________

   Other____

5. Any interventions? Ultrasound –if yes how many?________ Amniocentesis–if yes,explain____________________

   Other____

MOTHER'S HISTORY

1. Age at birth_______
2. Previous number of births ________ pregnancies __________
3. Was the pregnancy planned? Y N
4. Any problems conceiving? (Please circle)

   Ovulatory dysfunction Tubal dysfunction Endometriosis

   Sperm disorder Assisted Reproduction? In-vitro fertilization GIFT

   Other__________________________

5. What was the health of the mother at conception?

   Poor Fair Good Excellent Unknown

6. What was the health of the father at conception?

   Poor Fair Good Excellent Unknown

7. How was the mother's diet during the pregnancy?

   Poor Fair Good Excellent Unknown

8. What is/was the mother's occupation?____

9. Did the mother experience any of the following during the pregnancy?

   Bleeding High Blood Pressure Nausea Vomiting Diabetes Thyroid problems

   Physical/Emotional Trauma Other____

   Please describe severity of the above____

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

   Tobacco Alcohol (amount)____________Recreational drugs__________________

   Prescription drugs____________________________Over the counter drugs_________________________________

   Exposure to harsh chemicals____

   Supplements____

FAMILY HISTORY

How old is: mother_____ father_____ brothers_________ sisters_________

Indicate if a close relative (parent, sibling, grandparent) has any of the following:

	Who?		Who?
Allergies		Kidney disease	
Asthma		Juvenile arthritis	
Diabetes		Other	
Cancer		Other	

FEEDING HISTORY

1. Any difficulty feeding?____

2. Breast fed? How long?________ Formula: Milk Soy Other _____________

3. What foods were introduced before 6 months? And which month? Also describe reactions to the foods if any.

   ____

   ____

   6-12 months?

   ____

   ____

4. Did your child ever experience colic? Never Mild Moderate Severe

5. Does your child have any food allergies or intolerances? Please list and describe reactions:

____

____

MILESTONE EVENTS

1. At what age did your child first:

Sit alone________ Crawl__________ Walk____________ Teething_________ Talk________

ENVIRONMENT

1. Is the child in school / daycare/ home care /other_______________________
2. What are your child's favourite activities?

____

____

3. Does your child exercise? Y N ________hours/week. Please list any sports or recreational activities the child participates in____

____

Does your child enjoy these activities? Y N

4. How much television/videogames does your child watch?_______hrs/week.
5. 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

6. Does anyone in your child's household smoke? Y N
7. Are there animals in the home? Y N
8. Are there any toxins or hazards the child is regularly exposed to? Describe:________________________________
9. Describe your child's sleep pattern: Bedtime_________pm Wake time__________am Nap time______________

Trouble falling asleep Trouble waking Nightmares Bedwetting

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

____

11. Describe your child's personality. Is there anything you would like to change?______________________________

____

12. Does your child have any sensitivities to their environment (ie. Heat, cold, dark, light) ?

____

____

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

____

____

Statements of Acknowledgement & Consent to Treatment

Naturopathic medicine uses non-invasive method of assessing bodily functions, and natural therapeutics for their corrections. In order to clarify my position as your health care practitioner, and our mutual responsibilities in your health care, I ask for your co-operation in signing these statements of acknowledgement. In so doing, you understand that:

1. Your medical information discussed during your appointment is strictly confidential and will not be disclosed to a third party unless you give consent.

2. You authorize the release of medical records from your health care providers to this clinic for the purpose of diagnoses and monitoring of treatment progress.

3. While changes in dietary habits are not an absolute pre-requisite for treatment, the failure to follow sound nutritional, exercise and lifestyle programs could undermine the expected results.

4. You are accepting or rejecting this care at your own free will.

5. You accept the potential risks, although infrequent, fro9m the treatments we agree on.

6. The ultimate responsibility for your health care is your own, and I am here to support you in this. I reserve the right to discontinue my services when it is apparent that your expectations and what I can provide are not in agreement.

7. Naturopathic care is not covered under O.H.I.P. at the present time, and therefore you are responsible for any fees incurred while under treatment at the clinic. Naturopathic care is covered under many private insurance plans, and upon request, we will do the utmost to provide the appropriate documentation to your insurer.

8. All fees for services and supplements are payable at the time of the appointment by the patient or the guardian. There is a fee for telephone consultations of greater than 10 minutes.

9. Your appointment time is reserved for you. If you are unable to keep your appointment, please give us a 24 hours notice in advance to avoid a $35 cancellation charge.

Please sign below if you have read, understood and acknowledge the above statements.

____________________________________ ____________________________

Patient's/Guardian's Signature Date

____

Please print name