PEDIATRIC INTAKE FORM (AGES 0 – 12)

Child's Name: ____

Address: ____

City: ______________________ Province: _________ Postal Code: ________________

Phone (Home): ____________________ Who is filling out this form? ____________________

With whom does the child live? ____

Do you give Vive's doctors/staff permission to leave messages regarding your child's visits? yes❑ no❑

Male ❒ Female ❒ Age: ____________ Date of Birth: ______________________________

Emergency Contact: _______________ Phone: ______________ Relation: _____________

Other health care practitioners the child is seeing (ie. Medical Doctor, Pediatrician, Chiropractor):

Name: ______________________ Phone: ______________________________

Name: ______________________ Phone: ______________________________

Name: ______________________ Phone: ______________________________

How did you hear about the clinic? ____

CONTEXT OF CARE REVIEW

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. The nature of your response <u>for your child</u> to the following questions will go a long way in assisting my understanding of your child's health and the most appropriate approach toward improvement. Your time, thoughtfulness and honesty in completing this overview will greatly aid my assisting your child's health needs.

What do you know about the naturopathic approach to medicine?

What expectations for your child do you have from <u>this</u> visit?

What <u>long term</u> expectations for your child do you have from working with the clinic?

Health Concerns

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

1) ____________________
2) ____________________
3) ____________________
4) ____________________
5) ____________________

Medical History

Was this child adopted? yes❑ no❑ If yes, at what age?________

List any injuries and/or major surgery your child has had and when they happened:

____
____
____
____

Has your child ever experienced any of the following?

- ❑ Rubella
- ❑ Mumps
- ❑ Measles
- ❑ Chickenpox
- ❑ Whooping Cough
- ❑ Scarlet Fever
- ❑ Polio
- ❑ Rheumatic fever
- ❑ Diaper rash
- ❑ Cradle cap
- ❑ Diarrhea
- ❑ Constipation
- ❑ High fevers
- ❑ Bedwetting
- ❑ Strep throat
- ❑ Frequent colds
- ❑ Stomach aches
- ❑ Headaches
- ❑ Heat or cold intolerance
- ❑ Ear infections:
  How many? ________
  How often? ________
- ❑ Other illnesses/diseases:
  ____

Vaccinations (please check)

- ❑ DPT (Diptheria, Pertussis, Tetanus)
- ❑ MMR (Measles, Mumps, Rubella)
- ❑ Chicken Pox
- ❑ Polio
- ❑ Flu Shot
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Other: ____________

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

____
____

Medications and Supplements

Is your child **currently** taking any medications or supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)? Please list:

____
____
____

Does your child have any medical allergies or sensitivities? Please list:

____
____
____

Family History

Please indicate if any close relative *of the child* has any health condition(s) such as cancer, high blood pressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies, etc.

Relationship	**Age**	**Health Condition(s)**
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sister(s)		
Brother(s)		

Prenatal Health and History

Parental History	Health at conception (please circle)	Health throughout pregnancy (circle)	Age at time of child's birth	# of previous pregnancies
Mother	Poor Fair Good Excellent Unknown	Poor Fair Good Excellent Unknown		
Father	Poor Fair Good Excellent Unknown	Poor Fair Good Excellent Unknown		

Did the mother experience any food cravings/aversions during pregnancy? yes❑ no❑

If yes, please list: ____________________

Did the mother receive medical care during pregnancy? yes❑ no❑ unknown❑

Did the mother experience any of the following during pregnancy?

❑ Bleeding
❑ Vomiting
❑ High blood pressure
❑ Nausea
❑ Thyroid problems
❑ Diabetes
❑ Physical/emotional trauma
❑ Other: ____________________

Were any of the following interventions used during pregnancy?

❑ Ultrasound
❑ Amniocentesis
❑ Chorionic villi sampling
❑ Maternal serum screening
❑ Triple Screen
❑ Other: ____________________

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 wks): _______ wks
❑ Full-term (38-42 wks): _______ wks
❑ Post-term (43 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

APGAR score, if known (0 to 10): 1 minute ______ 5 minutes ______ 10 minutes ______

Did the child experience any of the following at or shortly after birth?
❑ Jaundice ❑ Infections: ______________________________
❑ Rashes ❑ Birth Injuries: ______________________________
❑ Seizures ❑ Infections: ______________________________
❑ Difficulties with feeding: ____
❑ Birth defects: ____

Health and Development

At what age did your child first:
Sit up ______ Crawl ______ Walk ______ Talk ______

At what age did your child begin teething? ______

Were there any difficulties associated with teething? ______________________________

Has your child experienced any pubertal changes? ______________________________

Nutritional History

How was your infant fed? ❑ Breast fed ❑ Formula: Milk/Soy/Other
For how long? ______ ____________________

Did your infant experience any reactions to the breast milk or formula? yes❑ no❑
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. ____
Has your child ever experience colic? yes❑ no❑
If yes, how severely? ❑ Mild ❑ Moderate ❑ Severe

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

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

Please describe your child's eating habits (e.g. good appetite, picky eater, etc.). ______________
____

Does the child have strong aversions to any foods? ______________________________

Does your child have any environmental allergies or sensitivities? Please list.
____
____

Sleep Patterns

What time does your child usually go to bed? ______ Wake in the morning? ______

Does your child nap during the day? yes❑ no❑ What time(s): ____________________

Does your child have nightmares? yes❑ no❑ How often? ______________________

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? ____
____

Social Patterns

Is your child in: ❑ school ❑ daycare ❑ homecare ❑other: ____________________
What grade level? ______

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

How would you describe your child's behaviour at home? _______________________________
____
____

Does your child make friends easily? yes❑ no❑

What are your child's interests & favourite activities? __________________________________

According to your child, does he/she enjoy these activities? ____________________________

Is your child physically active regularly? yes❑ no❑ How much & how often? _____________

Does your child have any habits (e.g. thumb sucking)? __________________________________

Does your child have any fears? ____

How much television does your child watch? ______ hours/day

Does your child play on the computer or video games? yes❑ no❑ If yes, ______ hours/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

Environment

Are there any pets in the home? yes❑ no❑ What type and how many? _________________

Does anyone in the child's household smoke? yes❑ no❑

How is the child's home heated? ____

Do you use humidifiers in your home? yes❑ no❑

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

Has your child ever had any significant physical or emotional traumas? ____________________
____
____

Please write a little about your child's personality, both positive and negative. Is there anything you would want to change? ____
____
____
____

SIGNATURE

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

Signature of the Guardian: ____________________________ Date: _________________________

This is a confidential record of your medical history and will be kept in this office.
The information it contains will not be released to any person without your authorization.

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 judgement 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 24 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.

Patient's Full Name: ____
First Middle Last

Date of Consent: ____________________________
Day Month Year

Naturopathic Doctor: _________________________

____

Signature of Parent/Guardian