



**NATUROPATHIC MEDICINE – PEDIATRIC INTAKE FORM (13 years of age & under)**

**General Information:**

<b>First name:</b>		<b>Last name:</b>	
<b>Birth Date:</b>		<b>Age:</b>	<b>Gender: M/F</b>
<b>Name of Guardian:</b>			
<b>Relationship to child:</b>			
<b>Name of individual accompanying child:</b>			
<b>Relationship to child:</b>			

<b>Address (including street/apt number):</b>		
<b>Postal code:</b>	<b>City:</b>	<b>Province:</b>
<b>Guardian Contact Number:</b>		
<b>Home:</b>	<b>Work:</b>	<b>Cell:</b>
<b>Guardian Email :</b>		
<b>Secondary Contact Number:</b>		
<b>Home:</b>	<b>Work:</b>	<b>Cell:</b>
<b>Secondary Email :</b>		
<b>Emergency Contact Numbers:</b>		
<b>Please indicate relationship of Emergency contact to child:</b>		

**May we leave messages relating to your visits?  Y  N**

**Which Phone Number?**

**With whom does the child live?**

**Other health care providers:**

**1. Name and Type of Care Provided:**

**Contact Number:**

**2. Name and Type of Care Provided:**

**Contact Number:**

**3. Name and Type of Care Provided:**

**Contact Number:**

**4. Name and Type of Care Provided:**

**Contact Number:**

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

**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:**

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**Please check off any of the following that your child has had?**

Chicken Pox	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Ear Infection	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>
Eczema or any other unexplained skin rash	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>
Impetigo	<input type="checkbox"/>	Rubella	<input type="checkbox"/>
Measles	<input type="checkbox"/>	Roseola	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>

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

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

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**Please list past prescription medications.**

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**How many times has your child been treated with antibiotics? \_\_\_\_\_**

**Please check off what immunizations your child has had:**

DPT (diphtheria, pertussis, tetanus)	<input type="checkbox"/>	“Flu”	<input type="checkbox"/>
Gardasil	<input type="checkbox"/>	Measles, Mumps, Rubella	<input type="checkbox"/>
Haemophilus influenza B	<input type="checkbox"/>	Polio	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	Small Pox	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	Tetanus booster: Last date? _____	<input type="checkbox"/>
Other:			

**Please indicate if you notice any adverse reactions following a vaccine:**

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**Please list any special screening tests your child may have had (blood, hearing, vision, etc.)?**

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**Prenatal health**

**What was the health of the parents at conception?**

Mother  Poor  Fair  Good  Excellent  Unknown

Father  Poor  Fair  Good  Excellent  Unknown

Comments:

**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?** \_\_\_\_\_

Comments:

**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:

Other:

Prescription medications:

If so, please list:

Over-the-counter medications:

Supplements:

Other:

**Birth History:**

**Term length:**  Full  Premature: \_\_\_\_\_ wks  Late: \_\_\_\_\_ wks

**Length of labour:** \_\_\_\_\_ **Weight at birth** \_\_\_\_\_

**Any complications? (Please List):**

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**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 injuries

Birth defects

Other

**Diet**

**How was your infant fed?**

- Breast fed. How long?
- Formula Please indicate: Milk/Soy/Other
- Other:

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

**What foods were introduced before 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.)?**

**Describe a typical day's diet:**

<p><b>Breakfast:</b></p> <p><b>Lunch:</b></p> <p><b>Dinner:</b></p> <p><b>Snacks:</b></p> <p><b>Beverages:</b></p>
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**Health and Development**

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

**At what age did your child first:**

Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_

Talk \_\_\_\_\_

**Describe your child's sleep pattern:**

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**How would you describe your child's temperament?**

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

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**Family History**

**Indicate if a close relative (parent, sibling) has had any of the following**

Allergies Diabetes

Asthma Kidney disease

Birth defects Other

Juvenile arthritis

I don't know the family medical history

**Do either of the parents have a chronic illness?**  Y  N Please describe:

**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

**Does anyone in the child's household smoke?**  Y  N

**Are there animals in the home?**  Y  N

**How is the child's home heated?**

Natural Gas  Oil  Electric  Wood  Other

**Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)?**

**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?**

Thank you for completing this form.



## **PATIENT DECLARATION AND CONSENT TO TREATMENT**

Naturopathic medicine is the treatment and prevention of disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional, and spiritual aspects of the individual. Gentle techniques are used to stimulate the body's inherent healing capacity.

The naturopathic doctor will take a thorough case history, do a screening or complaint oriented physical exam, and may analyze urine and blood samples where indicated.

Traditional Chinese Medicine (TCM) and acupuncture, nutrition, botanical (herbal) medicine, and physical medicine, are some of the treatments used by naturopathic doctors.

Caution must be taken in some physiological conditions such as pregnancy and lactation, very young children, people with diabetes, heart, liver or kidney impairment and/or with people taking multiple medications. It is very important that you inform your naturopathic doctor immediately of any disease from which you are currently suffering, or if you are currently taking any medications either prescribed or over-the-counter, or if you are pregnant, suspect that you may be pregnant, or if you are planning to become pregnant, or if you are currently breastfeeding.

Some of the health risks associated with naturopathic medicine include, but not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, and pain or bruising from acupuncture.

Your naturopathic doctor will answer any questions that you may have to the best of his/her ability. Results are not guaranteed. Your provider will exercise judgement during the course of your treatment that is in your best interest, based on the facts that are known.

As a patient, you must be aware that naturopathic treatment and conventional medical treatment are not mutually exclusive, and therefore, you are free to and encouraged to seek or continue medical care from a qualified physician.

## **PROTECTION/DISCLOSURE OF PERSONAL HEALTH INFORMATION**

King West Village Chiropractic Clinic understands the importance of protecting your personal information. Our privacy protocols comply with the Personal Health Information Protection Act (PHIPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the standards of our regulatory body. At times, your provider may share information with other medical experts in consultation for the purpose of discussing the best course of treatment and to deliver safe and efficient care. Please be aware that only necessary information about your case will be exchanged.

Also, your information may be accessed by regulatory authorities under the terms of the Drugless Practitioners Act, for the purpose of fulfilling our regulatory body's mandate or by the law. King West Village Chiropractic Clinic will not, under any circumstances, disclose any of

your personal confidential information to insurance companies. For any other type of disclosures we will require a release of records consent form signed by you.

**CANCELLING OR RESCHEDULING APPOINTMENTS**

Please understand that when you book an appointment, that time is specifically reserved for you. As such, we require that you give us 24 hours notice when cancelling or rescheduling an appointment. A missed appointment or late cancellation will result in a cancellation fee to be charged to your account. We appreciate your understanding.

I \_\_\_\_\_

*Name of Patient*

**ACKNOWLEDGE and DECLARE that I am aware and agree to all of the above and I thereby authorize naturopathic examination and treatment by:**

**Dr. Kathleen Regan**

**Date:** \_\_\_\_\_

**Patient's Signature:** \_\_\_\_\_

**Practitioner Signature:** \_\_\_\_\_

**If a minor, parent's/guardian's signature:** \_\_\_\_\_

**Name of parent/guardian:** \_\_\_\_\_

This consent will cover the entire course of your treatment but you are free to withdraw this consent and discontinue treatment at any time.