Advanced Naturopathic Medical Centre

Kensington Terrace
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PEDIATRIC INTAKE FORM

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Parent's Email: _____

Male ☐ Female ☐ Age: _____ Date of Birth: _____

Child lives with: _____

Emergency Contact: _____ Phone: _____ Relation: _____

How did you hear about our practice? _____

Would you like to receive our newsletter by email? Yes ☐

HEALTH CONCERNS

Please, list your health concerns in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Vitamins and Supplements

List all vitamins/minerals/herbal supplements your child is currently taking:

_____

_____

_____

Medications

List all prescription and non-prescription medications your child is currently taking: _____

Medical History

List any major illness, injuries and/or surgeries that your child has had and when:

_____

_____

_____

Has your child ever experienced any of the following?

- ☐ Rubella
- ☐ Mumps
- ☐ Measles
- ☐ Chickenpox
- ☐ Whooping cough
- ☐ Scarlet fever
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Colic
- ☐ Diaper rash
- ☐ Cradle cap
- ☐ Diarrhea
- ☐ Constipation
- ☐ High fever
- ☐ Bedwetting
- ☐ Strep throat
- ☐ Frequent colds
- ☐ Sleep problems
- ☐ Stomach aches
- ☐ Headaches
- ☐ Ear infections
- ☐ Hives
- ☐ Rashes
- ☐ Eczema
- ☐ Other illness/diseases: _____

_____

Vaccinations (Please check)

- ☐ DPT (Diphtheria, Pertussis, Tetanus)
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Chicken Pox
- ☐ Polio
- ☐ Flu Shot
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Other: _____

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

_____

_____

Allergies

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

_____

General

Height: _____ Weight: _____ lbs Weight 1 year ago:_____ lbs

Family History

Please put an "L" for living and "D" for deceased and present age or age at time of death. Indicate if the family member suffered from any disease or conditions such as cancer, high blood pressure, heart attack, stroke or diabetes.

Relationship	L/D	Age	Health Conditions/Cause of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Sister (s)			
Brother (s)			

Parental health history

Was this child adopted? Yes☐ No☐ If yes, at what age? ☐

Mother's age at time of child's birth_____ Father's age at the time of child's birth_____
Did the mother receive medical care during the pregnancy? Yes☐ No☐

Did the mother experience any of the following during pregnancy? Yes☐ No☐

☐Bleeding ☐Nausea ☐Physical/emotional trauma
☐Vomiting ☐Thyroid Problems ☐Other:
☐High blood Pressure ☐Diabetes

Were any of the following interventions used during pregnancy?
☐Ultrasound ☐Chorionic Villi Sampling ☐Triple screen
☐Amniocentesis ☐ Maternal serum screening ☐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 weeks) ☐ Full term (38-42 weeks) ☐ Post-term (43+ weeks)

_____ Wks _____ 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

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

☐ Jaundice ☐ Infections: _____

☐ Rashes ☐ Birth Injuries: _____

☐ Seizures ☐ Birth defects: _____

☐ Difficulties with feeding: _____

Health and Development

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

At what age did your child start teething? _____

Nutritional History

How was your infant fed? ☐ Breastfed ☐ Formula: Cow's milk/Soy/Other

For how long? _____ _____

Did your infant experience any reactions to the breast milk or formula?
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: _____

Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

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

Signature of Guardian: _____ Date: _____

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 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 judgment 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 48 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. I understand that there is a fee for completing insurance forms, letter writing, and telephone consultations greater than 10 minutes and emails that take greater than 10 minutes to answer. Notice of 48 hours is required for appointment cancellation, otherwise you will be charged an administrative fee of $35.00.

Patient's Full Name: _____ Date of Consent: _____

Signature of Guardian: _____