



**PEDIATRIC INTAKE FORM**

**Parent/Guardian, thank you for taking the time to accurately complete this intake form. The information you contribute is valuable in providing the highest standard of naturopathic health care for your child. For anything that does not yet apply, please write N/A.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Age: \_\_\_\_\_ D.O.B. \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Guardian's email: \_\_\_\_\_

Would you like you receive clinic updates/ special offers/upcoming events? Yes No  
 (Your e-mail address is kept strictly confidential)

Main Health Concerns (in order of priority)	How long have you had this concern?	How has it been treated so far?

Note: If there are more concerns, they will be covered in your first appointment.

**Past Medical History:**

Please circle any of the following that your child has experienced.

<b>General Health status:</b> weight gain or loss, weakness, fever, chills, sweats, night sweats, frequent colds/flu
<b>Cardiovascular:</b> chest pain, palpitations, known murmurs, anemia
<b>Respiratory:</b> asthma, bronchitis, pneumonia, shortness of breath, wheezing, cough, sputum
<b>Gastrointestinal:</b> Appetite changes, food sensitivity, food aversions, trouble swallowing, heartburn, indigestion, abdominal pain, burping, flatulence, bloating, nausea, vomiting, change in bowel movements, constipation, diarrhea, rectal itching, rectal bleeding, colic, hemorrhoids, diaper rash
<b>Skin:</b> chicken pox, eczema, hives, pigment or color change, moles, excessive dryness or moisture, itching, bruising, rashes, cradle cap, hair concerns, head lice/tinea, nail concerns
<b>Head:</b> headaches, dizziness, head injury
<b>Eyes:</b> change in vision, blurring, redness, pink eye, watering, itchy, discharge
<b>Ears:</b> earache, ear infections, discharge, ringing, hearing loss
<b>Mouth and throat:</b> frequent sore throat, bleeding gums, toothache, tonsillitis, canker sores
<b>Neurological:</b> seizures, fainting, coordination problems, mood changes, depression, anxiety
<b>Urinary:</b> frequency, urgency, bed wetting, UTI's
<b>Male:</b> testicular pain, discharge, hernia, circumcision

**Female:** yeast infections, menstrual concerns, vaginal itching, discharge

**MSK:** joint pain, deformities, delayed motor skills, restricted motion, muscle cramps

List any major illness, surgeries, hospitalizations, x-rays received: \_\_\_\_\_

**Immunizations received**

<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Diphtheria
<input type="checkbox"/> Pertussis	<input type="checkbox"/> Polio	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Flu shot	<input type="checkbox"/> Allergy	<input type="checkbox"/> Other		

Any adverse reactions to any vaccination? \_\_\_\_\_

	Current	Past
<b>MEDICATIONS</b>		
<b>SUPPLEMENTS</b>		

**Family History**

Do any of the child's family members (mother, father, siblings, grandparents) have any of the following conditions?

<input type="checkbox"/> alcoholism	<input type="checkbox"/> bleeding disorder	<input type="checkbox"/> heart disease	<input type="checkbox"/> stomach ulcers
<input type="checkbox"/> allergies	<input type="checkbox"/> cancer	<input type="checkbox"/> hyperactivity	<input type="checkbox"/> stroke
<input type="checkbox"/> anemia	<input type="checkbox"/> cataracts	<input type="checkbox"/> kidney disease	<input type="checkbox"/> TB
<input type="checkbox"/> arteriosclerosis	<input type="checkbox"/> celiac disease	<input type="checkbox"/> learning disability	<input type="checkbox"/> yeast infections
<input type="checkbox"/> arthritis	<input type="checkbox"/> colitis	<input type="checkbox"/> mental disease	<input type="checkbox"/> venereal disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> depression	<input type="checkbox"/> muscular dystrophy	<input type="checkbox"/> other (list below)
<input type="checkbox"/> bed wetting	<input type="checkbox"/> diabetes	<input type="checkbox"/> MS	<input type="checkbox"/>
<input type="checkbox"/> birth defects	<input type="checkbox"/> epilepsy	<input type="checkbox"/> schizophrenia	<input type="checkbox"/>

**Prenatal History:**

Mother's age at child's birth: \_\_\_\_\_ How many pregnancies before this child? \_\_\_\_\_

Mother's health at conception:  Excellent  Good  Fair  Poor

Mother's emotional state during pregnancy was:  Excellent  Stable  Stressed

Emotional climate of household:  Excellent  Stable  Stressed

Mother's diet during pregnancy was:  Poor  Fair  Good  Excellent

Please check the appropriate boxes regarding mother's pregnancy

<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Illnesses	<input type="checkbox"/> Physical or emotional trauma
<input type="checkbox"/> Bleeding	<input type="checkbox"/> Drug use	<input type="checkbox"/> Medications	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Cigarette	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Nausea	<input type="checkbox"/> Other complications

List any supplements/vitamins taken during pregnancy: \_\_\_\_\_

Was your child exposed to smoke during prenatal period? \_\_\_\_\_

**Birth History**

Full Term  Premature  Late

Pregnancy length (wks): \_\_\_\_\_ Labour length \_\_\_\_\_

Home birth  Hospital birth  Midwife  Vaginal birth  C-Section

Pain Meds? Which? \_\_\_\_\_

Were there any complications with the labour or birth? \_\_\_\_\_

### General Behaviour and Emotional Status of Child

Briefly describe your child's behaviours and/or emotional status in the following situations:

At home: \_\_\_\_\_

At school (e.g. anxiety, separation anxiety) \_\_\_\_\_

Current marital status of parents: \_\_\_\_\_

Current stability of the home: \_\_\_\_\_

Describe relationships with friends, family members: \_\_\_\_\_

Current ages of the child's siblings? \_\_\_\_\_

Mother's working hours/wk: \_\_\_\_\_ Father's working hours/wk: \_\_\_\_\_

Do you have a nanny or a babysitter? Yes  No  How often? \_\_\_\_\_

Who is with your child during the day? \_\_\_\_\_

How often have you moved since your child was born? \_\_\_\_\_

Have you noticed any particular time of day when your child's behaviour is, in general:  
Worse? \_\_\_\_\_ Better? \_\_\_\_\_

List any of your child's fears or worries: \_\_\_\_\_

\_\_\_\_\_

List current interests and/or activities your child currently partakes in (e.g. sports, dance lessons)

\_\_\_\_\_

List your child's sensitivities (e.g. hot, cold, bright lights, wool, emotionally): \_\_\_\_\_

\_\_\_\_\_

Has your child had any traumatic experiences (e.g. divorce, car accidents)?

\_\_\_\_\_

How does your child respond to discipline? \_\_\_\_\_

Was your child a quiet or fussy infant? \_\_\_\_\_

Are there any pets in the household? \_\_\_\_\_

Are there any smokers in the household? Yes  No

Please describe your child's personality: \_\_\_\_\_

### DIET

Was your child breastfed? Yes  No  For how long? \_\_\_\_\_

If not breastfed, what was first food? \_\_\_\_\_ Was

formula used? Yes  No  What kind? \_\_\_\_\_

At what age was formula introduced? \_\_\_\_\_ Age of solid foods introduced? \_\_\_\_\_

What were the first three solid foods introduced? \_\_\_\_\_

What solid foods were started prior to 6 months of age? \_\_\_\_\_

List your child's favourite foods: \_\_\_\_\_

What is the child's appetite like now? \_\_\_\_\_ Please

describe your child's typical daily diet? \_\_\_\_\_

\_\_\_\_\_

How much fluids does the child drink per day? \_\_\_\_\_ Preferred fluid? \_\_\_\_\_

Please list anything else you would like to add:

\_\_\_\_\_

Thank you very much for taking the time to fill out this form ☺

## **Informed consent**

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet, lifestyle counselling, clinical nutrition (primary via supplementation), botanical medicine, homeopathy, Asian medicine and acupuncture, hydrotherapy, and physical medicine

**Individual diets and nutritional supplements** are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved gastrointestinal function, enhanced immunity, and general well-being.

**Botanical medicine** is plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

**Homeopathy** is a form of medicine based on the Law of Similars; that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses, of plant, animal, or mineral origin, are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

**Asian medicine** includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas). Dietary advice is based on traditional Chinese medical theory.

**Physical medicine** refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation for the purpose of treating musculoskeletal and neurological problems.

**Lifestyle counselling** involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, your Naturopathic Doctor will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples for further testing, or blood samples for lab investigation.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important, therefore, that you inform your naturopathic doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

Health risks associated with Naturopathic Medicine include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process.
- Allergic reactions to supplements or herbs.

- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains or disc injuries from spinal manipulation

\_\_\_\_\_ I understand that a record will be kept of the health services provided to me. This record will be kept  
**Initials** confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

\_\_\_\_\_ I understand that the Naturopathic Doctor will answer any questions that I have to the best of her  
**Initials** ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

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\_\_\_\_\_ I understand that fees and supplements are to be paid for at the time of the consultation.  
**Initials**

\_\_\_\_\_ I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or  
**Initials** cancellations with less than 24 hours notice.

As the patient, you are responsible for the total charges incurred for each visit. We accept cash, debit or visa. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company – we will provide you with all of the information necessary to send your claim for reimbursement.

Your Naturopathic Doctor may prescribe supplements that can be purchased from our in-house dispensary, or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by Dr. Nevena Jovanovic, ND. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

**Patient Name (please print):** \_\_\_\_\_

Signature of Patient or Guardian: \_\_\_\_\_

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