Pediatric Intake Form

Insight Naturopathic Clinic

550 Eglinton Ave. East
Toronto, ON M4P 1N9
tel: (416) 322-9980

www.insightnaturopathic.com

Patient Information

Full Name: _____ D.O.B. _____
Address: _____ Home #: _____
_____ Cell #: _____
City, Prov, PC: _____ e-mail: _____

Contact Information Relationship: _____
Full Name: _____ Home #: _____
Address: _____ Cell #: _____
_____ Work #: _____
City, Prov, PC: _____ e-mail: _____

Contact Information Relationship: _____
Full Name: _____ Home #: _____
Address: _____ Cell #: _____
_____ Work #: _____
City, Prov, PC: _____ e-mail: _____

Contact Information Relationship: _____
Full Name: _____ Home #: _____
Address: _____ Cell #: _____
_____ Work #: _____
City, Prov, PC: _____ e-mail: _____

With whom does the child live with? _____

How did you hear about our clinic?

☐ Family or Friend
Name:

☐ Patient from our clinic
Name:

☐ Advertisement
Describe:

☐ Healthcare Practitioner
Name:
Contact:

☐ Other
Please specify:

Have the child ever had previous Naturopathic care? Y / N

If yes, when? _____
with whom? _____

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Chief Concerns

Please list your child's chief medical concerns in order of importance with a brief description.

1	
2	
3	

What other healthcare professionals did you consult for this (these) problems? _____

What treatment was provided? Please describe. _____

Prescription and Over-the-Counter Medications

Please list ALL current medications (prescription, over-the-counter, etc.) and include the dosage, frequency, duration and the reason(s) for taking them.

Medication	Dosage	Frequency	Duration	Reason for taking them

Natural Health Products

Please list ALL current natural products (supplements, botanical tinctures, herbs, teas, homeopathics, etc.) and include the dosage, frequency, duration and the reason(s) for taking them.

Medication	Dosage	Frequency	Duration	Reason for taking them

Is your child allergic to any medications or natural health products? Y / N

If yes, please list: _____

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Please list any other known allergies:

_____

_____

_____

_____

Family Health History

Please check any of the following conditions that are in your child's family (parents, siblings, grandparents, aunts, uncles, cousins).

☐ Alcoholism	☐ Diabetes	☐ Asthma	☐ Other
☐ Epilepsy, Seizures	☐ Thyroid Problems	☐ Hypertension	
☐ Depression	☐ Anemia	☐ High Cholesterol	
☐ Psychiatric Illness	☐ Cancer	☐ Heart Disease	
☐ Eczema	☐ Glaucoma	☐ Arthritis	

Other Healthcare Practitioners

Name:	_____	Address:	_____
Type:	_____		_____
Clinic Name:	_____	City, Prov, PC:	_____
Tel #:	_____	email:	_____

Name:	_____	Address:	_____
Type:	_____		_____
Clinic Name:	_____	City, Prov, PC:	_____
Tel #:	_____	email:	_____

Name:	_____	Address:	_____
Type:	_____		_____
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Prenatal Health History

What was the health of the parents at conception?

Mother	☐ Poor	☐ Fair	☐ Good	☐ Excellent	☐ Unknown
Father	☐ Poor	☐ Fair	☐ Good	☐ Excellent	☐ Unknown

What was the health of the mother during the pregnancy?

☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

What was the mother's age at the child's birth? _____

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?

☐ physical or emotional trauma ☐ bleeding ☐ other:
☐ diabetes ☐ high blood pressure
☐ thyroid problems ☐ nausea and/or vomiting

Did the mother use any of the following during pregnancy?

☐ alcohol ☐ tobacco ☐ recreational drugs _____
☐ prescription medications: _____
☐ over-the-counter medications: _____
☐ supplements: _____
☐ botanicals (tinctures, teas, herbs, etc.): _____
☐ homeopathics: _____
☐ other: _____

Birth History

Term length: ☐ Full Term (____ wks) ☐ Premature (by ____ wks) ☐ Late (by ____ wks)

Type of Birth: ☐ Vaginal ☐ C-Section ☐ Induced ☐ Forceps ☐ Use of Anesthetics

Length of Labour: ____ hrs

Weight at Birth: _____ kg or ____ lbs ____ oz Length at Birth: _____ cm or _____ in.

Complications: _____

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

☐ jaundice ☐ birth injuries: _____
☐ rashes ☐ birth defects: _____
☐ seizures ☐ other: _____

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Dietary History

How was your infant fed?

- ☐ Breastfed: for how long? _____
- ☐ Formula: type? _____
- ☐ Other: (describe) _____

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

_____

_____

_____

What foods were introduced between 6-12 months of age? (Please list approximately month as well)

_____

_____

_____

Did your child ever experience colic? Y / N

How severe was it? ☐ mild ☐ moderate ☐ severe

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

_____

_____

Does your child have any dietary restrictions?

_____

_____

Health & Developmental History

How was your child's health in his/her first year? ☐ Poor ☐ Fair ☐ Good ☐ Excellent ☐ Unknown

At what age did your child first: Talk _____ Sit Up _____ Crawl _____ Walk _____

Describe your child's sleeping pattern(s):

_____

_____

How would you describe your child's temperament?

_____

_____

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

Environmental History

Is your child in: ☐ Daycare ☐ School ☐ Home Care ☐ Other: _____

Grade: _____ School: _____

What are your child's favourite activities?

Does your child exercise regularly? Y / N
How much? How often? Please describe.

How much TV does your child watch? _____ hrs per wk

How much time does your child spend with the computer and/or video games? _____ hrs per wk

How often does your child read (not for school) _____ hrs per wk

How often does someone read to your child? _____ hrs per wk

Does anyone in your child's household smoke? Y / N

Are there animals in the home? Y / N

Do you know of any toxins or other hazards the child is regularly exposed to at home, school, hobbies, friends' homes, etc.)? Please describe.

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

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

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Declaration of Consent to Naturopathic Treatment
Naturopathic medicine is the treatment and prevention of diseases by natural means. Gentle techniques are used to stimulate the body' inherent healing capacity. Naturopathic Doctors (NDs) assess the whole person, including physical, mental, emotional and spiritual aspects of the individual. Your child's visit may consist of a thorough case history of and a screening physical examination. It is important that we are informed of any diseases that your child is suffering from and if he/she is on any medications or over-the-counter drugs.

There are some slight health risks to treatments in the Naturopathic scope of practice. These include but are not limited to: aggravation of pre-existing symptom; allergic reactions to supplements or herbs; pain, bruising or injury from acupuncture, cupping, venipuncture, intramuscular or intravenous injection; fainting or puncturing an organ with acupuncture needles. The results from Naturopathic treatments are not guaranteed and not all risk sand complication can be anticipated nor explained.

I agree to abide by the financial policies as outlined, and I accept full responsibility for any fees incurred during the treatment. I agree to fully discharge this responsibility at the time of the visit via cash, debit or credit card (Visa or Mastercard).

I have read all of the foregoing information and I understand that: the ultimate responsibility for my child's health is *my own*; I will be seeing a Naturopathic Doctor (ND), *not* a Medical Doctor (MD); the Naturopathic Doctors at Insight Naturopathic Clinic work within the Naturopathic scope of practice; any advice or treatments given to my child as a patient of Insight Naturopathic Clinic is not mutually exclusive from any advice or treatment that he/she has received in the past, receive now, or receive in the future from any other licensed healthcare practitioner; I am at liberty to seek or continue medical care from any other healthcare provider for my child; No healthcare provider or employee under the direction of the Insight Naturopathic Clinic has made the recommendation to me to refrain from seeking or following the advice of another healthcare provider for my child.

I declare that I have received a full and complete explanation of the treatment of services that my child may receive at the Insight Naturopathic Clinic, and hereby authorize consent to treatment.

<u>Consent Regarding Personal Information</u>
Privacy of your child's personal information is an important part of our clinic while providing him/her with quality Naturopathic care. We understand the importance of protecting your child's personal information and are committed to collecting, using and disclosing his/her personal information responsibly. We will try to be as open and transparent as possible about the way we handle your child's personal information.

All staff members who come into contact with your child's personal information are aware of the sensitive nature of the information that you and/or he/she have disclosed to us. They are trained in the appropriate use and protection of your child's information.

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I, _____, authorize Jill Shainhouse, Doctor of Naturopathic Medicine, to examine and administer Naturopathic care and treatment to _____, who is my _____ (relationship).

I have been given an explanation of, and understand the nature of the Naturopathic medical care and treatment. I authorize *Jill Shainhouse ND* to take whatever measures she considers necessary or desirable in connection with such Naturopathic care and treatment.

This consent is modified as follows: _____

_____

_____

_____

_____

My name, address, and telephone number, and/or that of another contact for the patient is as follows:

Full Name:		Home #:	
Address:		Cell #:	
		Work #:	
City, Prov, PC:		e-mail:	

Full Name:		Home #:	
Address:		Cell #:	
		Work #:	
City, Prov, PC:		e-mail:	

Dated at Toronto, in the Province of Ontario, this _____ day of _____, 20___.

(month)

Printed Name:		Witness:	
Signature:		Signature:	