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Naturopathic Child Intake Form

Full Name: _____

Name of Parent/Guardian: _____

Date of Birth: _____ **Age**: _____ **Gender**: F M

Mailing Address: _____

Home# (*Guardian*)_____ **Mobile#** _____ **Work#** _____

Email: _____

Emergency Contact:

Name: _____ **Relation**: _____

Home# _____ **Mobile#** _____ **Work#** _____

Medical Doctor:

Name: _____ **Phone**: _____

Address: _____ **Fax**: _____

Specialists and Other Current Health Practitioners:

_____

_____

Personal Health Number (Care Card) _____

How did you hear about *Active Back to Health Centre*?

_____

Would you like us to email you newsletters and special promotions? Yes No

Medical Information

Current Health Concerns and/or Goals

Please list your child's concerns in order of importance, when the symptoms began and any treatments that you have tried.

1. _____Onset: _____

   Treatments: _____

2. _____Onset: _____

   Treatments: _____

3. _____Onset: _____

   Treatments: _____

General Info

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

Allergies & Sensitivities

Please list any known drug, environmental or food reactions that you have experienced and the reaction that occurred.

Drug Allergy: _____ Reaction: _____

Drug Allergy: _____ Reaction: _____

Environmental Allergy: _____ Reaction: _____

Environmental Allergy: _____ Reaction: _____

Food Allergy: _____ Reaction: _____

Food Allergy: _____ Reaction: _____

Food Sensitivity: _____ Reaction: _____

Food Sensitivity: _____ Reaction: _____

MEDICATIONS (Prescription drugs and over-the-counter preparations)

Please list all medications that you child is currently taking, and any other information you can provide.

Drug	Dose	Reason for Taking	Year Started

SUPPLEMENTS (vitamins, herbal medicines, homeopathic preparations)

Please list all supplements that you are currently taking, and any other information you can provide.

Supplement *(Including brand if known)*	**Dose**	**Reason for taking** *(Including who prescribed this to you)*	**Year Started**

Social History

With whom does the child live with?

_____

What school does the child attend? _____ What grade?

_____

Favorite subject (s) _____ Favorite Activities

_____

What age did the child begin:

Sitting _____ Walking _____ Talking _____ Crawling _____

What are their favorite foods? _____

_____

What foods do they avoid? _____

_____

Past Medical History

Conditions

Please list any previous medical conditions that your child has experiences, and when they suffered from them

1. _____

2. _____

3. _____

4. _____

Other Medical Events: Hospitalizations, Injuries, Trauma & Surgery

Please list any hospitalizations, major injuries, emotional/physical trauma, or surgeries experienced and the year they occurred

1. Year: _____Condition: _____

2. Year: _____Condition: _____

3. Year: _____Condition: _____

4. Year: _____Condition: _____

Has your child been vaccinated? YES NO PARTIAL DELAYED SCHEDULE

What other vaccines have you received?

- ○ Hepatitis A
- ○ Hepatitis B
- ○ Typhoid
- ○ Flu Shot
- ○ Chicken Pox
- ○ HPV (Gardasil)

Infectious Disease History

Please check all conditions that the patient currently has or has had in the past

- ○ Chicken Pox
- ○ Impetigo
- ○ Rubella (German Measles)
- ○ Mumps
- ○ Rheumatic Fever
- ○ Measles
- ○ Whooping Cough
- ○ Strep Throat
- ○ Infectious Mononucleosis (Mono)
- ○ Croup
- ○ Scarlet Fever
- ○ Pneumonia

Birth History (Of Child)

Maternal age at time of birth: _____

Length of labour: _____

Term:

- ○ Full
- ○ Premature
- ○ Late

Type of Delivery:

- ○ Vaginal
- ○ C-Section
- ○ V-BAC

Complications:

Birth History (Of Mother)

Please provide the corresponding number

Pregnancies _____ Abortions _____
Miscarriages _____ Living Children _____
Caesareans _____ Vaginal Deliveries _____

Please check appropriate box if you have experienced any of these symptoms/conditions during this pregnancy

- ○ High Blood Pressure or Pre-Eclampsia
- ○ Gestational Diabetes
- ○ Abnormal Bleeding
- ○ Nausea
- ○ Post-Partum Depression
- ○ Physical Trauma
- ○ Induction
- ○ Cigarette and/or Alcohol Use

Medications: _____

Family Medical History

Below is a list of common health conditions. To the best of your knowledge please include which family member was or currently is affected.

	Mother	Father	Sibling	Children	Maternal Grandparents	Paternal Grandparents	Aunts	Uncles
Cancer (include type)								
Genetic Disorders (MS, ALS, etc.)								
Cardiovascular Disease (Heart Attack, Stroke, High Blood Pressure, etc)								
Diabetes								
Psychiatric or Mood Disorders								
Autism/ADHD								
Allergies								
Digestive Conditions (Crohns, IBS, Ulcerative Colitis, etc)								
Autoimmune Disease (Rheumatoid arthritis, Lupus, etc)								
Thyroid Disease								

Review of Symptoms

Please check all symptoms that your child has experienced during the last 6 months

GENERAL

- ○ Weight gain
- ○ Weight loss
- ○ Heat/Cold Intolerance
- ○ Insomnia
- ○ Fatigue
- ○ Night sweats
- ○ Motion/Car Sickness

HEAD, EYES, EARS, NOSE & THROAT

- ○ Headache
- ○ Migraine
- ○ Ear pain
- ○ Ear Infections/Tubes
- ○ Ringing in ears
- ○ Changes in hearing
- ○ Itching or watery eyes
- ○ Dry or red eyes
- ○ Eye pain
- ○ Changes in vision
- ○ Throat pain
- ○ Difficulty swallowing
- ○ Sinus infection/pain
- ○ Nasal congestion
- ○ Nosebleeds

CARDIOVASCULAR

- ○ Chest pain
- ○ Heart murmur
- ○ Easy bruising
- ○ Anemia
- ○ Cold hands/feet

RESPIRATORY

- ○ Difficulty breathing
- ○ Exercise intolerance
- ○ Cough
- ○ Hoarseness of voice
- ○ Snoring
- ○ Asthma or wheezing

GASTROINTESTINAL

- ○ Bloating & Flatulence
- ○ Constipation
- ○ Diarrhea
- ○ Vomiting
- ○ Nausea
- ○ Blood and/or mucous in stool
- ○ Pain during bowel movements
- ○ Belching
- ○ Hemorrhoids

EATING & APPETITE

- ○ Difficulty gaining weight
- ○ Difficulty losing weight
- ○ Frequent dieting
- ○ Poor appetite
- ○ Always hungry
- ○ Emotional eating
- ○ Cravings
- ○ Binge eating
- ○ Anorexia or bulimia

PSYCHOLOGY & NERVOUS SYSTEM

- ○ Anxiety or panic attacks
- ○ Depression
- ○ Difficulty concentrating
- ○ Irritability
- ○ Nightmares
- ○ Unusual Fears
- ○ Difficulty with speech
- ○ Seizures
- ○ Trembling or tremor
- ○ Hyperactivity
- ○ Fainting or feeling lightheaded

MUSCULOSKELETAL

- ○ Joint pain, redness, or stiffness

Specify _____

- ○ Neck or back pain
- ○ Foot cramps or pain
- ○ Wrist or hand pain
- ○ Joint deformity
- ○ Muscle pain or cramps
- ○ Muscle weakness
- ○ Restless legs
- ○ Tendonitis
- ○ TMJ /Jaw pain

URINARY

- ○ Acute or Chronic UTI's
- ○ Incontinence or Dribbling
- ○ Pain or burning on urination
- ○ Frequent urination
- ○ Blood in urine
- ○ Bedwetting

IMMUNE

- ○ Enlarged lymph nodes
- ○ Painful or tender lymph nodes
- ○ Frequent infections
- ○ Frequent colds or flu
- ○ Slow wound healing

SKIN & NAILS

- ○ Acne
- ○ Athlete's foot
- ○ Jock Itch
- ○ Dandruff /Cradles Cap
- ○ Dark circles under eyes
- ○ Profuse sweating
- ○ Rashes or hives
- ○ Dry or itchy skin
- ○ Bumps on the back of arms
- ○ Suspicious moles
- ○ Changes in pigment
- ○ Hair loss
- ○ Brittle or breaking nails
- ○ White spots or ridges on nail

O Jaundice

Informed Consent for Naturopathic Care

- I understand that the practice of naturopathic medicine requires taking a thorough case history, and may require a physical exam. In some cases, diagnostic testing including the collection of blood, urine and/or saliva may be required.

- I confirm that the information I have provided to *Active Back to Health Centre* is complete and inclusive of all health concerns including the possibility of pregnancy and use of all current medications, including over-the-counter drugs.

- I understand that naturopathic medicine carries a risk of complications and that a resolution of symptoms is not guaranteed. Health risks of some naturopathic treatments include, but are not limited to:
    - Temporary aggravation of pre-existing symptoms
    - Allergic reactions and other adverse effects to botanical medicines or supplements
    - Pain, fainting, bruising or injury from venipuncture, acupuncture or cupping treatments
    - Muscle sprain, ligament strain, swelling and/or pain from spinal manipulation

- I confirm that I have the ability to accept or reject the recommended treatment for this child at my own free will.

- I understand that I have the ability to seek and/or continue medical care for this child from another qualified health care practitioner. I recognize that I am encouraged to speak freely regarding the treatments received and recommendations made at *Active Back to Health Centre*.

- I understand that a record of this child's visits and medical history will be kept, that this record will be strictly confidential and will not be released to any persons without my written consent.

- I have read and understood the fee schedule and I acknowledge that these services are not covered by MSP and I am responsible for payment of goods and services in full at each visit.

- I understand that there is a cancellation fee for appointments missed without notice or cancelled with less than 24 hours notice. I acknowledge that if I arrive late for my scheduled appointment, the visit will be shortened to ensure that other patient visits are kept on time.

- I understand that the doctors at *Active Back to Health Centre* reserve the right to determine which cases fall outside their scope of practice, in which case an appropriate referral will be recommended.

Patient Name (Please Print): _____

Name of Parent/Guardian (Please Print): _____

Signature of Parent/Guardian: _____

Date: _____

THANK-YOU for your time and thoughtful consideration when filling out these forms, they will help us in understanding this child's whole health picture and create a plan that is unique to him/her.