



## PEDIATRIC INTAKE FORM

**Parent/Guardian, please take the time to accurately complete this questionnaire. The information you contribute is valuable in providing effective health care for your child.**

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

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_

What are your chief concerns regarding your child's health? \_\_\_\_\_

\_\_\_\_\_

If there is a specific condition, when did it start? \_\_\_\_\_

List practitioners seen for this condition: \_\_\_\_\_

\_\_\_\_\_

Is there a family history of this condition? \_\_\_\_\_

List any other supplements, medications, homeopathic/botanical preparations your child is currently taking, and dosages: \_\_\_\_\_

\_\_\_\_\_

List any major illnesses, surgeries, hospitalizations, x-rays your child has received: \_\_\_\_\_

\_\_\_\_\_

When was your child last well? \_\_\_\_\_

**Family History:** Please check appropriate box and indicate which family member

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Schizophrenia    |
| <input type="checkbox"/> Allergies        | <input type="checkbox"/> Cataracts      | <input type="checkbox"/> Hyperactivity       | <input type="checkbox"/> Stomach Ulcers   |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Colitis        | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Depression     | <input type="checkbox"/> Mental Disease      | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Bed Wetting      | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Muscular Dystrophy  | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Birth Defects    | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Other            |

**Prenatal History:**

Mother's age at child's birth: \_\_\_\_\_

Please check 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"/> Cigarette Use | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Nausea      | <input type="checkbox"/> Thyroid problems             |

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

Did the mother smoke before the pregnancy? If so, how many? \_\_\_\_\_

Does anyone in the household currently smoke? \_\_\_\_\_

Mother's diet during pregnancy was:     poor     fair     good     excellent

Mother's emotional state during pregnancy:     excellent     stable     stressed

Emotional climate of present household:     excellent     stable     stressed

**Birth History:**

- Full Term             Premature             Late

How was the birth? Please list whether home/hospital, vaginal/C-section, any interventions (forceps, epidural, etc), and any complications \_\_\_\_\_

Child's weight: \_\_\_\_\_    Length: \_\_\_\_\_    Length of Labour: \_\_\_\_\_

Check any of the following if they occurred at birth or soon after:

- |   |                                   |                                   |
|---|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Birth defects  | <input type="checkbox"/> Colic    | <input type="checkbox"/> Rashes   |
| <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures |

Other: \_\_\_\_\_

**General Information:**

Child's sleep patterns in the first year: \_\_\_\_\_

Child's sleep patterns presently: \_\_\_\_\_

Does your child:     wake early     have difficulty falling asleep     have nightmares/terrors

Feeding:     breast-fed    How long? \_\_\_\_\_     formula    dairy/soy (please circle)

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

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

List any food sensitivities/allergies: \_\_\_\_\_

Your child's appetite is:     poor     fair     good



## 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) to be taken internally or used externally as a wash. 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 and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

**Hydrotherapy** refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

**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

\_\_\_\_\_  
Initials 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 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.

\_\_\_\_\_  
Initials I understand that the Naturopathic Doctor will answer any questions that I have to the best of her 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): \_\_\_\_\_

\_\_\_\_\_  
Initials 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 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, cheque 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.

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I have read and understand the above-stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by Ruth Anne Baron, ND/Via Bitidis, ND and/or Tara Campbell, 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: \_\_\_\_\_

Welcome to the North Toronto Naturopathic Clinic. We look forward to working with you to help you achieve better health.

Naturopathic medical services are covered under many extended health care plans. Check your policy for coverage details.