

PEDIATRIC INTAKE FORM

Today's Date: _____

Child's Name: _____ Date of birth: _____

Sex: M F

Parent or Guardian: _____

Address: _____

Email Address: _____

Home Phone: _____ Work Phone : _____

Emergency Contact Name: _____

Phone number: _____ Relation to child: _____

How did you hear about our Clinic?: _____

Other health care providers:

- | | | |
|-----------|-----------|-----------|
| 1. _____ | 2. _____ | 3. _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| () _____ | () _____ | () _____ |

Please list your child's health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Current height _____ weight: _____

MEDICAL HISTORY

Please indicate which of the following illnesses your child has had:

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> rubella (german measles) | <input type="checkbox"/> measles |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> mumps |
| <input type="checkbox"/> scarlet fever | <input type="checkbox"/> roseola |
| <input type="checkbox"/> whooping cough | <input type="checkbox"/> strep throat |
| <input type="checkbox"/> mononucleosis | <input type="checkbox"/> impetigo |

How many times per year does your child get:

1. Ear infections never rarely once 2-3 times more than 3x
2. Colds / flu never rarely once 2-3 times more than 3x

Has your child ever experienced any other illnesses, severe injuries, or any hospitalizations?
Please list with approximate dates:

Does your child have any allergies (medications, environmental, etc)?

Please list all current medications (prescription, over the counter, supplements, etc.)

Please list all past prescription medications

How many times has your child been treated with antibiotics? _____

Immunizations

At what age did your child receive his/her first vaccination? _____

Please indicate what immunizations your child has had:

- | | |
|---|--|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Tetanus booster |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Haemophilus influenza | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Meningococcal | <input type="checkbox"/> Pneumococcal |
| <input type="checkbox"/> Varicella (chicken pox) | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> HPV |

Please indicate if any caused adverse reaction

ENVIRONMENT

What is the approximate age of the building in which your child lives? _____

Recent renovations? _____

Please indicate if your child is regularly exposed to any toxins or hazards that you are aware of: _____

Does your household have any pets? _____

LIFESTYLE

Does your child live with mother father both guardian

How many siblings? _____

Age/sex of each one _____

Who is responsible for childcare? _____

Is the child in: daycare elementary school high school home-schooled

What are your child's favourite activities? _____

How much time is spent watching TV / playing videogames per day?

> 3 hours 1-3 hours < 1 hour none

How much time is spent in physical activity per day?

> 3 hours 1-3 hours < 1 hour none

How long is an average night's sleep?

> 7 hours 7-8 hours 9-10 hours > 10 hours

Please indicate if any of the following apply:

sleepwalking talking in sleep wake frequently bed-wetting

nightmares other _____

DIET

How was your child fed as an infant?

formula, what kind? _____

breast-milk, for how long? _____

At what age did your child first eat solid foods? _____

Which foods were introduced first to your child? _____

Typical foods consumed now:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Drinks _____

Food sensitivities?

Dairy Wheat Corn Peanuts Other _____

Dietary restrictions (egs. religious, vegetarian, etc.) _____

Appetite: Large Moderate Small

Thirst: Large Moderate Small

FAMILY HEALTH HISTORY

Identify any family member (egs. mother, father's mother, brother) who has each of the following diseases/conditions:

Juvenile Arthritis _____

Heart Disease _____

Cancer _____

Allergies _____

Asthma _____

Eczema _____

Psoriasis _____

Kidney Disease _____

Mental Illness _____

Sickle cell anemia _____

Other genetic condition _____

Do either of the parents have a chronic illness? Please describe _____

HEALTH & DEVELOPMENT

How would you describe your child's temperament?

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

INFORMED CONSENT

As a patient of this clinic I have read all of the information given to me and I understand that the form of medical care is based on naturopathic and other supportive principles and practices. As such, I understand that my practitioner is not a medical doctor and does not prescribe prescription medications.

In the course of my care at Healing Path, I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications. Hence the information I have provided is complete and inclusive of all health concerns including risk of pregnancy, use of all medications, including over the counter drugs and supplements. I agree to inform Healing Path, in a timely manner and prior to any treatment received through Healing Path, all information relating to changes in my medications and/or treatments received through other healthcare providers, as I realize that important and dangerous interactions may occur between the concomitant use of natural and medical or other therapies.

There are some slight health risks associated with treatment by naturopathic medicine. These include, but are not limited to:

- homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your practitioner of any allergies you may have.
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from use of moxa
- Muscle strains and sprains, disc injuries from spinal manipulation
- The N.D.'s are trained to handle emergencies should the need arise.

I understand that treatment results for each individual are variable and that Healing Path does not and cannot predict or guarantee individual treatment results at any time. I also understand that the treatment times or length of treatment plans suggested to me by my practitioner are general guidelines only, based on my practitioner's experience and clinical judgment, but do not guarantee any type of treatment results.

Patient Name (please print name): _____

Patient (or Guardian) Signature: _____

Date: _____

PRIVACY POLICY AND AGREEMENT

This document is your Consent Form for Collection, Use, and Disclosure of Personal Information.

Privacy of your personal information is an important part of our clinic, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing this information responsibly. We will be as open and transparent as possible with you about the way we handle your personal information.

Our Privacy Policy:

- only necessary information is collected about you;
- only with your consent do we share information with others outside the clinic;
- storage, retention, and destruction of your information complies with existing law;
- our policy conforms to privacy legislation and standards of our regulatory body – the Board of Directors of Drugless Therapy – Naturopathy

We collect personal information in order to:

- assess your health
- provide health care
- advise you of treatment options
- establish and maintain contact with you for appointments, invoicing, follow-up care
- send you information mailings
- facilitate your insurance claims
- allow potential purchasers, practice brokers or advisors to conduct audits in preparation for sale of the practice.
- Comply with regulatory requirements and laws under the Drugless Practitioners Act

By signing below, you will have agreed that you have given your informed consent to the collection, use, and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I, _____ (print name) agree that Michael Torreiter, N.D. or Rachel Vanden Berg, N.D., can collect, use, and disclose information about my child as detailed above.

Signature (Guardian): _____ Date: _____

Witness: _____