



**Family Focused
Naturopathic Care**

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Pediatric Intake Form (Under 12)

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Dr. Claire Wilson ND

Thank you for taking the time to complete the following new patient forms to the best of your ability. Often, if your child can, it is fun and informative to complete them together. They are an important step towards defining your health care needs and achieving your health goals. Please email this form in advance for review, drop in off in advance, or bring this form to your first appointment. Please also include any relevant blood work or health reports.

*All the answers on this form will be held
absolutely confidential.*

Name: _____ **Birthdate:** _____

Address with P.O. Box: _____

City: _____ **Prov:** _____ **Postal Code:** _____

Family Doctor: _____ **Phone #:** _____

Referring Professional: _____ **Phone #:** _____

Care Card #: _____

Guardian Information:

Name: _____ **Relationship:** _____

Phone (Home): _____ **Phone (Cell):** _____ **Phone (Work):** _____

Email: _____ **Occupation:** _____

Preferred Method of Communication: _____

Spouse's Name: _____

Other Children's Names and Ages: _____

Emergency Contact (Name, Relationship): _____

Phone: _____

Why did you choose to come to this clinic?: _____

Have you seen a Naturopathic Doctor before? (Y/N) _____ **Dr:** _____

PRESENT HEALTH CONCERNS:

	Please list most important health concerns in their order of significance.	Please list any prior diagnosis including when and by whom.
1		
2		
3		
4		
5		

ALLERGIES:

(Please list your allergy, your reaction and severity on a scale of 1-10)

Medications:

Food:

Environmental

:

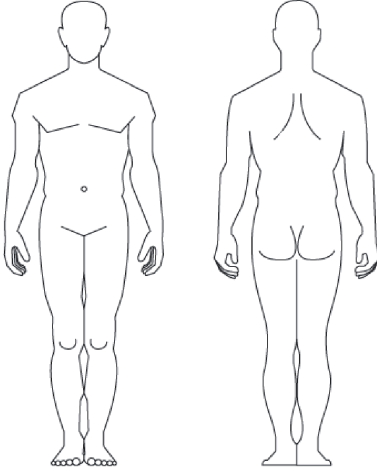
PAST MEDICAL HISTORY:

Have you ever been hospitalized? Y/N Why and which dates?

Have you ever had any major accidents, traumas or surgeries? Y/N Explain and which dates?

PHYSICAL CONDITION:

(Please indicate on the diagram the nature of your symptoms using the provided symbols.)

	Aching	O
	Stabbing	X
	Shooting	=
	Burning	~
	Numbness or Tingling	^

If you have indicated pain above, please use the next 2 lines to explain the onset, duration and frequency with which you experience this pain:

Please describe your current physical condition (Truth please):

Exercise: **Daily** **5x Week** **3x Week** **Weekly** **Monthly** or **Never**

Type (length, aerobic, strength, intensity): _____

FAMILY MEDICAL HISTORY:

MEDICAL CONDITION	RELATION
Alcoholism	
Allergies	
Anemia	
Arthritis	
Asthma	
Diabetes	
Eczema	
Epilepsy	

MEDICAL CONDITION	RELATION
Heart Disease	
Hearing Loss	
Hypoglycemia	
Mental Illness	
Obesity	
Stroke	
Thyroid Disorder	
Other(s)	

HAS HAD:

CONDITION
Chicken Pox
Red Measles
Mumps
Rubella

CONDITION
Scarlet Fever
Rheumatic Fever
Strep Throat
Pneumonia

CONDITION
Mononucleosis
Ear Infection(s)
Tonsillitis
Other

AGE	IMMUNIZATION	DOSE	DATE/REACTIONS?
2 Months	DTaP	1 of 3	
	Hib (Haemophilus influenza type b)		
	Polio (IPV)		
	Hepatitis B		
	Pneumococcal (PCV)	1 of 3	
	Meningococcal (Men-C)	1 of 3	
4 Months	DTap / Hib / Polio (IPV)	2 of 3	
	Hepatitis B		
	Pneumococcal (PCV)	2 of 3	
6 Months	DTap / Hib / Polio (IPV)	3 of 3	
	Hepatitis B		
	Flu (Influenza)	yearly	

12 Months	Chicken pox (varicella)	1 dose	
	MMR	1 of 2	
	Meningococcal (Men-C)	2 of 3	
	Pneumoococcal (PCV)	3 of 3	
18 Months	DTap / Hib / Polio (IPV) booster	1 of 1	
	MMR	2 of 2	
4-6 Years	DTap / Polio (IPV)	1 of 1	
	Chicken Pox (varicella) (Catch up dose if not previously given & no exposure)	1 dose	
Grade 6	Hepatitis B (if not previously given)	2-3 doses	
	Human Papillomavirus (HPV)	3 doses	
	Meningococcal (Men-C)	3 of 3	
	Chicken Pox (varicella) (Catch up dose if not previously given & no exposure)	1 dose	
Grade 9	Human Papillomavirus (HPV) (if not previously given)	3 doses	
	Tdap (adult formulation; for age 7 & older)	1 dose	
OTHER SHOTS			
AGE OR DATE GIVEN			
H1N1			
Hepatitis A			
Pneumococcal (PPV)			
Seasonal Flu			

Age
Alcohol
Bleeding
Cigarettes
Diabetes

Drugs
Extreme Nausea
High Blood Pressure
Illness
Medications

Stress
Toxemia
Trauma/Injury
X-Rays
Other

Details:

FOOD:

Breast Fed – How long?

Formula Fed – How long & type:

Age solids began:

Which foods:

Food Allergies/Intolerances:

Favourite Foods:

(Please describe a typical day's diet:)

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

How many hours do you spend per day:

Watching TV:

On the Computer:

Texting:

Talking on the Phone:

Have you tried any previous treatment?

**Please report all medications on the medication history page, including vitamins/supplements.*

On a Scale of 1 (low) to 10 (high) how would you rate:

Sleep quality:

Eating Habits:

Stress Level:

Exercise Habits:

of Hours of

Use of Sleep Aids (which

Uninterrupted Sleep:

ones?)

SETTING THE STAGE:

(Please ask these questions to your child, if appropriate, and allow for as candid of a response as possible:)

What is your main expectation from this visit?

What would you like to see the future of your health look like?

What would your ideal doctor be like?

If things in your life needed to change, like what you eat, or exercise or listening, how likely would you be able to make these changes: [1 (low) – 10 (high)]:

What do you do that is healthy?

What do you do that you don't think is healthy?

What do you think would be the hardest part to making changes in your life?

Who do you know that will sincerely support you and help you out?

What do you LOVE to do:

Best Possible Medication History

(Include all current and relevant past prescription medications, OTCs, and complementary medicines)

MEDICATIONS

Name: _____

Start Date	Name of Medication	Strength	How to take this medication				Purpose	Comment	Prescribed By
			Quantity?	Route?	Frequency?	Food?			
dd/mm/yyyy	Brand and Generic name (If available)		Quantity?	Route?	Frequency?	Food?			

Pharmacy:

Informed Consent For Treatment

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honor to take your care and health seriously. The following document is an agreement between you and I that states that you are entitled to understand any detail you wish about your health condition, treatment and diagnosis. It states that you are aware of the costs of naturopathic medicine (including late cancellation policies), the benefits and potential risks and side effects. Your health is ultimately up to you, therefore you also have the right to refuse any suggested treatment. We are in this together, so be sure to ask any questions you have, no matter what they are, at anytime and I will do my best to fulfill the meaning of doctor (docere) "To Teach".

STATEMENT OF ACKNOWLEDGEMENT

I, _____ as a patient of _____ understand that I am being treated under the practice philosophy and scope of naturopathic principles and practices. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my naturopathic doctor because I understand that safe care requires that I truthfully and completely disclose this information. I also will inform my naturopathic doctor if I am pregnant or breastfeeding so that she can take proper precautions for treatment.

I am aware and understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative treatments that may be applicable. I am encouraged to take an active role in my care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that she has answered all of my questions to the best of her ability.

I understand that though naturopathic treatments re generally safe and gentle, there may be health risks associated with some treatments. This may include, but not limited to: aggravation of pre existing symptoms, allergic reactions to supplements, herbs or pharmaceuticals and bruising or injury from acupuncture or intravenous therapies.

I understand that my naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at anytime. I accept full responsibility for any fees incurred during care and treatment, including a 50% late cancellation fee if providing less than 24 hours notice for cancellation of any appointments. I am aware that I am always at liberty to seek or continue care form another healthcare provider.

Signature (of patient, or legal guardian):

Date: _____

Witness: _____

Printed: _____