Wild Heart
Therapies and Farmacy
Family Focused Naturopathic Care
561 M Highway 3 Fernie, BC
Phone: (250) 531-0154
Fax: 1-800-858-8623
info@wildheartTandF.ca
wildheartTandF.ca

Pediatric Renewal Intake Form (Ages 0 to 12)

Have you been out of the clinic for over 1.5 years?
Catch us up on basics and what has prompted your return.
Please also include any relevant blood work or health reports.

All the answers on this form will be held ***absolutely confidential.*** **Please note any *changes* to the following information:.**

Full Name (Last, First, Middle Initial): **Birthdate (dd/mm/yyyy):**

Address with P.O. Box:

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

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

Sex (please circle one): **Male/ Female/ Other/ Prefer Not to Say** **Height:** **Weight:**

Care Card #:

*** Guardian Information:**

Parent/ Legal Guardian #1 Name: **Phone #:**

Email:

Please check the box that applies ☑ **Joint Custody ☐** **Sole Custody ☐**

Parent/ Legal Guardian #2 Name: **Phone #:**

Contact Information if Different than Above:

Please check the box that applies ☑ **Joint Custody ☐** **Sole Custody ☐**

Preferred Method of Communication:

Other Children's Names and Ages:

Emergency Contact (Name, Relationship):

Phone # (if different than above):

Why did you choose to come to this clinic?

Have you seen a Naturopathic Doctor before? (Y/N)
Doctor Name:

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?

____

____

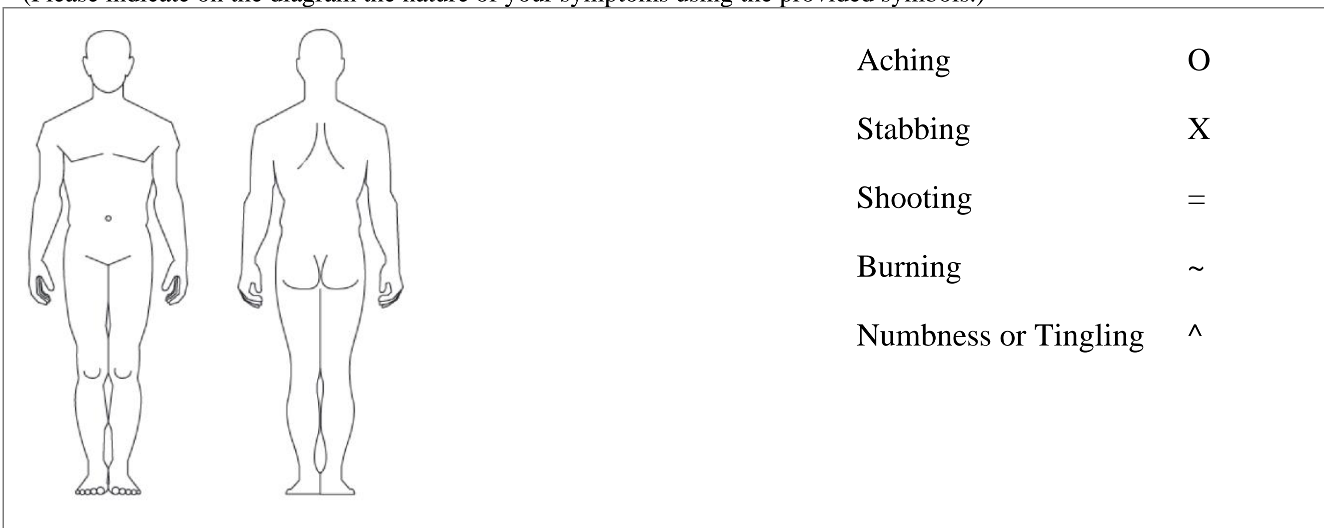
Have you ever had any major accidents, traumas or surgeries? Y/N Explain and which dates?

____

____

PHYSICAL CONDITION:

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



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If you have indicated pain on previous diagram, 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	

During pregnancy did the mother experience any of the following:

	Age		Drugs		Stress
	Alcohol		Extreme Nausea		Toxemia
	Bleeding		High Blood Pressure		Trauma/Injury
	Cigarettes		Illness		X-Rays
	Diabetes		Medications		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 Uninterrupted Sleep: **Use of Sleep Aids (which 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
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 honour to take your child's care and health seriously. The following document is an agreement between the legal guardians of a pediatric patient and the doctor you see. This document states that you are entitled to understand any detail you wish about your child's 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 child's health is ultimately up to your family; 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 fulfil the meaning of doctor (docere) "To Teach".

STATEMENT OF ACKNOWLEDGEMENT
I, ______________________________The legal guardian of ______________________________ as a patient of (Dr Name): ______________________________ understand that my child is being treated under the pediatric practice philosophy and scope of naturopathic principles and practices, as regulated by the Canadian College of Naturopathic Physicians and the Health Professions Act of Canada. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my child's naturopathic doctor because I understand that care requires that I truthfully and completely disclose this information. I also will inform my child's naturopathic doctor if I am aware of any pre-existing medications or conditions, so that she can take proper precautions for treatment.
I am aware and understand that I am entitled to know about my child's 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 to my child. I am encouraged to take an active role in my child's care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my child's proposed treatment with their practitioner and that she has answered all of my questions to the best of her ability. I understand that should parental access change, it is the parents' responsibility to update the clinic with the most up to date separation agreement, parenting agreement, or court order notarized by a lawyer outlining the change of rights. Without this documentation, it will be assumed that both guardians have equal access to parenting rights and responsibilities even without equal parenting time.
I understand that though naturopathic treatments are generally safe, 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 child's naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue my child's 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 the cancellation of any appointments. I consent to email as a form of communication, and have provided the best email to do so with on my child's intake form. I acknowledge that some of the professionals that Naturopathic Doctors refer to are a part of unregulated professions in Canada, and that my ND will always disclose the nature of their referrals, the reason for their referral along with the benefits of seeing this practitioner (ie; Nutritionsists). I consent to appropriate interoffice verbal communication amongst practitioners when my child's ND feels it is appropriate and relative to the outcome of my child's care, if my child is being cared for by more than one practitioner in the clinic. My child's primary ND will be the only practitioner that has access to their chart unless I request otherwise. I am aware that I am always at liberty to seek and/or continue my child's care from another healthcare provider.

Signature (of patient, or legal guardian): ____
Date: _____________________________________
Witness: ___________________________________
Printed: ___________________________________