

Pediatric Intake Form

Who are you?

Name: _____

Gender: M F

Age: _____

Date of Birth: _____

Parent's Names: _____

Address: _____

Postal Code: _____

Phone Number: (____) _____

Who does the child live with: _____

Emergency Contact: _____ Phone Number: _____

Does the child have a medic alert? _____

Or life threatening allergies? _____

What's going on?

What is the main health concern? _____

When did this begin? _____

How long has this gone on for? _____

What other treatments have been attempted? _____

What was the result with these treatments? _____

What factors may be contributing to this problem? _____

What have you had? Check all applicable

Chicken pox	<input type="checkbox"/>	Measles	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	Rubella	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	Allergies	<input type="checkbox"/>

Vaccinations: Check all applicable

D-PTP (Diphtheria, Pertussis, Tetanus, Polio)	<input type="checkbox"/>	Hib (H. influenza, often given with D- PTP)	<input type="checkbox"/>
MMR (Measles, Mumps, Rubella)	<input type="checkbox"/>	Td + P (Tetanus, Diphtheria, Polio)	<input type="checkbox"/>
OPV (oral polio vaccine)	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>
Flu shot	<input type="checkbox"/>		<input type="checkbox"/>

Have you ever been to the emergency room? _____

What was it for? _____

What are you taking?

Please list any medications you have taken in the past and the ones you are taking presently. _____

Please list any supplements; vitamins, minerals, herbal medication, homeopathics, that you are currently taking.

How was your birth?

During the pregnancy were you exposed to any of the following:

Alcohol		Cigarette smoke	
Recreational drugs		Prescription medications	
Over the Counter drugs		Herbal preparations	
Ultrasound		Amniocentesis	
Illness		Large amount of stress	

Were there any complications during the pregnancy?

Nausea		Hypertension	
Vomiting		Preeclampsia / eclampsia	
Bleeding		Placenta previa	
Gestational diabetes		Maternal rubella	
Maternal chicken pox		Maternal cytomegalovirus	
Maternal toxoplasmosis		Other	

At Birth:

Weight: _____

Length: _____

Were you term? _____ pre-term? _____ post-term? _____ premature? _____

Where did the birth take place? Home Hospital

What type of delivery occurred? Vaginal Cesarean Section

Were there any complications with the birth?

Difficult delivery		Breech delivery	
Long 2 nd stage of labour		Shoulder dystocia	
Forceps or suction used		Other	

What were the APGAR scores? _____

Were any interventions administered at birth? Vitamin K Eye drops

What were your mother's feelings about the birth? _____

As a Newborn:

Did you have any of the following conditions?

Jaundice		Colic	
Hip displacement		Meningitis	
Scoliosis			

What do you like to eat?

As a baby were you breastfed? Yes No For how long? _____

Were you fed formula? Yes No

What kind of formula was used? _____

Were there any reactions to the formulas? _____

How old were you when were you introduced to food? _____

What did you eat first? _____

Were there any reactions to any foods? _____

What do you eat now? _____

What are your favourite foods? _____

What foods do you like the least? _____

Do you exclude any foods for religious or ethnic reasons? _____

Where do you live?

What kind of a building do you live in (house, apartment, etc.)? _____

How old is the building? _____

Has it been renovated recently? _____

Does your home have carpet? _____

Has there ever been a problem with mildew in the home? _____

What is your family like?

Has anyone in your family had any of the following diseases? If yes, please indicate who.

Cancer		Diabetes		Heart Disease	
Stroke		Hypothyroidism		Arrhythmia	
Rheumatoid Arthritis		Hyperthyroidism		High blood pressure	
Lupus		Sickle-cell anemia		Crohn's Disease	
An Autoimmune disease		Irritable Bowel Syndrome		Ulcerative Colitis	

What do you like to do?

Do you go to school? Which one? _____

Do you go to daycare? _____

Do you have a nanny? _____

How do you like playing with other kids? _____

Do you have a pet? _____

Do you watch TV? Yes No How often? _____

Do you play video games? Yes No How often? _____

Do you play on the internet? Yes No How often? _____

Do you have family time? Yes No How often? _____

Do you get exercise? Yes No

What do you like to do for exercise? _____

What else do you like to do? _____

How is your sleep?

What position do you like to sleep in? _____

How long do you sleep at night? _____

How long does it take you to fall asleep? _____

Do you wake up during the night? _____

Do you have nightmares? _____

How do you feel when you wake up? _____

Are you rested? _____

Do you take naps? _____

How long are your naps? _____

What is your energy like during the day? _____

From Head to Toe: Please check all that apply.

Cradle cap (seborrheic dermatitis)		ADHD/ ADD	
Eczema		Urinary incontinence	
Diaper rash		Bedwetting	
Yeast infection		Fecal incontinence	
Impetigo		Seizures	
Conjunctivitis		Paralysis	
Scabies		Cerebral Palsy	
Sinusitis		Spina bifida	
Ear infections		Cystic Fibrosis	
Chronic Colds		Chronic Diarrhea	
Croup		Appendicitis	
Bronchitis		Constipation	
Asthma		Chronic Abdominal pain	
Pneumonia		Short stature	
Cardiovascular problems		Other	

Welcome to Naturopathic Care

I want you to enjoy and benefit from your visits.

Your first visit will consist of a **consultation, detailed history, a general physical exam and more specific naturopathic assessments**. Based on this information, initial recommendations for your treatment protocol will be made on your first visit. If it is necessary for a more complete analysis of your health status, you may be asked to have further laboratory tests done, these may include; blood testing, salivary hormone testing, urine, hair and stool analysis. Through this healthcare assessment, a baseline measure of health is established which will be used to monitor your progress.

Naturopathic treatment programs often include **dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy, acupuncture and Bowen therapy**. Any side effects or risks associated with your treatment will be explained to you. Part of the program will also involve lifestyle recommendations that are logical and sensible; I encourage you to have a support team as you make these changes, often having someone else, be it a partner, family member or friend, undergoing naturopathic care at the same time, will help ease you both toward better health. Your second visit is a good time to ask any questions that you may have had after your initial visit. If you need immediate clarification on remedies, dietary recommendations or have a concern over any unfamiliar symptoms that may arise, please call the office.

On your following visits your progress will be monitored and treatments will be modified accordingly. The second visit is usually one to four weeks after your initial visit. If you are receiving acupuncture treatments, visits will be more frequent, either once or twice weekly for 6-10 sessions, Bowen therapy sessions are usually 5-10 days apart. As you start to experience a new level of wellness, an office visit every three to four months is recommended for general disease prevention and health maintenance. If an acute, non-emergency condition occurs, please give us a call as we may be able to help with a naturopathic treatment.

Many patients have allergies and are environmentally sensitive. On the day of your visit to the office please do not wear any scented products (perfumes, shaving lotions, etc.).

If you are unable to keep a scheduled appointment, please give the office 24 hours notice. We are then able to give the appointment time to someone else. If we do not receive sufficient notice you will be charged for the missed visit.

Payment for visits shall be made at the time of the appointment
Please be advised of the fees effective November 1, 2006

Dr. Rebecca Sagan ND

Initial visit	1.25 hr	\$150
Regular visit	30 min	\$75
Child Initial visit		\$106
Child Regular visit		\$60
Acupuncture Initial visit		\$106
Acupuncture follow-up		\$60
Bowen Therapy Initial		\$106
Bowen Follow-up		\$75
Hair Analysis		\$85
In-Office Urinalysis		\$55

A dispensary of professional quality supplements, botanicals and homeopathics is maintained for the treatment of our patients. Items are individually priced.

We accept the following methods of payment:

Visa, MasterCard, Debit card, cheque or cash

If you have any concerns please contact the office and we will happily help you to the best of our abilities.

Naturally Good Health Clinic

INFORMED CONSENT

I would like to take this opportunity to welcome you to the Naturally Good Health Clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. Your Naturopathic Doctor will complete a physical exam, as well as, specific blood, salivary and/or urinary laboratory reports as part of the treatment work-up if determined to be appropriate.

Statement of Acknowledgement

Printed name _____

As a patient of this clinic I understand that the form of medical care is based on Naturopathic and other supportive principles and practices. All information that is disclosed will remain confidential and will only be released with my permission. 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 and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

SIGNATURE/ Guardian Signature

DATE

WITNESS