Naturopathic Pediatric Intake Form

Please complete only the applicable areas.

1 Patient's Contact Information

Child's Name: _____
Sex: M / F Age: _____ Date of birth: _____ Height: _____ Weight: _____
Address: _____ City/Province: _____ Postal Code: _____
Phone (Home): _____ (Work): _____

Mother's Name: _____ Father's Name: _____
Mother's Occupation: _____ Father's Occupation: _____
Name and Relationship of Person filling out this form: _____
Email Address: _____

Emergency Contact Information

Name and Relation to Child: _____
Address: _____
Phone # Home: _____ Work: _____ Cell: _____

Other Health Care Provider: _____ Date of Last Visit: _____
Address: _____ Phone Number: _____

2 Medical History

List the child's health concerns, in order of importance?

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

How would you describe your child's general state of health? (circle) Excellent / Good / Fair / Poor

Please indicate any **serious conditions, illnesses or injuries and any hospitalizations**, along with treatment interventions:

Please list all current and past **medications** your child is/has taken (include dose, duration, side-effects if any):

Please list any **supplements, vitamins, minerals, herbal medication, homeopathics**, etc. that your child is taking:

Please list any **allergies** (medications, environment, foods):

Has the child taken **antibiotics**? If yes, how many times? _____

What screening **tests** has your child had (blood, hearing, vision, speech, learning etc.)?

Immunization Record (Indicate where applicable)

Vaccination	Date(s)	Adverse Reactions
DPT (Diphtheria, Pertussis, Tetanus)		
Td + P (Tetanus, Diphtheria, Polio)		
D-PTP (Diphtheria, Pertussis, Tetanus, Polio)		
Tetanus		
OPV (Oral Polio Vaccine)		
MMR (Measles, Mumps, Rubella)		
Hepatitis B		
Hemophilus B		
Influenza (Flu Shot)		
Men-C conjugate		
Pneumo-coccal conjugate		
Varivax (Chicken pox)		
Other:		

If a sibling of the child has had an adverse reaction to any of the above vaccinations please describe reaction:

_____

3 Review of Systems

Please indicate an N or P, if applicable (**N** – has the condition now; **P** – had the condition in the past):

Abdominal bloating		Dizziness		Mumps	
Acne		Earaches		Nose bleeds	
ADHD/ADD		Early menses (<age 12)		Palpitations(fast heart rate)	
Allergies-Seasonal		Eczema		Paralysis	
Allergies-Environmental		Encephalitis		Pleurisy	
Anal fissures		Eye crusting		Pneumonia	
Anemia		Fevers		Polio	
Anxiety		Frequent infections		Psoriasis	
Appendicitis		Frequent runny nose		Recurring ear infections	
Asthma		Headaches		Rheumatic fever	
Back aches		Heart murmur		Roseola	
Bedwetting		Hemorrhoids		Rubella	
Bladder infection		Herpes		Scabies	
Body odour		High blood pressure		Scarlet fever	
Bronchitis		HIV		Seizures	
Cancer		Hives/rashes		Severe head injury	
Cerebral Palsy		Hyperthyroid		Short stature	
Chicken Pox		Hyperactivity		Strep throat	
Chronic colds		Hypoglycemia		Spina bifida	
Conjunctivitis		Hypothyroid		Scoliosis	
Cold sores		Impetigo		Thrush	
Colic		Indigestion/ Gas		Tinnitus (Ringing in ears)	
Colitis		Influenza		Tonsillitis	
Constipation		Insomnia		Ulcers	
Cough/wheezing		Irritable Bowel Syndrome		Ulcerative colitis	
Crohn's Disease		Jaundice		Undescended testicles	
Cradle cap		Joint pain		Urinary tract infection	
Croup		Measles		Vitiligo	
Cystic Fibrosis		Meningitis		Vomiting	
Depression		Mitral valve prolapse		Whooping cough	
Diaper rash		Mononucleosis		Warts	
Diabetes		Moodiness		Yeast infection	
Diphtheria		Multiple Sclerosis		*Other*	

4 Family Medical History

Please check all conditions that apply to child's family medical history (i.e. health of parents and extended family):

Addiction		Depression		Lupus	
Allergies		Diabetes		Obesity	
Arrhythmia		Down Syndrome		Rheumatoid Arthritis	
Asthma		Epilepsy		Sickle-cell anemia	
Autism		Heart disease		Stroke	
Autoimmune disorder		High blood pressure		Ulcerative Colitis	
Bleeding Disorder		Hypothyroidism		Other	
Cancer		Hyperthyroidism			
Crohn's Disease		Irritable Bowel Syndrome			

5 Prenatal Health

Age of biological mother at the time of the child's birth: _____
Number of previous pregnancies carried to term: _____
Number of previous pregnancies not carried to term (miscarriage, stillborn, abortions) _____
Was the pregnancy planned? Y / N Pounds gained during the pregnancy: _____
Were there any fertility issues surrounding the child's conception? _____
Describe mother's diet during pregnancy, any food cravings? _____
_____
Did mother exercise during pregnancy? Y / N How much and what type? _____
Emotional state of mother during pregnancy: _____
Supplements and medications used during pregnancy: _____
Complications during pregnancy and any tests performed: _____

During the pregnancy was the mother exposed to any of the following (check all that apply):

Alcohol		Colds/Flus	
Recreational drugs		Cigarette smoke	
Over the Counter drugs		Prescription medications	
Ultrasound		Herbal preparations	
Illness		Amniocentesis	
X-Ray		Large amount of stress	
Viral infection		Travel	
Yeast infection		Amalgam fillings put in/removed from teeth	
Group B strep infection		Chemical exposure	

Were there any complications during the pregnancy (check all that apply)?

Nausea		Hypertension	
Vomiting		Preeclampsia / eclampsia	
Bleeding		Placenta previa	
Gestational diabetes		Maternal rubella	
Maternal chicken pox		Maternal cytomegalovirus	
Maternal toxoplasmosis		Thyroid Dysfunction	
Physical/Emotional Trauma		Other	

What was the health of the mother during pregnancy? (circle)
Poor Fair Good Excellent Unknown

6 Natal History

Place of Birth: □ Hospital □ Home □ Clinic □ Other:_____ Length of hospitalization for mother: _____ Baby: _____
Type of delivery: □ Vaginal □ Cesarean Section □ Induced Length of pregnancy: _____ wks Length of labour: ____
Birth Weight: _____ Birth Length: _____ Head Circumference _____ APGAR Score: _____

Please check any conditions that apply:

Difficult delivery		Breech delivery	
Long 2nd stage of labour		Shoulder dystocia	
Forceps or suction used		Vitamin K administered	
Jaundice		Antibiotic Eye Drops	
Problems with feeding		Congenital abnormalities	
Respiratory abnormalities		Hip displacement	
Seizure		Birth Injuries	
Medication (e.g., for pain management)		Emotional trauma (mother)	

7 Developmental History

How was your child's health in the first year? (circle)
Poor Fair Good Excellent Unknown

Please indicate the approximate age at which the child:

Weaned		Absent bedwetting		Took first steps	
Sit-up		First words		Walked alone	
Crawl		Spoke clearly		Dressed self	
Pulled to stand		Ate solid foods		Tied shoe laces	
Potty trained		Fed self		Rode 2-wheeled bike	

Please explain any developmental concerns: _____
_____

Is your child particularly sensitive to any of the following?
□ claustrophobia □ cold □ heat □ drafts □ wind
□ height □ music □ sunlight □ wool □ smells, list: _____

8 Diet, Sleep, Lifestyle and Environment

Typical diet for your child:
Breakfast:_____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

My child was: Breast fed ____ formula _____ both _____ for how long? _____
If on formula, what type was used? _____
Solid foods were introduced at age _____

Please indicate newly introduced foods and any adverse reactions (e.g., bloating, gas, diarrhea, constipation or rashes):

Current food allergies: _____
Dietary restrictions (e.g., vegetarian, religious) _____
Food cravings _____
Is your child thirsty? Y / N Child is a picky eater: Y / N
Describe child's appetite in general: _____

Please describe your child's dental history (including oral hygiene practice, grinding etc):

Sleep:
Time child goes to sleep: _____ Wakes up: _____ Hours per night: ____ Time it takes to fall asleep: _____

Please check any behaviours that are applicable:

	YES	NO	COMMENTS
Dreams/nightmares			
Naps (time and length)			
Refreshed after sleeping			
Wakes often			
Wakes for food			
Wakes up irritable			
Night sweats/Fever			
Sleepwalking			
Bed wetting			
Grinds/clenches teeth			

Social/Lifestyle + Home Environment:

Parents: □ Married □ Separated □ Divorced Age of child when divorced/separated? _____

Please describe child's **living environment** (house, apartment, new, old, last renovation):

Indicate all applicable exposures:
□ Cigarette smoke □ Pets □ Mold □ Chemical (paint, new carpet, cabinets etc)
□ Gasoline □ Pesticides/Herbicide Other: _____

Please describe the **emotional climate** of your home:

Daily Activity:
Please indicate how often the child engages in the following activities:

Reading		Family Time	
TV		Exercise	
Internet		Social play	
Video Games		Other	

Education:
My child is currently in: □ Daycare □ School □ Home
Type of school: _____ Grade: _____

Please describe your child's general disposition, interaction with others, like/dislike and performance in daycare/school?

Please add anything you feel to be relevant that has not been covered:

INFORMATION COLLECTION POLICY

Privacy protocols at Cornell Chiropractic Centre comply with the Personal Health Information Protection Act (PHIPA), the Personal Information Protection and Electronic Documents Act (PIPEDA), and the standards of the Board of Directors Drugless Therapy – Naturopathy (BDDT-N), our regulatory body.

Your information may be accessed by regulatory authorities under the terms of the Drugless Practitioners Act, for the purpose of fulfilling our regulatory body's mandate or by law. Our office will not disclose your personal confidential information to insurance companies or to third-party companies. For all other types of disclosure, we require a signed consent form by the patient.

Cornell Chiropractic Centre recognizes the sensitive nature of the information that you have disclosed and all associates of the clinic have been trained in the appropriate use and protection of your information. Proper adherence of our Information Collection Policy ensures:

- Only necessary information is collected about you
- We only share your information with your consent
- Storage, retention and destruction of your personal information complies with the BDDT-N regulations
- Our ability to remind you of upcoming appointments and maintain ongoing contact with you
- Advisement of proper treatment options
- Delivery of newsletters and other informational mailings where appropriate

_____ INITIAL

NATUROPATHIC FEE POLICY

- Fees are due at time of service
- Phone consultations are available only after the initial consultation has been completed
- Supplements recommended to patients as part of therapeutic protocols may be purchased at this clinic when available but patients are not required to purchase supplements from this clinic
- Patients may ask to view their records from Cornell Chiropractic Centre; if copies are required, they can be provided for a nominal fee
- 24-hour cancellation or change of appointment time is required to avoid being charged in full for the missed appointment
- All fees do not include any applicable taxes and are subject to change at any time

SERVICE	FEE	DETAILS
Initial adult appointment	$180	75-90 minutes
Initial pediatric appointment	$150	60-75 minutes
60 minute follow-up appointment	$150	Initial appointment required
45 minute follow-up appointment	$115	
30 minute follow-up appointment	$75	
15 minute follow-up appointment	$40	
Phone consultation	$35 per 15 minutes	Minimum 15 minute charge applies
Acupuncture appointment	$75	Initial appointment required
Acupuncture package – 3 appointments	$195	
B12 & folic acid injection	$20	
Supplements	Priced accordingly	

_____ INITIAL

INFORMED CONSENT FOR NATUROPATHIC TREATMENT

Naturopathic medicine is a system of healthcare that takes a natural approach to assessment, diagnosis and treatment with a focus on prevention, restoration and health maintenance. Naturopathic doctors (ND) assess the whole person, taking into consideration the physical, mental, emotional, and spiritual aspects of the individual. Gentle, non-invasive therapies and treatment approaches are used to stimulate the body's innate healing capacity.

Your naturopathic doctor will take a thorough medical and health history and answer any questions that may arise throughout the treatment process. A physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. Your ND will exercise judgment during the course of your treatment that is in your best interest, based on the facts that are known.

A number of different approaches may be used throughout the treatment process. Naturopathic modalities include diet & lifestyle counseling, clinical nutrition, botanical medicine, traditional Chinese medicine & acupuncture, homeopathy, hydrotherapy, and physical medicine.

It is very important that you inform your ND immediately of any disease process from which you are suffering and any medications/over-the-counter drugs or supplements that you are currently taking. Please advise your naturopathic doctor immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding. Caution must be taken in some physiological conditions such as pregnancy and lactation, very young children, people with diabetes, heart, liver or kidney impairment and/or with people taking multiple medications. The staff and doctors at Cornell Chiropractic Centre are trained to handle emergencies, should the need arise.

There are some risks to treatment by naturopathic medicine. These include but are not limited to aggravation of pre-existing symptoms, allergic reactions to supplements/herbs, pain/bruising/injury from acupuncture, fainting or puncturing of an organ with acupuncture needles, and muscle strains or disc injuries from spinal manipulation.

I understand (please initial beside each statement):

_____ A record will be kept of the health services provided to me and that it will be kept confidential and will not be released to others without my consent or unless required by law. I may look at my medical record at any time and request a copy by paying the appropriate fee.

_____ Information from my medical record may be analyzed for internal clinical purposes and that my identity will be protected and kept confidential, unless consent has been provided.

_____ Treatment results are not guaranteed.

_____ My naturopathic doctor will explain to me the exact nature of any treatment provided and will answer any questions I may have to the best of his or her ability.

_____ I am free to withdraw my consent and discontinue treatment at any time.

_____ Fees and supplements are to be paid for at the time of the appointment.

_____ A fee will be charged for missed appointments or cancellations with less than 24 hours' notice.

I understand, as a patient, I am responsible for the total charges incurred with each visit. Payment can be made in cash, cheque, debit, VISA and Mastercard. If I have coverage for naturopathic medicine, I am responsible for billing my own insurance company – Cornell Chiropractic Centre will provide me with the receipt necessary to send my claim for reimbursement.

My naturopathic doctor may prescribe supplements that can be purchased from the clinic dispensary; however, I am under no obligation to purchase them on-site. Most insurance companies do not cover the cost of supplements prescribed and dispensed by naturopathic doctors.

I have read and understand the policies and information stated above. I intend this consent form to cover the entire course of treatment for my present condition.

_____	_____	_____
Patient name	Signature of Guardian	Date