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PEDIATRIC INTAKE FORM
 PERSONAL INFORMATION

Today's Date:

Full (Legal) Name:	Gender:
Parent/Guardian Name:	Birthdate (M/D/Y): Age:
Parent/Guardian Relationship:	Are you on MSP Premium Assistance?
Home Address:	If yes, would you like an MSP claim submitted for visits?
City/Prov: Postal Code:	BC MSP#:
Mailing Address (if different):	Family Doctor:
City/Prov: Postal Code:	Family Doctor Phone:
Home phone:	Other Healthcare Provider:
Work phone:	Other Provider Phone:
Cell phone:	Extended Health Insurance Provider:
Email:	Occupation:
Emergency Contact (Name):	Employer:
Emergency Contact (Phone):	Hours/week:
Live with: Parents <input type="checkbox"/> Grandparents <input type="checkbox"/> Sibling <input type="checkbox"/> Partner <input type="checkbox"/> Friends <input type="checkbox"/> Alone <input type="checkbox"/> Other _____	
Childcare (please indicate where your child spends significant time outside of home): Grandparents/Family <input type="checkbox"/> Nanny/Babysitter <input type="checkbox"/> Friends <input type="checkbox"/> Alone <input type="checkbox"/> Daycare <input type="checkbox"/> School <input type="checkbox"/> Other _____	

HEALTH STATUS

CURRENT HEALTH CONCERNS: list by priority and describe the diagnosis (name of condition), tests performed, symptoms (what your child experiences), when it started, what makes it better or worse, and what treatments have been used and their effects:

- 1) _____

- 2) _____

- 3) _____

What are your goals for your child's visits? _____

On a scale of 1 to 10 (1 being very poor, 10 being excellent), rate the status of your child's health and well-being today: 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY

Mother's age at child's birth: _____		
Were there any difficulties with conception? If yes, please list concerns and therapies used (e.g., in vitro fertilization, hormone treatments). _____		
Medications taken before/during pregnancy: _____		
Supplements/vitamins taken before/during pregnancy: _____		
Please indicate conditions present during pregnancy:		
<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Cigarette use	<input type="checkbox"/> Hypertension/Pre-eclampsia	<input type="checkbox"/> Illness
<input type="checkbox"/> Drug use	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Group B Strep (GBS) Positive
<input type="checkbox"/> Nausea	<input type="checkbox"/> Physical/emotional trauma	<input type="checkbox"/> Other: _____
How was the birth? Please list any interventions used (forceps, epidural, IV antibiotics, etc.):		
<input type="checkbox"/> Hospital birth	<input type="checkbox"/> Vaginal Birth	<input type="checkbox"/> Child's Birth Weight: _____
<input type="checkbox"/> Home birth	<input type="checkbox"/> C-Section	<input type="checkbox"/> Child's Birth Length: _____
Please indicate if any of the following occurred during or soon after birth:		
<input type="checkbox"/> Birth injuries	<input type="checkbox"/> Seizures	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Rashes	<input type="checkbox"/> Low weight gain	<input type="checkbox"/> Colic
Feeding:		
<input type="checkbox"/> Breastfed	If yes, how long? _____	<input type="checkbox"/> Solid foods introduced. Age: _____
<input type="checkbox"/> Formula	If yes, how long? _____	<input type="checkbox"/> Favorite foods: _____
Formula type:	Soy/Cow/Other: _____	<input type="checkbox"/> Food allergies/sensitivities: _____

Childhood Illnesses:		
<input type="checkbox"/> Measles	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Varicella (Chickenpox)
<input type="checkbox"/> Mumps	<input type="checkbox"/> Pertussis (Whooping Cough)	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Rubella	<input type="checkbox"/> Tetanus	<input type="checkbox"/> Other:
Surgeries:		
Accidents/Injuries/Trauma:		
Hospitalizations:		
Results of Medical Investigations (X-Rays, CT Scans, MRI, EKG, EEG...):		
Infections:		
Genetic/Congenital disorders:		
Allergies:		
Please indicate if you child uses or is regularly exposed to any of the following: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Other Drugs: _____		
Immunizations:		
<input type="checkbox"/> Measles	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pneumococcus
<input type="checkbox"/> Mumps	<input type="checkbox"/> PolioV	<input type="checkbox"/> Influenza
<input type="checkbox"/> Rubella	<input type="checkbox"/> Varicella (Chickenpox)	<input type="checkbox"/> Tuberculosis (BCG)
<input type="checkbox"/> Diphtheria	<input type="checkbox"/> HPV	<input type="checkbox"/> Meningococcus
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Hib	<input type="checkbox"/> Influenza
<input type="checkbox"/> Pertussis (Whooping Cough)		
Other: _____		

Please list any CURRENT MEDICATION being used including dosage, duration of use, reason for use and its effects:

Name	Dosage	Duration	Reason	Effects

List any CURRENT SUPPLEMENTS (e.g. vitamins, minerals, herbs) being used including dosage, duration, reason for use, and effects:

Name	Dosage	Duration	Reason	Effects

Please indicate if there is FAMILY HISTORY of the following conditions and indicate which family member:

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Alzheimer's |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Bed wetting | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Eczema/Psoriasis | <input type="checkbox"/> Sleep difficulty | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression | <input type="checkbox"/> Other: _____ |

NEW PATIENT CHECK-LIST

Please check any of the following health conditions your child has experienced in the past 3 months.

General

- | | | |
|---|---|---|
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Bleed/bruise easily |
| <input type="checkbox"/> Poor appetite/change in appetite | <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Peculiar tastes/smells |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Cravings |

Neuropsychological

- | | | |
|---|---|---|
| <input type="checkbox"/> Depressed mood | <input type="checkbox"/> Considered suicide | <input type="checkbox"/> Loss of balance/coordination |
| <input type="checkbox"/> Anxiety/nervousness | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Mood swings/quick temper | <input type="checkbox"/> Dizzy/light headed | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Susceptible to stress | <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures |

Endocrine

- | | | |
|--|---------------------------------------|---|
| <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Goitre | <input type="checkbox"/> Excessive hunger |
| <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Heat/cold intolerance | <input type="checkbox"/> Hypoglycemic | |

Immune

- | | | |
|--|--|---|
| <input type="checkbox"/> Chronic swollen glands | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Regular flu shots |
| <input type="checkbox"/> Frequent/chronic infections | <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Antibiotic use |
| <input type="checkbox"/> Slow wound healing | <input type="checkbox"/> Drug allergies | <input type="checkbox"/> Autoimmune condition |

Skin & Hair

- | | | |
|------------------------------------|---|--|
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Other rashes | <input type="checkbox"/> Recent moles |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Lumps |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Itching | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Sensitive to touch | <input type="checkbox"/> Dandruff |
| <input type="checkbox"/> Boils | <input type="checkbox"/> Color change | <input type="checkbox"/> Hair dye/bleach |

Head, Ears, Eyes, Nose & Throat

- | | | |
|---|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Ear ringing | <input type="checkbox"/> Jaw pain/clicking |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Nose stuffiness | <input type="checkbox"/> Glasses/contacts | <input type="checkbox"/> Dental cavities |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Copious saliva |
| <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Blurriness | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Double vision | <input type="checkbox"/> Sore tongue/lips |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Mouth sores |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Tearing/dryness | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Ruptured tympanic membrane | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Ear tubes | <input type="checkbox"/> Itchy/inflamed/infected eyes | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Lump in throat |

Respiratory

- | | | |
|---|---|-------------------------------------|
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Coughing up mucous | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Wheezing | <input type="checkbox"/> |
| <input type="checkbox"/> Pain on breathing | <input type="checkbox"/> Asthma | |

Cardiovascular

- | | | |
|--|---|---|
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Cold hands/feet |
| <input type="checkbox"/> Heart racing/pounding | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Fainting | <input type="checkbox"/> Swelling of hands/feet |
| <input type="checkbox"/> Murmurs | <input type="checkbox"/> Chest pain | <input type="checkbox"/> |

Peripheral vascular/Blood

- | | | |
|---------------------------------|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Easy bleeding/bruising | <input type="checkbox"/> Cold hands/feet |
|---------------------------------|---|--|

Gastrointestinal

- | | | |
|--|---|---|
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Jaundice (yellow skin) | <input type="checkbox"/> Mucus in stool |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Gas | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Abdominal pain/cramps | <input type="checkbox"/> Rectal cuts/fissures | <input type="checkbox"/> Laxative use |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bowel movements:
How often? _____ |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Blood in stool | Is this a change? _____ |
| <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Black stools | Consistency? _____ |
| <input type="checkbox"/> Ulcer | <input type="checkbox"/> Difficulty retaining stool | |

Genitourinary

- | | | |
|---|---|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Change in color |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Change in odor |
| <input type="checkbox"/> Pain on urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Kidney infection/disease |
| <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Bladder infections |

Male Reproductive

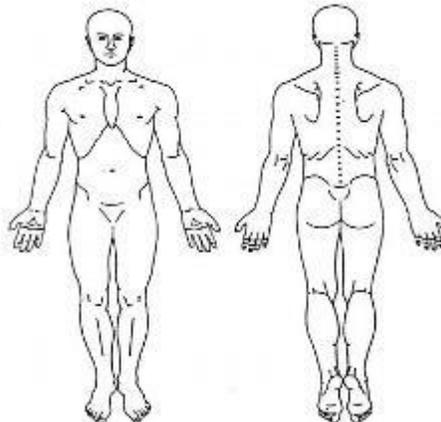
- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Hernias | <input type="checkbox"/> Discharge or sores | <input type="checkbox"/> Testicular pain/masses |
|----------------------------------|---|---|

Female Reproductive

- | | | |
|--|---|--|
| <input type="checkbox"/> Menstruating | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Sexually active | <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Vaginal sores |

Musculoskeletal *Please indicate on the attached picture where there is pain/stiffness/discomfort with the following symbol:*

- A Aching
- B Burning pain
- S Sharp stabbing pain
- C Cramping pain
- N Numbness
- T Tingling
- St Stiffness
- W Weakness
- Broken bones
- Arthritis
- Scoliosis
- Injury



Lifestyle *Please circle the choices that apply to your child.*

- Drink coffee/tea/pop
- Drink beer/wine/liquor
- Smoke cigarettes/cigars/marijuana
- Recreational drug use/abuse
- Trouble sleeping/relaxing
- Exercise regularly/rarely
- How many hours/week? _____
- Relationship/family difficulties
- Unhealthy/stressful living conditions
- Other stressful conditions
- Eat chicken/turkey/eggs/fish
- Eat beef/lamb/buffalo
- Eat cold cuts/sausages/hot dogs
- Eat cheese/yogurt/ice cream/milk
- Eat bread/pasta/rice/ potatoes/cereal
- Eat sugar/chocolate/candies/chips
- Eat fresh/frozen/canned vegetables
- Eat fresh/frozen/canned fruit
- Drink tap/filtered/spring water
- Drink fresh/canned/bottled juices
- Cook with microwave/aluminum
- Steam/poach/bake/broil/fry/BBQ foods
- Eat often in restaurants/fast food
- Use salt regularly
- Eat mostly organic/local/non-organic
- Eat mostly pre-packaged/home made foods

Is there anything else you can think of that affects your child's health?

FINANCIAL POLICY

MSP POLICY FOR B.C. RESIDENTS

Non-insured Fee (Office Fee): Naturopathic Doctors (ND) are registered with the College of Naturopathic Physicians of BC. There is a fee charged for consultations based on the amount of time spent with the ND. Please review the information below for more details.

Insured Fee (MSP Fee): If you have a valid BC Medical and are receiving MSP premium assistance, you will be reimbursed \$23.00 for each consultation (up to a combined maximum of 10 visits). Premium assistance patients are insured for a total of 10 visits per calendar year for any combination of services provided by the following licensed health professionals: Naturopathic Physicians, Chiropractors, Registered Massage Therapists, Physiotherapists, Acupuncturists, and Podiatrists. For example: 8 visits to a Naturopath, 2 visits to a Chiropractor equals the 10 visit insured maximum limit. If you have used up your allowable visits for the year, then no more reimbursements can be issued. We submit a MSP claim on your behalf so that you can receive the partial reimbursement for all eligible consultations. The MSP will mail a cheque directly to your home address (processing will take approximately 6 to 8 weeks).

Extended Health Coverage: Some extended health insurance plans cover Naturopathic services. Please verify with your Extended Healthcare provider whether consultations, testing, and/or treatments are covered under your plan. We will issue a receipt for you to submit to your extended health insurance carrier at each visit.

NATUROPATHIC SERVICES

Consultation	Duration	Fee
Initial visit	60 - 90 minutes	\$160.00 to \$240.00
Follow-up visit	30 - 45 minutes	\$80.00 to \$120.00

- CANCELLATION POLICY:** 48-hr notice is required for cancellations or you will be billed a \$75 cancellation fee.
- MISSED APPOINTMENTS:** A \$75 cancellation fee is charged for missed appointments unless proof of emergency is provided.
- \$25 processing fee for NSF cheques.
- All products sold are subject to GST.
- The clinic reserves the right to change fees at any time without notice.
- Please see the Clinic Policy posted at the Clinic for current fee guidelines and policies.

By signing the bottom of this policy, you are indicating that you have read and understood the above statements and agree to pay upon receiving the products and services as outlined.

Signature: _____ Date: _____

Please indicate, "Yes" or "No", regarding the use of your email address for Clinic Announcements and appointment reminders:

Yes _____ No _____

INFORMED CONSENT TO NATUROPATHIC TREATMENT

Naturopathic Medicine uses natural approaches to the treatment and prevention of disease. Naturopathic Doctors (ND) take into account physical, mental and emotional aspects of the individual and develop treatment protocols based upon the unique needs of each individual. NDs generally use natural and non-invasive treatment modalities with the intention of stimulating the body's own inherent healing abilities.

Naturopathic Treatment Modalities

Dietary Counseling and Nutritional Supplements

Diet and nutrition are used to address possible nutrient imbalances and/or deficiencies, to treat and/or prevent illness and to improve overall health. This may include recommendations to include and/or avoid particular foods, and the use of nutritional supplements that may include vitamins, minerals and/or other nutrients, plant and/or animal matter, enzymes, or amino acids.

Lifestyle and Wellness Counseling/Coaching

Your ND will help you to identify the lifestyle factors that may be negatively impacting your health. This may include identifying risk factors for illness and providing recommendations for reducing your risk.

Botanical (Herbal) Medicine

Refers to the use of plant-derived products in the treatment and/or prevention of illness and can include teas, tinctures (alcohol-based preparations), baths, topical applications (creams, ointments, etc.), capsules or tablets.

Oriental Medicine and Acupuncture

Can include acupuncture (the insertion of thin, sterile needles into specific points in the skin and underlying tissues, diet therapy, moxa or moxibustion (the burning of a stick of compressed herb over acupuncture needles that have been inserted into the skin and underlying tissue), herbal formulas, and the examination of the tongue and pulse for diagnostic purposes.

Homeopathy

Refers to the use of minute doses of plant, mineral and/or animal matter to treat and/or prevent illness.

Physical Medicine

Physical medicine can include the use of soft tissue and joint manipulation as well as hydrotherapy (the use of hot and/or cold water to manipulate the circulation of blood and lymphatic fluid in the body and to stimulate the immune system.) This may also include the use of Laser therapy to help heal chronic tissue inflammation and injuries by using low-intensity lasers and infrared lights to warm the tissues and improve circulation.

Consultation Visits

Consultations can vary depending upon your requirements or requests. Initial consultations and interpretation of test results take approximately 60 to 90 minutes, while most follow-up consultations are approximately 30 minutes. The initial consultation may include an extensive health history review, a detailed discussion of your main health concerns, and physical examination as required.

Your ND may request information, such as results of recent tests that may have been performed, from your other healthcare practitioners (medical doctor, chiropractor, etc.) in order to create a complete health profile. Your ND may recommend laboratory blood tests, biochemical tests, and/or other tests as required. You will be informed of the cost of all tests before they are performed and have the right to refuse any test.

Treatment Risks

Naturopathic medicine utilizes primarily non-invasive and low-risk treatment modalities. You will be informed of the cost of all treatments before they are performed and have the right to refuse any treatment. However, all therapies are associated with some potential risks. Side effects from naturopathic treatments are relatively uncommon but can include (but not limited to):

Aggravation of symptoms, allergic reactions to herbs or supplements, complications from acupuncture (pain, bruising, bleeding, lightheadedness or fainting, nausea and vomiting, puncture of internal organs), injury to soft tissues and/or joints/bone/spine arising from the use of physical medicine, accidental burns associated with the use of moxa, or unforeseen interactions between recommended herbs/supplements and over the counter or prescription medications.

Confidentiality

A record of all interactions with your ND including health history, exams/tests performed and treatments recommended will be kept by your ND. This record is kept strictly confidential and is not released to others without written consent provided by you or your representative or unless your ND is required to do so by law. Information from your file may be used for the purposes of research, teaching, or development of treatment protocols. In all cases, your identity will be protected. In the event that you require naturopathic consultation and/or treatment and your regular attending ND is not available, the ND substituting for your regular ND will be permitted full access to your naturopathic health record for the purposes of providing you with appropriate advice and/or treatment.

STATEMENT OF CONSENT

I understand the description of the treatment modalities that my naturopathic doctor may recommend for me. I understand that there may be potential risks and side effects of naturopathic treatment and that my naturopathic doctor cannot anticipate and/or explain all risks and complications that may arise. I agree that any questions or concerns that I may have about my naturopathic care will be addressed with my naturopathic doctor. I understand that my naturopathic doctor, like all medicine, cannot guarantee results. I further understand that advice and/or treatments offered to me by my naturopathic doctor are not intended to substitute for or replace advice and/or treatment provided by my other healthcare practitioners. With this knowledge I voluntarily consent to the diagnostic and therapeutic procedures outlined above which may be recommended by my naturopathic doctor except for (please list exceptions, if any).

This consent form is intended to apply to the entire course of my care by my naturopathic doctor (and/or naturopathic doctor substituting for him/her). I understand that at any time I may (in writing) withdraw consent for any further treatment and discontinue treatment at any time.

Signature of Patient or Guardian

Date