

Confidential Pediatric Intake Form

Today's Date _____

Child's Name: _____ Age: ____ Birthdate: _____ Sex: F M Adpoted: Y N
 Parent/Guardian/Caretaker Name: _____
 Address: _____ City: _____ Postal Code: _____
 Home Phone: _____ Business Phone: _____
 OHIP Number (Child): _____
 Profession: _____ Employed Full of Part-time: _____
 Employer: _____
 Check one: Married Single Widowed Divorced Separated Common law Same sex
 Person to notify in case of emergency: _____
 Phone Number: _____ Relationship: _____ Address: _____
 E-mail Address: _____

Family Medical History: Please check relevant areas for blood relatives, not including patient.

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hayfever, Allergies | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Thyroid Problems |

Current Health Condition

What health concerns/problems brought you into this office today? _____

Has anything recently changed or become worse? _____

Are you being treated by a medical physician now? Y N Name: _____

Current Medications

Please list all medications (for cough, asthma, ADHD, Diabetes, etc), non-prescription medications (Tylenol, allergy relief, etc) , vitamins, minerals, herbs, etc.

Known Allergies: such as medications, pollens, foods:

Hospitalizations, Surgeries, Serious Injuries: Date and reason for hospitalization:

Vaccination/Immunization History: please fill in the appropriate boxes

Vaccine	Age at each	Date(s) of each immunization:	Noted reactions/side effects:
Hep B			
HiB			
Polio			
MMR			
Varicella			

Other:

Please complete if your child is under 2 years of age. Prenatal Health History:

Mother's Health (write M) and Father's Health (write F) for each appropriate space.

Height: _____ Weight: _____

Smoker: Y N Smoked _____ Years, Amount/Day _____ Year Stopped: _____

Alcohol use: Y N Type: _____ Frequency: _____

Coffee: Y N _____ cups/day Soft Drinks: Y N _____ 8 oz servings/day

Artificial Sweeteners: Y N _____ teaspoons/day

Diet: Food Groups Avoided: _____ Why: _____

Diet: Food Cravings: _____

Diet: Do you consume dairy products? Y N

Regular exercise: Y N Type: _____ Duration: _____ Frequency: _____

Type of birth control used: _____

Did you take vitamins: Y N Please list them: _____

Is there anything regarding this child that should not be mentioned in his/her presence? _____

Post-Partum Health History (mother's health after birth):

Birth Experience: (Please write any details pertaining to the birth of this child that you feel are important to his/her well-being)

Delivery Information: Premature Post-Due _____ days Midwife Home Hospital

Induction Episiotomy Forceps/suction Other: (please describe)

Diet: Food Groups Avoided: _____ Why: _____

Diet: Food Cravings: _____

Diet: Do you consume dairy products? Y N Did you breast feed? Y N How long? _____

On a scale of 1 to 10 with 10 being the highest, please rate your stress _____ and energy levels _____

How many hours of sleep did you get per night? _____ Did you wake feeling rested?

Type of birth control used: _____

Did you take vitamins: Y N

Any new events/changes/symptoms/conditions that occurred during pregnancy? Y N

Physical Examination Notes (to be completed by physician).

as a newborn: Height: _____ Weight: _____ Apgar score: _____

currently: Head circumference if under age 3: _____ Chest circumference: _____

HNTTEE:

Head: Range of motion: _____ Skin: _____ Hair: _____

Masses: _____ Lymph Nodes: _____ Thyroid: _____

Nose and Throat : Frenulum: _____ Pharynx: _____ Gums: _____ Teeth: _____

Tonsils: _____ Mucosa: _____

Eyes: Nystagmus: _____ Strabismus: _____ Pupil Size: _____

Ears: _____ TM: _____ COL: _____ Hearing: _____

Lungs: Percussion/Auscultation: _____

Circulatory system: Pulses: Femoral R L Brachial R L

Musculoskeletal/Nervous System: Scoliosis: _____ Posture: _____

Range of Motion: Hips: Ortolani: +ve -ve Barlow's sign: +ve -ve

Gait: _____ Genu Valgum Genu Varum Coordination: _____

Muscle Tone: Good/Healthy spastic flaccid

Reflexes: Babinski +ve -ve Abdominal: +ve -ve Anal: +ve -ve

Cranial Nerve abnormalities: _____

Abdomen:

Hernia present on straining/crying: Y N Bowel Movements: _____

Liver: _____ Kidneys: _____ Masses: _____ Lymph Nodes: _____ Umbilicus: _____

Genitalia:

Discharge: _____ Urination: _____ Testicular Descent: Y N

Informed Consent to Treatment

This consent form applies to patients of the Naturopathic Doctors (ND) at the Armstrong Clinic for Naturopathic Medicine. By consenting to treatment you are authorizing your ND to have access to your file and personal information. Please see the privacy policy if you have questions about the use of your personal information by the Armstrong Clinic.

Even the gentlest therapies have their complication in certain physiological conditions such as pregnancy, lactation, in patients who are very young/very old, or in people who take multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, lung, heart, liver, or kidney disease. It is very important that you are completely forthright in informing your ND of any disease process currently going on in your body, if you are on any prescription medication or OTC drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding please inform your ND immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing conditions and symptoms
- Allergic reactions to supplement or botanical prescriptions
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting, organ puncture with acupuncture needles, accidental burning of the skin from the use of moxa.
- Muscle strains, sprains and disc injuries from spinal manipulation
- The potential for stroke or emboli is a concern in cervical spinal manipulation and proper pre-requisite tests will be done before such manipulations are performed to prevent such an outcome.

I understand that my ND keeps a record of services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that I must pay for all tests, in-office prescriptions and services when rendered, without refund after 14 days from purchase date. I understand that my identity will be protected and kept confidential.

I understand that my ND will answer my questions that I have to the best ability, in a manner, which I can comprehend. I understand that the results are not guaranteed. I do not expect my ND to be able to anticipate and explain all risks and complications. I will rely on my ND to exercise the best judgement in my best interests, based on the facts and findings then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below)

I intend this consent form to cover the entire course of treatment presented for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time in written or verbal format.

Patient Name: _____

Parent Signature if under 18 _____

Patient Signature: _____ Naturopathic Doctor: _____