

**New Patient Information**

Welcome to the Armstrong Clinic for Naturopathic Medicine!

We kindly ask that you complete the following intake form prior to your first visit.

This will help us to maximize your visit time.

**We also ask that you bring in the following:**

□All prescription and non-prescription medications (name, dose, frequency)

□All natural health product or supplement information (name, dose, frequency)

□Recent (within 3 months) lab test and diagnostic imaging results if applicable.

Thank you in advance for this preparation for your first visit to The Armstrong Clinic.

**Pediatric Intake**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Information** | | | | | | | | | |
| **Date** | |  | |  | |  | |  | |
| **First Name** | |  | | **Last Name** | |  | |  | |
| **Parent/Guardian** | |  | |  | | **Relationship** | |  | |
| **Address** |  | | **City** | |  | | **Postal Code** | |  |
| **Phone** |  | | **Cell** | |  | | **Email** | |  |
| **Age** |  | | **DOB: (yy/mm/dd)** | |  | | **Gender** | |  |
| **Preferred Form Communication** | | **□Phone** | | **□Email** | |  | |  | |
| **Emergency Contact** |  | | **Relation** | |  | | **Number** | |  |
| **How did you find out about our office?** | | | | |  | | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health concern/problems that brought you in?** | | | | |
| **1** | | | **2** | |
| **3** | | | **4** | |
| **Is a physician treating you currently?** | **□Yes** | **Name** | |  |
| **□ No** | **Phone** | |  |
| **Treatment Provided** |  |  | |  |

**Please list any concerns that you have about your child’s health and length of time:**

|  |  |
| --- | --- |
| Concern | Length of symptoms |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |

**Please list any medications (including over-the- counter) that your child has taken:**

|  |  |
| --- | --- |
| Medication | Dosage |
| 1. |  |
| 2. |  |

**Please list health products that your child is taking detail the reason and duration:**

|  |  |
| --- | --- |
| Natural Health Product | Dosage |
| 1. |  |
| 2. |  |
| 3. |  |
| 4. |  |

**Please list all known allergies: (Food, environmental, medications, etc.)**

|  |  |
| --- | --- |
| Substance | Reaction |
| 1. |  |
| 2. |  |
| 3. |  |

**Please list any known food sensitivities:**

|  |  |
| --- | --- |
| Food | Symptoms |
| 1. |  |
| 2. |  |
| 3. |  |

**FAMILY HISTORY**

What was the age of the parents at the time of the conception? Mother: \_\_\_\_\_\_Father:\_\_\_\_\_\_\_

What was their general state of health at that time?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mother | **□**Excellent | **□**Average | **□**Fair | **□**Poor |
| Father | **□**Excellent | **□**Average | **□**Fair | **□**Poor |

**Please indicate which of the following conditions apply to your child’s immediate family:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **□**Allergies | **□**Arthritis | **□**Asthma | **□**Autoimmune | **□**Birth Defects |
| **□**Bleeding disorders | **□**Cancer | **□**Deafness | **□**Depression | **□**Diabetes |
| **□**Eczema | **□**Heart Disease | **□**Hepatitis | **□**Herpes | **□**HIV/AIDS |
| **□**Hypertension | **□**Kidney Disease | **□**Mental Illness | **□**Peptic Ulcer | **□**Thyroid disease |
| **□**Visual Problems | **□**Speech problems | **□**Frequent infections |  |  |

**PRENATAL HISTORY (Relating to mothers health)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Mothers age at birth of child | /years | Number previous | | /Pregnancies | /Births |
| Any difficulties with fertility prior to pregnancy? | **□**yes  **□**no | What assistive techniques were utilized during delivery? | | 1. | 2 |
| **Please indicate if any of the following conditions were experienced during pregnancy:** | | | | | |
| **□**Diabetes | **□**Edema  (swelling) | **□**Emotional trauma | | **□**Depression | **□**Fainting |
| **□**Germen measles (Rubella) | **□**Herpes | **□**Nausea/  Vomiting | | **□**Physical Trauma | **□**Pregnancy induced hypertension |
| **□**Thyroid problems | **□**Toxemia | **□**Excessive weight gain | | **□**Weight loss |  |
| **Please list any medications taken during pregnancy (including over-the- counter)** | | | | | |
| 1. 1. | | | 3. | | |
| 2. | | | 4. | | |
| **Were any of the following used during pregnancy? Please indicate how much and for how long?** | | | | | |
| **□**Alcohol | **□**Tobacco | **□**Hormones | | **□**Laxatives | **□**Sedatives |
| **□**Antacids | **□**Recreational drugs | **□**Aspirin | | **□**Coffee | **□**Tylenol |
| **Please list any supplements/herbs taken during pregnancy.** | | | | | |
| 1. | | 3. | | | |
| 2. | | 4. | | | |
| **How would you describe the pregnancy?** | | | | | |
|  | | | | | |
| **Are you aware of any potential exposure to toxic substances prior or during pregnancy?** | | | | | **□**yes  **□**no |
| **Describe:** | | | | | |

**IMMUNIZATION HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Has your child ever travelled outside of Canada? | □yes  □no | If yes, where? |  |
| Did your child follow the Health Canada recommended immunization schedule? | □yes  □no | If no, what vaccines were given if any? |  |
| Any adverse reactions to immunizations? | □yes  □no | Describe: |  |

**BIRTH HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Length of gestation** | /weeks | /days |  |  |
| **Length of labor** | /hours | Spontanous  **□**yes **□**no | **Type of induction** |  |
| **Type of delivery** | **□**vaginal | **□** schdeuled cesarean | **□** emergency cesarean |  |
| **Location** | **□**home | **□**hospital | **□**birth center | **□**other |
| **Interventions** | **□**anesthesia | **□**epidural | **□**episiotomy | **□**forceps |
|  | **□**vaccum | **□**other |  |  |
| Childs weight at birth |  |  |  |  |
| **Did your child experience any other the following at or near delivery?** | | | | |
| **□**allergic reaction | **□**failure to thrive | **□**respiratory distress | **□**jaundice | **□**hypoxia |
| **□**seizures | **□**difficulty feeding | **□**meningitis | **□**fevers | **□**meconium |

**CHILD’S HEALTH HISTORY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Does your child sleep through the night? | | **□yes**  **□no** | | Number or hours nightly? | |  | |
| Does your child nap during the day? | | **□yes**  **□no** | | Does your child experience frequent nightmares? | | **□yes**  **□no** | |
| Which of the following conditions apply for your child. Please indicate C (current), and P (past). | | | | | | | |
| \_\_\_\_ allergies | \_\_\_\_diarrhea | | \_\_\_\_hair loss | | \_\_\_\_rheumatic fever | | \_\_\_\_asthma |
| \_\_\_\_ear infections | \_\_\_\_hearing problems | | \_\_\_\_rubella | | \_\_\_\_bed wetting | | \_\_\_\_easy bleeding |
| \_\_\_\_scarlet fever | \_\_\_\_bladder infections | | \_\_\_\_easy bruising | | \_\_\_\_eczema | | \_\_\_\_meningitis |
| \_\_\_\_body/breath odour | \_\_\_\_emotional trauma | | \_\_\_\_mood changes | | \_\_\_\_bronchitis | | \_\_\_\_eye infections |
| \_\_\_\_tonsillitis | \_\_\_\_frequent colds | | \_\_\_\_fractures | | \_\_\_\_frequent urination | | \_\_\_\_nosebleeds |
| \_\_\_\_vision problems | \_\_\_\_constipation | | \_\_\_\_pneumonia | | \_\_\_\_fungal infections | | \_\_\_\_whooping cough |
| \_\_\_\_strep throat | \_\_\_\_nausea | | \_\_\_\_stomach flu | | \_\_\_\_physical trauma | | \_\_\_\_cradle cap |

**NUTRITIONAL HISTORY**

|  |  |  |  |
| --- | --- | --- | --- |
| Was your child breastfed? | | □yes  □no | If so how long? |
| Age of child when solid foods introduced. | |  |  |
| **Please provide a brief list of solid foods given in order of approximate introduction, detail any reactions** | | | |
| **Food Group** | | **Age** | **Reaction** |
|  | |  |  |
|  | |  |  |
|  | |  |  |
| How would you describe your child’s eating habits/cravings? | |  | |
| **Please provide a general outline of your child’s daily diet.** | | | |
| Breakfast |  | | |
| Lunch |  | | |
| Dinner |  | | |
| Snacks |  | | |
| Water intake |  | | |
| Other fluids |  | | |

**HOME/SOCIAL HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| How would you describe your child’s temperament? | |  |  |  |
| How does your child interact with others?(adults and other children) | |  |  |  |
| How does your child handle stressful situations? | |  |  |  |
| How does your child express his/her emotions? | |  |  |  |
| How would you describe your child’s performance at school/daycare? | |  |  |  |
| How do you think others would describe your child? | |  |  |  |
| Does your child take part in any extracurricular activities? | |  |  |  |
| How many people live in your home? |  | Are there any smokers in your home? |  |  |
| Do you have any pets? |  | How would you describe the emotional balance in your home? |  |  |

**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, personal information, and authorizing payment of services and tests rendered. Please ask to review 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 prerequisite 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 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 a physical exam, diagnostic and therapeutic procedures, except for: (please list exceptions)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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.

Appointments missed or cancelled with less than 24 hours notice are subject to a $30 missed appointment fee. Client please initial as read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Sign: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature if under 18 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Naturopathic Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_