Jennifer Chen, B.Sc., N.D.
OPTIMAL HEALTH NATUROPATHIC & WELLNESS CLINIC
307-500 Sheppard Ave. E.,Toronto, ON M2N 6H7 (416) 222-4325

Pediatric Intake Form

Full Name: _____ Date: _____
(First) (Middle) (Last)

Date Of Birth: _____ Age: _____ Gender: _____ Tel No.: _____
dd / mm / yr

Complete Address: _____ City: _____ Postal Code: _____
Street No. Street Name Apt. No.

Emergency No.: _____ Mother's Name: _____ Father's Name: _____

Who does the child live with? _____
Emergency Contact: _____ Telephone No.: _____
Sibling (name(s), age(s)): _____
Medical Doctor's name: _____ Telephone No.: _____
Extended Healthcare Insurance Company (if applicable): _____
How did you find out about the naturopathic services at this clinic? _____

Chief health concerns in order of importance (including duration of complaint, previous treatment(s) and effect):

_____
_____
_____

Birth History:

Pre-natal History:
Previous pregnancies by natural mother, miscarriages, or complications: _____
_____

Health of mother before and during pregnancy (please check appropriate box(es) and elaborate where applicable (e.g. before or during pregnancy, frequency, duration):

☐ Illness	☐ Nausea/Vomiting
☐ Bleeding	☐ Medications (type, dosage)
☐ Toxemia	☐ Supplements (type, dosage)
☐ High blood pressure	☐ Cigarette smoking (amount)
☐ Alcohol ingestion	☐ Recreational drug use (type, frequency, amount)
☐ Diabetes	☐ Physical/Emotional Shock/Trauma
☐ Thyroid Problems	☐ Exercise (type, frequency)

Age of mother at child's birth _____ Age of father at child's birth _____

General health of mother before pregnancy: ☐ Poor ☐ Fair ☐ Very good ☐ Excellent
General health of father before pregnancy: ☐ Poor ☐ Fair ☐ Very good ☐ Excellent

Labour History:
Duration of Labour: _____ Baby's birth weight: _____ Length: _____
Vaginal or caesarean? _____ Physical or emotional trauma during delivery? (please specify):
_____

Complications or interventions during birth (e.g. breech birth, forceps, vacuum, epidural, episiotomy, etc.):
_____

Gestation: □ Term □ Premature □ Late

Expected arrival date: _____ Actual arrival date: _____
Was the pregnancy planned or unexpected? Reactions to the pregnancy? _____
_____

Neonatal History:
APGAR score: _____
State the approximate age at which your child reached the following milestones:
Sitting _____ Crawling _____ Walking _____
Talking _____ Toilet Trained _____ First Teeth _____

Feeding History:
Was the child breastfed? If so, for how long? _____
When was formula introduced? What type(s) of formula(s) has (have) been used? _____
_____
When were solid foods first introduced and what were they? _____
_____
Any noticeable reactions to any of the above foods? _____
_____

Vaccination History (please check appropriate box(es) and specify date where applicable)

TYPE OF VACCINATION	DATE
□ Measles, mumps, rubella (MMR)	
□ Diptheria, pertussis, tetanus (DPT)	
□ Hepatitis B	
□ Polio	
□ Hib	
□ Influenza	
□ Other (please specify)	

Medical History:
Past or present use of medication or supplements (please specify type, for what reason, at what age and for how long):
_____
_____
Allergies/adverse reactions to any of the above: _____
Has the child ever been hospitalized for any reason? If so, why and for how long? _____
_____
Has the child ever undergone surgery (including circumcision, if male)? If so, when and for what reason? _____
_____
History of trauma (mental, emotional physical): _____

Past or present illnesses and state of age of occurrence/frequency (if applicable):

□ Whooping cough	□ Asthma
□ Chicken pox	□ Tonsillitis
□ Measles	□ Ear infections
□ Mumps	□ Frequent colds
□ Rubella	□ Pneumonia
□ Other (please specify)	

Allergies and Intolerances (please check appropriate box(es)):

□ Dust/dust mites	□ Food (please specify)
□ Animal dander	□ Drug (please specify)
□ Pollen	□ Chemicals (please specify)
□ Other (please specify)	

Does or did your child ever experience any of the following symptoms (please check off those that apply)

□ anemia	□ heart murmur	□ rash/hives/eczema/cradle cap
□ bedwetting	□ high fever	□ seizures
□ colic	□ frequent colds/coughs	□ sleep problems
□ constipation	□ jaundice	□ stomach problems
□ diarrhea	□ night sweats	□ wheezing
□ gas	□ nosebleeds	□ other (please specify)

Family History (please check any of the health conditions that have afflicted any members of your family):

□ chemical allergies	□ birth defects	□ hypertension
□ environmental allergies	□ cancer	□ mental illness
□ food allergies	□ diabetes	□ stroke
□ arthritis	□ heart disease	□ tuberculosis
□ other		

Please list age and health or age and cause of death of:
Child's Mother: _____ Child's Father: _____
Child's siblings: _____
Child's Maternal Grandmother: _____ Child's Maternal Grandfather: _____
Child's Paternal Grandmother: _____ Child's Paternal Grandfather: _____

General Information:
Child's sleep patterns (first year; including where, with whom, napping, regimen, nightmares, difficulty falling asleep, difficulty staying asleep, etc.): _____
_____

Schooling History (Daycare? Pre-school? Home? Private? Public School?): _____
_____
Interests/Hobbies: _____
Temperament/Personality: _____
Behavioural Problems: _____
Relationship with Family (please describe): _____
Relationship with Others in school: _____
School Performance: _____

Has the child undergone: special scholastic tests (please specify)?

TYPE OF TEST	DATE
□ Audio testing	
□ Speech/Language	
□ Visual testing	
□ Other (please specify)	

Is there anything else that you would like to add about your child's health?: _____
_____
_____
_____

Thank you for taking the time to fill out this form

Statement of Acknowledgement and Informed Consent to Treatment

N.B. This form must be completed before any treatment will be rendered.

Naturopathic medicine is personalized, complete, and co-ordinated system of healthcare which utilizes natural therapies and gentle techniques in order to empower an individual to achieve optimal health and well-being.

In order to clarify my position as your health care practitioner, as well as to establish our mutual responsibilities in your health care, I ask for you co-operation in signing this statement of acknowledgement and informed consent. In doing so, you understand that:

1. Any treatment prescribed or recommended to you is not mutually exclusive from any treatment or advice that you are now receiving or that you may receive in the future from another licensed health care practitioner.

2. Treatment and or/referral to other health care practitioners is based on the assessment of your health as determined by: personal history, physical examination, laboratory testing and other appropriate methods of evaluation. You are at liberty to seek or continue medical care from a doctor of conventional medicine (M.D.) or any other licensed healthcare practitioner in Ontario.

3. I reserve the right to determine which cases fall outside my scope of practice, in which case an appropriate referral will be recommended.

4. While the treatment prescribed or recommended to you, including, but not limited to, changes in dietary habits, lifestyle changes, and exercise programs are not mandatory, per se, failure to follow sound nutritional advice and lifestyle modification programs will hinder expected positive results.

5. You are accepting or rejecting this care of your own free will

6. The ultimate responsibility for your health care is your own and that I am here to guide you in your journey towards better health. I reserve the right to discontinue treatment, should it be apparent that your expectations and what I can provide are not in agreement.

7. You understand that all fees for services and supplements are payable at the time of the appointment by the patient or guardian. As well, notice of 24 hours is required for appointment cancellation, otherwise, an administrative fee will be charged.

I,_____, have read, understood, and acknowledge the above statements.
(parent/guardian)

Signature:_____ Date:_____