www.monctonnaturopathic.com
12 Fifth Street, Moncton, NB, E1E 3G9
Ph: 506-382-1329 Fax: 506-382-1828

Pediatric Intake Form (Birth - 5 years)

Patient's name: ____________________________________ Date of first visit: ______________________
Age: ________ Date of Birth: _________/_____/_____ Gender (circle one): female or male
Mother's name:______________________________ Father's name: ______________________________
Address: ____
City: ___________________________ Province: ____ Postal Code: ___________________
Phone # (home): (___)________________________Parents # (work): (___)________________________
NB Medicare #: ____
Parents e-mail address: ____
Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: _____________________
____
Which is your preferred contact method for visit reminders (circle one)? email or phone
Which is your preferred spoken language during office visits (circle one)? English or Français

How did you hear about this clinic (be as specific as you can)? ______________________________

Reason for referral or presenting problems: ____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_______	______	Antibiotics	_______	______
Tylenol	_______	______	Anti-histamine	_______	______
Decongestant	_______	______	Other	_______	______
Ibuprofin	_______	______	Allergies to medicines	___________________	

Please list **any** prescription medications, over the counter medications, <u>vitamins</u> or other <u>supplements</u> your child is *currently* taking:
1) ___________________________________ 3) ___________________________________
2) ___________________________________ 4) ___________________________________

MEDICAL HISTORY (Y/N)

_______ Chicken pox _______ Scarlet fever _______ Tonsillitis, approx. no. _______________
_______ Measles _______ Pneumonia _______ Ear infections, no. _________________
_______ Mumps _______ Frequent colds _______ other (please list) __________________
_______ Rubella _______ Rheumatic fever

Has your child had any of the following tests?	<u>When</u>	<u>Where</u>	<u>Results</u>
Electroencephalogram	....	....	....
Psychological evaluation	....	....	....
Hearing	....	....	....
Speech/Language	....	....	....

Injuries/Surgeries/Hospitalizations (please list): ____
____

IMMUNIZATIONS

_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria
_____ Mumps _____ DPT _____ Tetanus _____ Influenza
Others (list) ____

Any adverse reactions? Y N What ? ____

FAMILY HISTORY

_____ Heart disease _____ Diabetes _____ Birth defects
_____ Hypertension _____ Arthritis _____ Tuberculosis
_____ Cancer _____ Allergies _____ Mental illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? ________________________________

____

Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid problems _____ Diabetes

BIRTH HISTORY

Term: Full __________ Premature ___________ Late _______ Weight at birth____________________
Length of labor _____________ Complications? ______________________________________
Did your child have any of the following problems shortly after birth?

_______ Birth defects _______ Birth injuries _______ Blue baby
_______ Cerebral palsy _______ Seizures _______ Jaundice
_______ Colic _______ Fever _______ Rashes

Other (explain) ____

Child's sleep patterns (first year) ____

Food intolerances (if any) ____

Feeding: Breastfed? _____ how long? __________ Formula? __ milk / soy / other________________________

Age began solids ________________________ Which foods? ____________________________________

Age began: Sitting ____________ Crawling ____________ Walking _____________ Talking _________________

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_______ Hives
_______ Eczema
_______ Bleeding gums
_______ Nose bleeds
_______ Acne
_______ High fevers
_______ Chronic rash
_______ Hearing loss
_______ Diarrhea
_______ Sore throats
_______ Headaches
_______ Frequent colds
_______ Wheezing
_______ Cough
_______ Burning of urine
_______ Frequent urination
_______ Heart murmur
_______ Vomiting spells
_______ Anemia
_______ Stomach aches
_______ Jaundice
_______ Easy bruising
_______ Flat feet
_______ Constipation
_______ Gas
_______ Bleeding tendency
_______ Joint pains
_______ Dizzy spells
______ Bloody urine
______ Cries easily
______ Nervous
______ Sleep problems
______ Night sweats
______ Sensitive to light
______ Body/breath odor
______ Motion/car sickness
______ No appetite
______ Nightmares
______ Canker sores
______ Unusual fears
______ Excessive fatigue
______ Hair loss

DIET

Please describe your child's typical daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To Drink: ____

Thank you. We look forward to helping your child in any way we can.

Moncton Naturopathic
Medical Clinic - Clinique Médicale

www.monctonnaturopathic.com
90 Weldon St, Moncton, NB, E1C 5W2
Ph: 506-382-1329 Fax: 506-382-1828

Declaration and Informed Consent for Naturopathic Care

We would like to take this opportunity to welcome you. Your naturopathic doctor will conduct a thorough case history, physical examinations (when indicated) and may recommend specific blood, urinary or other laboratory reports as part of the treatment work-up. Your naturopathic doctor integrates supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

Statement of Acknowledgement
Printed name of patient: ________________________

As a patient, I have read this information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided in this intake form is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms;
- allergic reactions and other adverse effects to supplements, homeopathics or herbs;
- pain, fainting, bruising or injury from acupuncture, venipuncture or intramuscular vitamin injections; and
- muscle strains, sprains and spasms, disc injuries from spinal manipulations.

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. It is highly recommended that I update my health care providers of any new treatments.
- I also confirm that I have the ability to accept or reject this care of my own free will and choice. I understand results are not guaranteed. I accept full responsibility for any fees incurred during care and treatment.
- I understand that a record will be kept of my visits. This record will be kept confidential and **will not be released** without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for **payment at the time services are rendered.** Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.
- I understand that your naturopathic doctor reserves the right to determine which cases fall outside of his scope of practice, in which case the **appropriate referral will be recommended.**
- I have read and understand the **Privacy Policy** which is available on the clinics website at www.monctonnaturopathic.com (see Forms).

I consent to receive naturopathic treatment. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: ______________________ Date: _____________