Dr. Barbara Dao, N.D.
Dr. Devangi Patel, N.D.

24 George St. N Cambridge, ON N1S 2M8
Tel: (519) 623-7800

NATUROPATHIC CHILD INTAKE FORM

Child's name ____________________________ Date of birth ______________________________

Sex: M F

Parent or guardian ____

Address ____ Postal Code ___________

Phone number: Home ____________________________ Cell ________________________________

Email ____ Would you like to receive e-news? Yes No

How did you hear about us? ____

Other health care providers:

Name _____________________________________ Title ___________________________________

Address ____

Phone ____

Name _____________________________________ Title ___________________________________

Address ____

Phone ____

Please list your child's health concerns in order of importance

1. ____
2. ____
3. ____
4. ____

Current height __________________________ Weight _____________________________________

Ethnicity ____

Religion ____

MEDICAL HISTORY

Please indicate which of the following illnesses your child has had:

❑ rubella (german measles)	❑ measles	❑ mononucleosis
❑ chicken pox	❑ mumps	❑ impetigo
❑ scarlet fever	❑ roseola	❑ strep throat
❑ whooping cough		

How many times per year does your child get:

1. Ear infections	❑ never	❑ rarely	❑ once	❑ 2-3 times	❑ more than 3x
2. Colds	❑ never	❑ rarely	❑ once	❑ 2-3 times	❑ more than 3x
3. Flu	❑ never	❑ rarely	❑ once	❑ 2-3 times	❑ more than 3x

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Please list any other illnesses, severe injuries, or any hospitalizations your child has had. Include approximate dates:

____
____
____
____

Does your child have any allergies (medications, environmental, etc)?

____
____

Please list all current medications (prescription, over the counter, supplements, etc.)

____
____
____

How many times has your child been treated with antibiotics? _________________________

Vaccinations: Please fill out OR provide a copy of your child's immunization record

At what age did your child receive his/her first vaccination? __________________________
Please indicate what vaccinations your child has had and date received if possible:

	Date received		Date received
❑ DPT (diptheria, pertussis, tetanus)	___________	❑ Tetanus booster	___________
❑ MMR (measles, mumps, rubella)	___________	❑ Polio	___________
❑ Haemophilus influenza	___________	❑ Flu	___________
❑ Meningicoccal	___________	❑ Pneumococcal	___________
❑ Varicella (chicken pox)	___________	❑ Hepatitis A	___________
❑ Hepatitis B	___________		

Please indicate if any caused adverse reaction

____
____

Do you have concerns about your child's hearing? ❑ Yes ❑ No
Has your child's hearing been tested? ❑ Yes ❑ No
Do you have concerns about your child's vision? ❑ Yes ❑ No
Has your child's vision been tested? ❑ Yes ❑ No

Comments:____
____
____

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PRENATAL HISTORY

Health status of parents at time of conception

Mother ❑ poor ❑ fair ❑ good ❑ excellent ❑ unknown
Father ❑ poor ❑ fair ❑ good ❑ excellent ❑ unknown

Were any measures taken to conceive?
❑ fertility drugs ❑ in vitro fertilization ❑ other ________________________

Health status of mother during pregnancy
❑ poor ❑ fair ❑ good ❑ excellent ❑ unknown

Age of mother at child's birth__________

Mother's diet during pregnancy
❑ poor ❑ fair ❑ good ❑ excellent ❑ unknown

Any food cravings experienced during pregnancy?
____

How much weight gain during pregnancy? ____

Did the mother experience any of the following health concerns during pregnancy?
❑ Bleeding ❑ High blood pressure ❑ Nausea ❑ Vomiting
❑ Diabetes ❑ Thyroid problems ❑ Seizures
❑ Flu ❑ Physical or emotional trauma
❑ Other: ____
____

Did the mother use any of the following during pregnancy?
❑ Tobacco, If yes how much?_____________ ❑ Alcohol, If yes how much? ___________________
❑ Recreational drugs, If yes how much? ____
❑ Prescription medications: ____
❑ Over the counter medications: ____
❑ Vitamins and supplements: ____
❑ Other: ____

BIRTH HISTORY

What was the term length of the pregnancy? ____
How long did the labour last? ____
Who delivered the child? ____
Was the delivery: ❑ in hospital ❑ in a birthing centre ❑ at home ❑ other ________________
Any labour complications? ____
Was the birth: ❑ vaginal ❑ c-section ❑ induced
Were any interventions used? ❑ forceps ❑ vacuum ❑ anaesthesia ❑ antibiotics
❑ other ____
Child's weight at birth __________________ length at birth _____________________________
Head circumference at birth _____________ APGAR Score ______________________________
Did the child experience any of the following at birth or shortly after birth?
❑ jaundice ❑ rashes ❑ seizures ❑ birth injuries _______________________________
❑ birth defects ____
❑ other ____

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ENVIRONMENT

Does your child live in: ❑ apartment ❑ house ❑ other ________________________
What is the approximate age of the building? ____
Recent renovations? ____
How is the house heated? ❑ furnace ❑ electric heat ❑ other __________________
Please indicate if your child is regularly exposed to any toxins or hazards that you are aware of:
____
____
Exposure to household smoke:
❑ always ❑ often ❑ sometimes ❑ rarely ❑ never
Does your household have any pets?
____

LIFESTYLE

Does your child live with
❑ mother ❑ father ❑ both ❑ guardian ___________________________
How many siblings? ___________
Age/sex of each one ____
Who is responsible for childcare?
____
____
Is your child in: ❑ daycare ❑ elementary school ❑ high school ❑ home-schooled
What are the child's favourite activities? ____
____
How much time is spent watching TV / playing videogames per day?
❑ > 3 hours ❑ 1-3 hours ❑ < 1 hour ❑ none
How much time is spent in physical activity per day?
❑ > 3 hours ❑ 1-3 hours ❑ < 1 hour ❑ none
How long is an average night's sleep?
❑ < 7 hours ❑ 7-8 hours ❑ 9-10 hours ❑ > 10 hours
Please indicate if any of the following apply:
❑ sleepwalking ❑ talking in sleep ❑ wake frequently ❑ bed-wetting
❑ nightmares ❑ other ____

DIET

How was your child fed as an infant?
❑ formula, what kind? ____
❑ breast-milk, for how long? ____

Food introduction (approximate):
At 6 months: ____
At 9 months: ____
At 12 months: ____
At 15 months: ____

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Typical foods consumed now:
Breakfast ______________________________
Lunch ______________________________
Dinner ______________________________
Snacks ______________________________
Drinks ______________________________

How much water does the child consume? ______________________
Food sensitivities?
❑ Dairy ❑ Wheat ❑ Corn ❑ Peanuts ❑ Other ____________

Dietary restrictions (eg. religious, vegetarian, etc.)? ____________________

Appetite: ❑ Large ❑ Moderate ❑ Small
Thirst: ❑ Large ❑ Moderate ❑ Small

FAMILY HEALTH HISTORY

Identify any family members (eg. mother, father's mother, brother) who have each of the following diseases/conditions:
❑ Juvenile Arthritis ______________________________
❑ Heart Disease ______________________________
❑ Cancer ______________________________
❑ Allergies______________________________
❑ Asthma ______________________________
❑ Eczema ______________________________
❑ Kidney Disease ______________________________
❑ Mental Illness ______________________________
❑ Sickle cell anemia ______________________________
❑ Other genetic condition ______________________________

Do either of the parents have a chronic illness? Please describe ______________
____

HEALTH & DEVELOPMENT

Age (in months):
sit up ______ first tooth _______ crawling ______ walk ______ talk _______

How would you describe your child's temperament?
____
____

How would you describe your child's behaviour at school?
____
____

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POLICIES AND PROCEDURES

Please note the following pricing policy:

Type of Visit	Duration	Cost
First visit	60 minutes	$135.00
Follow up visits	15 minutes 30 minutes 45 minutes	$ 35.00 $ 70.00 $ 95.00
Missed appointment fee		$ 40.00

Payments are due at time of service, payable by debit, credit card, cash or cheque.

A receipt will be issued for insurance purposes. Please check with your insurance provider to see if you have any Naturopathic coverage.

Direct billing is available with some insurance providers, please ask us for more details.

Lab Services

Lab tests are available as part of your health assessment. Cost is dependent on the test and may be covered by your insurance provider. These include:

- Food sensitivity test
- Celiac test
- Candida test
- Heavy metal test (hair and urine tests)
- Blood testing

Professional Supplements

Supplements may be prescribed at some of your child's visits. For your convenience we carry a variety of professional grade supplements. You may purchase them in office, or you may purchase your supplements from a health food store of your choice.

Cancellations

If you need to cancel your appointment, please call us as soon as possible. **Failure to give 24 hours notice will result in a missed appointment charge.**

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INFORMED CONSENT

The principles and practices of Naturopathic Medicine and other supportive therapies will be practiced to assist the body's own ability to heal and to improve the quality of life and health through natural means. Your ND will conduct a thorough case history and a physical exam. She may also request additional blood and/or urinary laboratory or functional tests as part of your naturopathic work-up.

It is important to recognize that even the gentlest therapies come with some health risk. These risks include:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from acupuncture or intramuscular injection

Although generally safe, some treatments have the potential for complications in certain physiological conditions. Thus, it is important to provide a complete health history and advise the ND of:

- all current medications (including over the counter drugs and supplements) and any changes in these medications
- pregnancy or breastfeeding status

PRIVACY POLICY

Protecting your personal information is of vital importance to us. Our privacy policy is as follows:

- only necessary information is collected about you
- only with your consent do we share information with others outside the clinic
- storage, retention and destruction of your information complies with existing law
- our policy conforms to privacy legislation and standards of the College of Naturopaths of Ontario

We collect personal information in order to:

- assess your health and provide treatment
- establish and maintain contact with you for appointments, billing and follow-up care
- facilitate your insurance claims
- comply with regulatory requirements and laws under the College of Naturopaths of Ontario

I have read the Naturopathic Pricing Policy posted, and I understand that I am fully responsible for any fees relating to any services rendered or products sold to me.

I have read the cancellation policy and understand that 24 hours notice is required to avoid charges.
I have also read and understood the consent form and privacy policy.

Date: ____

Patient Name: ____

Parent or Guardian Signature: ______________________________________

Naturopathic Doctor's Signature: ______________________________________