Pediatric Intake Form

Full Name: _____ Date: _____
(First) (Middle) (Last) (dd/mm/yy)

Age: _____ Birth date: _____ Sex: _____ Gender: _____
(dd/mm/yy)

Contact Information

Address: _____ City: _____ Postal: _____
(Street No.) (Street Name) (Apt. No.)

Home Phone: _____ Work Phone: _____ Other: _____

E-mail Address: _____ Relationship to child: _____

May we leave messages relating to your visits? □ Y □ N. Which Phone Number: _____

Emergency Contact Information

Emergency Contact Name: _____

Phone: _____ Relationship to child: _____

Other Health-care Providers

Names and types of other Healthcare providers:

1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

Date of last medical visit: _____ Date of last physical exam: _____
(dd/mm/yy) *(dd/mm/yy)*

How did you hear about this clinic?

If referred, please state by whom?

Have you been treated by Naturopathic Doctor before? □ Y □ N

If yes, by whom? _____ Date of last ND visit? _____
(dd/mm/yy)

Health Assessment Questionnaire

Chief Concerns (please list in order of importance):

1. _____
2. _____
3. _____
4. _____
5. _____

Medications/Supplements/ Drugs

Please list all the current prescription medications:

Name	Dose	Frequency	Duration	Side effects (any)

List all past medications: _____
_____

Please list all the current supplements, vitamins, herbs, homeopathic, over-the-counter, non-prescription medications:

Name	Dose	Frequency	Duration	Side effects (any)

Medical History

How would you describe your child's general state of health? □ Excellent □ Good □ Fair □ Poor

Please list any major trauma, accident, illness, injuries, surgeries, and hospitalizations:

Incident/Procedure	Date	Long term effect/results

Please indicate what immunizations the child has had:

□ DPT (diptheria, pertussis, tetanus) □ Haemophilus Influenza B □ Hepatitis A
□ Tetanus booster; when? □ "Flu" □ Hepatitis B
□ MMR (measles, mumps, rubella) □ Polio □ Smallpox
□ Other:_____

Please indicate if any caused adverse reactions:_____

_____

Current Weight: _____Height: _____Weight 1 year ago: _____

Date of last dental check up: _____ Any mercury fillings? □ Y □ N If yes, how many? ____

Does the child have any known allergies? □ Y □ N If yes, please list the allergies:_____

_____

Does the child have any food allergies or sensitivities? Please list: _____

_____

Is the child on a restricted diet? □ Y □ N Has the child ever been on a restricted diet? □ Y □ N

Please describe: _____

_____

Describe the child's typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluid intake: _____

Childhood Illnesses

Please check all that apply and indicate child's age at time of infection:

□ Chicken Pox _____ □ Polio _____ □ Strep Throat _____ □ Fifth's Disease _____
□ Pneumonia _____ □ Frequent colds _____ □ Rubella _____ □ Ear infections _____
□ Rheumatic Fever _____ □ Scarlet Fever _____ □ Hand, foot & mouth _____ □ Measles _____

Please check any of the following that your child has experienced in the PAST (P) or CURRENT (C)

General

	P	C		P	C		P	C
Chills			Poor sleep			Fatigue		
Night sweats			Weight gain/loss			Sweat easily		

Head, Eyes, Ears, Nose and Throat (HEENT)

	P	C		P	C		P	C
Headaches			Eyes bothered by sun			Stuffiness		
Head injury			Itching in eyes			Hay fever		
Dizziness			Redness in eyes			Sinus problems		
Impaired vision			Discharge from eyes			Frequent sore throat		
Glasses/contacts			Tearing/dryness in eyes			Sore tongue/mouth		
Eye pain			Impaired hearing			Gum problems		
Blind spot			Earache			Hoarseness		
Double vision			Discharge from ears			Dental cavities		
Glaucoma			Ear infections			Loss of taste		
Cataracts			Frequent colds			Other		
Blurring			Nose bleeds					

Neck

	P	C		P	C		P	C
Lumps			Swollen glands			Goiter		
Pain			Stiffness			Other		

Respiratory

	P	C		P	C		P	C
Difficulty breathing			Pain with a deep breath			Pneumonia		
Cough			Production of mucus			Asthma		
Bronchitis			Coughing blood			Pleurisy		
Emphysema			Shortness of breath			Last chest x-ray		
Tuberculosis			Shortness of breath at night			Other		
Tuberculin test			Shortness of breath lying down					

Blood/lymphatic

	P	C		P	C		P	C
Anemia			Past transfusions			Lymph node swelling		
Easy bleeding			Easy bruising					

Skin and Hair

	P	C		P	C		P	C
Rashes			Eczema, hives			Itching		
Acne, boils			Loss of hair			Dandruff		
Dryness			Ulcerations			Skin cancer		
Recent moles			Change in hair/skin texture			Color change		
Lumps			Dryness/moistness			Temperature		
Nail changes			Other					

Cardiovascular

	P	C		P	C		P	C
Fainting			High blood pressure			Cold hands or feet		
Chest pain			Low blood pressure			Irregular heartbeat		
Angina			Swelling of ankles/feet/hands			Varicose veins		
Murmurs			Blood clots			Heart disease		
Rheumatic fever			Palpitations, fluttering			Cyanosis		

Gastrointestinal

	P	C		P	C		P	C
Trouble swallowing			Change in bowel movements			Indigestion		
Heartburn			Blood in stool			Diarrhea		
Change in thirst			Belching/passing gas			Rectal bleeding		
Change in appetite			Jaundice			Hemorrhoids		
Nausea			Liver disease			Black, tarry stool		
Vomiting			Gall bladder disease			Abdominal pain		
Vomiting blood			Hernia			Food allergy		

Urinary

	P	C		P	C		P	C
Frequent urination			Unable to hold urine			Blood in urine		
Kidney stones			Frequency at night			Frequent UTIs		
Decrease in flow			Urgency to urinate			Hesitancy		
Pain on urination			Increased frequency			Other		

Musculoskeletal

	P	C		P	C		P	C
Joint pain/stiffness			Weakness			Broken bones		
Backache			Muscle spasms/cramps			Joint swelling		

Neurologic

	P	C		P	C		P	C
Fainting			Seizures/convulsions			Paralysis		
Muscle weakness			Numbness/tingling			Loss of memory		
Loss of balance			Involuntary movement			Speech problems		

Endocrine

	P	C		P	C		P	C
Thyroid trouble			Heat/cold tolerance			Excessive thirst		
Excessive hunger			Excessive urination			Excessive sweating		
Diabetes			Hypoglycemia					

Family Medical History

Indicate which close relative (parent, sibling, grandparent) has any of the following:

□ Cancer _____
□ Asthma _____
□ Diabetes _____
□ Allergies _____
□ Seizures _____
□ Alcoholism _____
□ Arthritis _____
□ High Blood Pressure _____
□ Depression _____
□ Heart Disease _____
□ Thyroid Disease _____
□ Stroke _____
□ Kidney Disease _____
□ Other _____

Please list all family members the child lives with: _____
_____

Prenatal History

Was the child conceived naturally? □ Y □ N
Any fertility interventions? □ Y □ N
Please describe: _____

Any illness or difficulties during pregnancy? Check all that apply.

□ Bleeding □ Hypertension □Physical trauma □Diabetes □ Illness
□ Vomiting □ Thyroid problems □ Emotional trauma □ Nausea □ Other: _____

Please list any drugs, alcohol, cigarette smoking or medications taken during pregnancy: _____

_____

Please list any vitamins or other supplements taken during pregnancy: _____

_____

Mother		Father	
Health at conception		Health at conception	_____
Age at birth		Age at conception	_____

Pregnancy weight gain _____

Birth History

How long was the pregnancy? □ Full term □ Late □Premature # of weeks:
Was the labour? □ Spontaneous □ Induced Duration:
Were there any difficulties or complications? _____
What type of delivery? □ C-section □ Vaginal □ Hospital □ Home birth
Were any interventions used? □ Epidural □ Episiotomy □ Forceps □ Suction
Was mom Strep B positive? □ Y □ N Were antibiotics given during birth? □ Y □ N
Baby's Birth Weight: ____Length: _____ APGAR Score 1 min _____ 5 min_____

Neonatal History

Any difficulties or complications soon after birth? Check all that apply:

□ Anemia □ Convulsions □ Poor feeding □ Birth defects
□ Infections □ Rashes □ Colic □ Jaundice
□ Respiratory distress □ Other _____

Age began: Sitting: _____ Crawling: _____ Talking: _____ Walking: _____
Any problems with teeth? □ Y □ N _____ Age of 1st tooth: _____
How would you characterize your child's development?
Physically □ Slow □ Average □ Fast Mentally □ Slow □ Average □ Fast
Has your child started puberty? □ Y □ N If yes, when? _____

Nutrition

Breast Fed? □ Y □ N How long? _____
Formula Fed? □ Y □ N Age started? _____ Type? _____
Solids? □ Y □ N Age started? _____
First foods introduced: _____

Please describe eating habits: _____

_____

Sleep Patterns

Please describe your child's sleep patterns during the first year: _____

_____

Usual bed time: _____ Usual wake time: _____

Any napping during the day? □ Y □ N Describe: _____

Any difficulties falling asleep or staying awake? □ Y □ N Describe: _____

Environment

Is your child exposed to significant tobacco smoke (work, home, etc.)? □ Y □ N

Is your child frequently exposed to animals (work, pets, etc.) □ Y □ N

How is your home heated? _____

Is your child regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?_____

_____

How would you describe the emotional climate of your home? _____

_____

Personality & Behaviour

Please describe your child's daycare or school (if applicable) experience in terms of enjoyment, performance and socialization: _____

_____

What are your child's interests? _____

_____

How many days per week does your child participate in out-of-school programs? _____

_____

How many hours per day does your child use:
Television: _____ Computer: _____ Video games: _____ Tablets/other: _____
Does your child use a cell phone? □ Y □ N
Is your child particularly sensitive to any of the following? Check all that apply.

□ Claustrophobia	□ Drafts	□ Heights	□ Smells	□ Wind
□ Cold	□ Heat	□ Music	□ Sunlight	□ Wool

Briefly describe your child's personality, including both positive and negative characteristics:

_____

_____

Is there anything that you feel is important that has not been covered? _____

_____

Consent to Treatment of a Minor

Patient Information

First Name: _____ Last Name: _____

Male □ Female □ Age: _____

I authorize Arashdeep Khaira, ND, who has been engaged by me and such other naturopathic practitioners and assistants as she may select or approve, to examine and administer naturopathic care and treatment to _____whose relationship to me is as a _____.

I have been given an explanation of and understand the nature of the naturopathic medical care and treatment.

I authorize Arashdeep Khaira, ND, to take whatever measures she considers necessary or desirable in connection with such naturopathic care and treatment.

This consent is modified as follows: _____

_____

My name, address and telephone number, or that of another contact person for the patient (whichever is appropriate) is as follows:

_____

_____

_____

Dated on this _____of _____, _____.
(day) *(month)* *(year)*

_____ _____

Parent or guardian of minor – print name *Signature*

_____ _____

Witness – print name *Signature*

Arashdeep Khaira, ND

Patient Consent Form for Collection, Use and Disclosure of Personal Information

Privacy of your information is an important part of our office, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.

Our privacy policy outlines what we will do to ensure that:

- Only necessary information is collected about you;
- We only share information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;

How we Collect, Use and Disclose Patients' Personal information

We understand the importance of protecting your personal information. To help you understand how we are doing that, we have outlined how we will be using and disclosing your information.

We will collect, use and disclose information about you for the following purposes:

- To assess your health concerns
- To provide health care
- To advise you of the treatment options
- To establish and maintain contact with you
- To remind you of upcoming appointments
- To communicate with other treating health-care providers
- To allow us to efficiently follow-up for treatment, care and billing
- To complete claims for insurance purposes
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advice authorities of child abuse and reporting diseases and individuals who may be an imminent threat to harm themselves or others
- To comply generally with the law
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for practice sale.

By signing this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information as outlined above

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Patient Consent

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I agree that the office can collect, use and disclose personal information about _____ as set out above in the information about the office's privacy policy. (Print Name)

_____ _____

(Print Name) (Signature)

_____ _____

Date Signature of Witness