



### PEDIATRIC INTAKE FORM

*Every detail you provide on this form will remain confidential and will contribute to achieving your child's health goals. Where possible, we ask that the child's primary caregiver fill out this form.*

Child's name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Child's address: \_\_\_\_\_

Home Tel: \_\_\_\_\_ Please indicate your relationship to the child: \_\_\_\_\_

#### PARENT/GUARDIAN CONTACT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Tel: \_\_\_\_\_ Work Tel: \_\_\_\_\_ Email: \_\_\_\_\_

What is the best way for us to contact you? \_\_\_\_\_

May we leave telephone messages at home or work? \_\_\_\_\_

Would you like to receive our clinic email newsletter? \_\_\_\_\_

Please circle the name of the Naturopathic Doctor you are seeking healthcare services from:

Dr. Sonya Nobbe

Dr. Christina Vlahopoulos

Dr. Jennifer Wheeler

How did you hear about this naturopathic medical practice? \_\_\_\_\_

Please list all other healthcare practitioners caring for your child:

1. \_\_\_\_\_ 2. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Please list your primary concerns about your child, in order of importance:

1. \_\_\_\_\_ Date of onset: \_\_\_\_\_

2. \_\_\_\_\_ Date of onset: \_\_\_\_\_

3. \_\_\_\_\_ Date of onset: \_\_\_\_\_

4. \_\_\_\_\_ Date of onset: \_\_\_\_\_



## MEDICAL HISTORY

Please list your child's hospitalizations, surgeries, traumas or major illnesses:

1. \_\_\_\_\_ Date of onset: \_\_\_\_\_
2. \_\_\_\_\_ Date of onset: \_\_\_\_\_
3. \_\_\_\_\_ Date of onset: \_\_\_\_\_
4. \_\_\_\_\_ Date of onset: \_\_\_\_\_
5. \_\_\_\_\_ Date of onset: \_\_\_\_\_

Please indicate which of the following immunizations your child has received:

- |                                    |             |                                 |             |
|------------------------------------|-------------|---------------------------------|-------------|
| <input type="checkbox"/> Polio     | date: _____ | <input type="checkbox"/> Hep B  | date: _____ |
| <input type="checkbox"/> MMR       | date: _____ | <input type="checkbox"/> DTP    | date: _____ |
| <input type="checkbox"/> Varicella | date: _____ | <input type="checkbox"/> Hib    | date: _____ |
| <input type="checkbox"/> Hep A     | date: _____ | <input type="checkbox"/> Other: | _____       |

Please describe any complications or reactions to the immunizations: \_\_\_\_\_

Please list any allergies or sensitivities your child may have (e.g. to medications, food, scents):

\_\_\_\_\_  
\_\_\_\_\_

Please list any medications or supplements (e.g. vitamins, herbs) your child is **currently taking**:

1. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
2. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
3. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
4. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_
5. \_\_\_\_\_ Date started: \_\_\_\_\_ Dose: \_\_\_\_\_

Please list any medications or supplements your child has taken **in the past**:

1. \_\_\_\_\_ Dose: \_\_\_\_\_ Start: \_\_\_\_\_ Finish: \_\_\_\_\_
2. \_\_\_\_\_ Dose: \_\_\_\_\_ Start: \_\_\_\_\_ Finish: \_\_\_\_\_
3. \_\_\_\_\_ Dose: \_\_\_\_\_ Start: \_\_\_\_\_ Finish: \_\_\_\_\_
4. \_\_\_\_\_ Dose: \_\_\_\_\_ Start: \_\_\_\_\_ Finish: \_\_\_\_\_
5. \_\_\_\_\_ Dose: \_\_\_\_\_ Start: \_\_\_\_\_ Finish: \_\_\_\_\_

On average, how many times a year is the child on antibiotics? \_\_\_\_\_



**PRENATAL HISTORY**

Were there any complications during the pregnancy (e.g. nausea and vomiting, high blood pressure, gestational diabetes)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What medications (including supplements, herbs, recreational drugs or alcohol) did the mother take during pregnancy?

- 1. \_\_\_\_\_ Dose: \_\_\_\_\_ Reason: \_\_\_\_\_
- 2. \_\_\_\_\_ Dose: \_\_\_\_\_ Reason: \_\_\_\_\_
- 3. \_\_\_\_\_ Dose: \_\_\_\_\_ Reason: \_\_\_\_\_
- 4. \_\_\_\_\_ Dose: \_\_\_\_\_ Reason: \_\_\_\_\_

Did the mother experience any illness, traumas, or hospitalizations during her pregnancy?

- 1. \_\_\_\_\_ Date of onset: \_\_\_\_\_
- 2. \_\_\_\_\_ Date of onset: \_\_\_\_\_
- 3. \_\_\_\_\_ Date of onset: \_\_\_\_\_

What prenatal tests were performed during pregnancy (e.g. ultrasound, amniocentesis)?

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**NATAL HISTORY**

Your baby's delivery was (please circle): Vaginal C-section Induced Early Late  
Your baby was delivered at (please circle): Home Hospital Other

Were there any complications during labour and/or delivery? Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please indicate your child's weight at birth: \_\_\_\_\_ Length: \_\_\_\_\_

**BREASTFEEDING HISTORY**

How long was your child breastfed? \_\_\_\_\_

Did any complications occur during this time? \_\_\_\_\_

At what age were solid foods introduced? \_\_\_\_\_

Did any complications occur with the introduction of solid foods? \_\_\_\_\_



**DEVELOPMENTAL HISTORY**

Please describe any concerns you have about your child's behaviour or development:

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At what age did your child experience the following milestones:

Lift his/her head alone: _____	Develop his/her first tooth: _____
Roll over: _____	Walk (with hand held): _____
Crawl: _____	Speak his/her first word: _____

**LIFESTYLE**

Please describe a typical day's diet:

Breakfast: \_\_\_\_\_  
Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_  
Snacks: \_\_\_\_\_  
Beverages: \_\_\_\_\_

Please describe what forms of exercise your child participates in, and how often:

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How many hours does your child sleep each night? \_\_\_\_\_  
How many times does he/she wake up in the middle of the night? \_\_\_\_\_  
How often does he/she experience nightmares? \_\_\_\_\_

Please give a brief description of your child's daily routine (e.g. do they attend daycare, public school, wake/sleep schedule etc.):

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Where has your child traveled to outside of this country? \_\_\_\_\_  
\_\_\_\_\_

What (if any) pets reside in the home? \_\_\_\_\_



## FAMILY HEALTH HISTORY

Please indicate whether the following health conditions pertain to anyone **in the child's family**:

Condition	Relative	Age of Onset	Details
Heart or blood problems			
Lung problems (e.g. asthma)			
Nervous system problems (e.g. seizures)			
Digestion problems (e.g. Celiac disease)			
Allergies (moderate/severe)			
Skin problems			
Cancer			
Concerns about weight			
Mental illness (e.g. depression)			
Learning difficulties			
Difficulties with drugs and/or alcohol			
Other			

## EMOTIONAL HEALTH

*Your child's home environment plays a significant role in their health and well-being. Please answer the following questions regarding your home and family situation. Your answers will remain confidential.*

Has your child suffered any emotional trauma (e.g. divorce, death, moving homes)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does anyone in the child's home or place of regular attendance smoke? \_\_\_\_\_

Is there any alcohol or drug use in the child's home? \_\_\_\_\_

Have you ever felt sad or depressed for two weeks or more at a time in the past year? Yes No

Do you feel that your home is a safe place for your child? \_\_\_\_\_

*Thank you.*



## INFORMED CONSENT FOR DIAGNOSIS AND TREATMENT

Naturopathic Medicine is a distinct system of primary care that addresses the whole body and root cause of illness and disease. It promotes health by assisting the body's own healing mechanisms according to current medical research and ancient healing knowledge. Naturopathic doctors integrate standard medical diagnostics with a broad range of natural therapies, including botanicals (herbs), acupuncture, clinical nutrition, counseling, and homeopathy. They work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your child's first naturopathic appointment will generally last 60 to 90 minutes and may include a physical exam and referral for laboratory tests. (For young children, please bring a care-giver with you to watch your child during the latter part of the appointment.) Follow-up appointments may range from 15 to 60 minutes each, according to your child's individual health requirements. The first consultation fee is \$150 and does *not* include the cost of laboratory testing or prescription items. Follow-up consultation fees are prorated at \$140 per hour. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare providers do.

### STATEMENT OF ACKNOWLEDGEMENT

As the parent or legal guardian of \_\_\_\_\_, I, \_\_\_\_\_, understand that the form of medical care is based on naturopathic principles and practices. I will inform my Naturopathic Doctor of all health concerns, medications and medical interventions, including over-the-counter drugs and supplements because safe care requires that I truthfully and completely disclose this information.

As the parent or legal guardian of \_\_\_\_\_, I understand that I am entitled to know about my child's diagnosis and treatment, including the costs, benefits, risks and potential side-effects. I am entitled to know consequences of *not* accepting treatment and of alternative courses of action. I am encouraged to request more information as needed, and to take an active role in my child's care. I am always at liberty to seek or continue care for my child from another qualified healthcare provider.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, and bruising or injury from acupuncture.

I understand that the Naturopathic Doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at any time. I accept full responsibility for any fees incurred during care and treatment.

\_\_\_\_\_  
FULL NAME OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN

\_\_\_\_\_  
WITNESS



You and your child's health privacy is a primary concern and the personal health information you disclose to your Naturopathic Doctor during your appointments will be handled in accordance with current privacy legislation and standards determined by the naturopathic regulatory body, the Board of Directors of Drugless Therapy – Naturopathy. Personal health information includes identifiable information such as age, gender, family status, and health history.

Your Naturopathic Doctor, employees, and health practitioners of 541 Palace Road will collect, use, and disclose information about you and your child for the following purposes:

- To assess your child's health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you and your child;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Employees and health practitioners of 541 Palace Road will have access to your record of personal health information and may come into contact with personal health information that is sent to or from the clinic. Staff members and practitioners will collect, use, and disclose your personal health information accordingly to protect your privacy and the confidentiality of your information.

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I have reviewed the above information and authorize \_\_\_\_\_, Doctor of Naturopathic Medicine, employees, and health practitioners of 541 Palace Road, to collect, use, and disclose my personal health information as outlined above.

\_\_\_\_\_  
NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
WITNESS