# Natural Terrain Naturopathic Clinic

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# CHILD INTAKE FORM

Name: ___________________________________________Alberta Health Care #: ______________________

Address: _________________________________________________________________________________

Street City Province Postal code

Parents E-mail: ____________________________Cell : [____] ______________ Work:[____] _____________

Telephone: (home) [____] _______________ Age: _________ Birth Date: __________________ Sex: *M / F*

Parents Names: Mother - __________________________ Age - _____ Occupation - _____________________

Father - ____________________________ Age - _____ Occupation - ____________________

Whom does the child live with? ____________________ Name of Medical Doctor: _____________________

Ethnic Background: ____________________________ Religious Background: _________________________

How did you find out about our clinic? Who referred you? *Newspaper, Internet, Health food store, Friend, Another heath care practitioner* *Name:*____________________________________________

Has your child been treated by a Naturopathic Doctor before? *Y or N*

If 'yes', by whom? ______________________________ When? ___________________________

For what reason(s)? _________________________________________________________________

In Case of Emergency:

Contact: _______________________ ______________________ [ ____ ] _________________

Full name Relation Telephone

Signature: _______________________________ Date: ______________________________

**List your child's health concerns and how long they have been occurring, in order of importance:**

1.________________________________________________________________________________

2.________________________________________________________________________________

3.________________________________________________________________________________

4.________________________________________________________________________________

5.________________________________________________________________________________

6.________________________________________________________________________________

# CONFIDENTIAL HEALTH QUESTIONNAIRE

Dear Patient: Please complete your child's questionnaire with care. Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. This is a confidential record of your child's medical history. It will not be released without your prior authorization.

Has your child had similar health concerns before? ________ Explain: ______________________________

_____________________________________________________________________________________

Does your child have any relatives with similar problems? ________________________________________

What do you feel is causing the health problems your child may have? ______________________________

_____________________________________________________________________________________

When did your child last feel well? __________________________________________________________

What long-term expectations do you as a parent have from working with this clinic? ___________________

_____________________________________________________________________________________

_____________________________________________________________________________________

What expectations do you have of me personally as your physician? ________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

What behaviours or lifestyle habits does your child currently engage in regularly that you believe support his/her health? Please list.

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

What behaviors or lifestyle habits does your child currently engage in regularly that you believe are self-destructive to their health? Please list.

_____________________________________________________________________________________

_____________________________________________________________________________________

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your child's health and in adhering to the therapeutic protocols that I will be sharing with you?

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes your child will be making?

_____________________________________________________________________________________

What is your present level of commitment to address any underlying causes of your child's health concerns that relate to your lifestyle? Rate on a scale from 1 to 10, with 10 indicating 100% commitment.

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

# MEDICATIONS

How many times has your child been treated with antibiotics?_________ When was the last time?________
Main reason for antibiotic use: Ear Infections Bronchitis Pneumonia Sinus Infection Intestinal Infection Other (please explain)________________________
Was your child ever treated for a yeast infection following antibiotic use ________________________________

Please list all **“current”** prescription medications

| Medication | Date started [m/y] | Dose | Effectiveness |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Please list all **“past”** prescription medications

| Medication | Date started [m/y] | Dose | Effectiveness |
|---|---|---|---|
| | | | |
| | | | |

Please list all **“current”** vitamins, herbs, homeopathics, non-prescription, etc

| Supplement / Vitamin (Brand Name) | Date started [m/y] | Dose | Effectiveness |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list all **“past”** vitamins, herbs, homeopathics, non-prescription, etc

| Supplement / Vitamin (Brand Name) | Date started [m/y] | Dose | Effectiveness |
|---|---|---|---|
| | | | |
| | | | |

# HEALTH HISTORY

Does your child have any known contagious diseases at this time? *Y N* If yes, what?_______________

How would you describe your child’s current state of health? *Excellent Good Fair Poor*

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that your child has had. Include approximate dates.

________________________________________________________________________

________________________________________________________________________

List any X-rays, CT scans, or other studies that your child has had.

________________________________________________________________________

________________________________________________________________________

Significant physical or emotional trauma: ____________________________________________

Type of birth: Vaginal C-section

**Allergies:** Is your child sensitive or allergic to…

Any drugs?________________________________ Any environmentals?________________________

Any chemicals?______________________________ Any supplements?__________________________

Any food allergies or intolerances?__________________________________________________________

**Childhood Illnesses:** (check those that apply) Which of the following conditions has your child had?

| | | | |
|---|---|---|---|
| Asthma/Wheezing | Cradle cap | Frequent colds | Night sweats |
| Bedwetting | Cries easily | Frequent urination | Nose bleeds |
| Body/breath odor | Croup | Hair loss | Rubella |
| Burning of urine | Diaper rash | Heart disease | Seizures |
| Canker sores | Diarrhea | Heat intolerance | Sore throats |
| Change in appetite | Dizzy spells | High fevers | Stomach aches |
| Chicken pox | Easy bruising | Measles | Strep throat |
| Cold intolerance | Eczema | Mumps | Tonsillitis |
| Constipation | Fatigue | Nervous | Whooping cough |

Unusual fears, describe:_________________________________________________________

Ear infections – How many and how often?_______________________________________________

Other:_______________________________________________________________________

**Immunizations:** What immunizations has your child had?

| | | |
|---|---|---|
| DPT (diphtheria, pertussis, tetanus) | Hepatitis A | Flu shot |
| Haemophilus influenza B | Hepatitis B | Polio |
| MMR (measles, mumps, rubella) | Hepatitis C | Smallpox |
| Chicken pox | Other: ______________________ | |

Please indicate any adverse reactions your child has experienced from an immunization.

_____________________________________________________________________________

_____________________________________________________________________________

**Digestive Health:**

Does child have periodic loose stools/diarrhea? *Y / N*

Undigested food in stool? *Y / N*

Does your child suffer with reflux/heartburn? *Y / N*

Does your child produce formed stools? *Y / N*

Is your child currently taking an acid-blocking medication such as Losec, Pepcid, etc? *Y / N*

Did occurrence of digestive problems occur following a particular vaccine? *Y / N / Unsure*

Offensive Gas? *Y / N*

Is your child potty trained? *Y / N*

Bloating after eating? *Y / N*

**Diet:** Describe a typical day's diet.

Breakfast____________________________________________________________________

Lunch_______________________________________________________________________

Supper______________________________________________________________________

Snacks______________________________________________________________________

How many cups/bottles/glasses does your child drink on average per day?

| **Beverage** | **Amount** | **Beverage** | **Amount** | **Beverage** | **Amount** |
|---|---|---|---|---|---|
| Water | | Fruit juice | | Soft drinks regular | |
| Milk | | Vegetable juice | | Soft drinks diet | |
| Soy milk | | Herbal Tea | | Caffeine/energy drinks | |

Does your child have any dietary restrictions (religious, vegetarian, vegan, etc.)? ______________________

_____________________________________________________________________________

## Feeding History:

Breast    Bottle    What kind of formula?________________    How long for either?:____________

Did your infant experience any reactions to formula or breast milk?____________________________________

________________________________________________________________________________

Please list any foods that were introduced before 6 months, as well as any reactions noted:

________________________________________________________________________________

________________________________________________________________________________

What foods were introduced between 6 and 12 months? Were there any reactions to these foods?

________________________________________________________________________________

________________________________________________________________________________

Does your child have any cravings?_______________________________________________________

Please describe your child's eating habits (e.g., good appetite, picky eater, etc.).

________________________________________________________________________________

## Prenatal Health and History:

What was the health of the parents at the time of conception (please circle)?

Mother: *Poor  Fair  Good  Excellent  Unknown*

Father: *Poor  Fair  Good  Excellent  Unknown*

What was the health of the mother during pregnancy? *Poor  Fair  Good  Excellent  Unknown*

Emotional state during pregnancy? *Poor  Fair  Good  Excellent  Unknown*

On a scale of 1 - 10 (10 being highest), while pregnant, please rate your stress____ & energy levels____ .

Any new events/changes/symptoms/conditions in your life that occurred during pregnancy? *Y / N*

________________________________________________________________________________

How was the mother's diet during pregnancy? *Poor  Fair  Good  Excellent  Unknown*

Did the mother exercise during pregnancy? *Y / N*  Type:__________Duration:_______Frequency:______

What was the mother's age at the time of the child's birth?______Occupation during pregnancy?_________

How many previous pregnancies _______and births________?

Did the mother experience any of the following during pregnancy?

Bleeding    High blood pressure    Nausea    Vomiting

Diabetes    Thyroid problems    Trauma    Forced bed rest

Other:__________________________________________________________________

Did the mother receive medical care during pregnancy and/or delivery? *Yes  No  Unknown.* If yes, why?

________________________________________________________________________________

Were any of the following interventions used during pregnancy?

Ultrasound    Amniocentesis    Chorionic villi sampling    Triple Screen

Maternal serum screening    Other:_____________________________________________ _______

Did the mother use any of the following during pregnancy?

Tobacco    Alcohol    Recreational drugs:_____________________________________________

Prescription medications (incl antibiotics):_________________________________________

Over-the-counter medications:___________________________________________________

Vitamins and/or supplements:____________________________________________________

Coffee: *Y / N* _______cups/d    Soft drinks: *Y / N* _______cups/d  Artificial sweeteners: *Y / N*

Did you consume dairy products? *Y / N*

**Birth History:** (please complete if your child is less than 2 years old)

Term length: Pre-term (37 weeks or less): ____ weeks Full-term (38-42 weeks): ____ weeks
Post-term (more than 42 weeks): _____ weeks

Location of birth: Hospital Home Birthing Center Midwife Other:______________

Types of Intervention: Induction Forceps/suction Epidural/anesthesia Episiotomy
Other:____________________________________________________________________________

Were there any complications during delivery (e.g., breech, induction)?

______________________________________________ _______________________________

___________________________________________________________________________________

Length of labour: __________ Weight of infant at birth:__________Length of infant at birth:____________

APGAR score (0 to 10): 1minute _______ 2 minutes _______ 5 minutes:________

Did the child experience any of the following at or shortly after birth?

Anemia Bradycardia Cyanosis Congenital defects:______________________
Jaundice Rashes Seizures Birth injuries:__________________________
Infections:__________________________ Breathing difficulty:_________________________
Difficulties with feeding:______________ Colic:_____*mild*______*moderate*______*severe*
Birth defects:________________________ Atrioventricular septal defect:__________________
Other:________________________________________________________________________

Please write any details pertaining to the birth experience that you feel are important to their well-being:

___________________________________________________________________________________

___________________________________________________________________________________

**Developmental Milestones:**

How was your child's health in the first year? *Poor Fair Good Excellent Unknown*

How is your child's health now? *Poor Fair Good Excellent Unknown*

At what age did your child first: Sit up _________ Crawl __________ Walk __________ Talk _________

At what age did your child begin teething? __________ Were there any difficulties associated with it?

___________________________________________________________________________________

**Sleep Patterns:**

What time does your child usually go to bed?_______ wake in the morning?_______

How many times does your child wake during the night?________ Does your child wake rested? *Y / N*

Does your child nap? *Y / N* Length of nap:_____

Does your child have nightmares? *Y / N* Please describe (ie theme, how often)______________________

Does your child have any problems associated with sleeping (e.g., trouble falling asleep, trouble waking up, bed wetting, etc.)?

___________________________________________________________________________________

___________________________________________________________________________________

**Social History:**

Are parents divorced? *Y / N* Number of siblings (birth order):___________________________

Is your child in: school daycare home care other:____________________________

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

___________________________________________________________________________________

How would you describe your child's behaviour at home?______________________________________

___________________________________________________________________________________

What are your child's interests and favourite activities? ______________________________________

___________________________________________________________________________________

What recreational activities is your child involved in?________________________________________
_____________________________________________________________________________________
How would you describe your child's temperament/personality?______________________________________
_____________________________________________________________________________________
Is there anything that you would want to change?__________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Does your child exercise regularly? *Y / N* Type, duration, frequency?_____________________________
_____________________________________________________________________________________
How much television does your child watch? ________ hours a day/week
How often does your child play video games? ________ hours a day/week
How often does your child read (not for school) or How often does someone read to your child?
Daily Several times a week Weekly Less than weekly
Is there anything regarding this child that should not be mentioned in his/her presence?_________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Family History:**

Indicate if a close relative (parent, grandparent, sibling) has had any of the following:

| Condition | Relative(s) | Condition | Relative(s) | Condition | Relative(s) |
|---|---|---|---|---|---|
| Alcoholism | | Depression | | Learning disabilities | |
| Allergies | | Diabetes | | Mental Illness | |
| Anemia | | Eczema | | Multiple sclerosis | |
| Arthritis | | Epilepsy | | Muscular dystrophy | |
| Asthma | | Glaucoma | | Seizures | |
| Bed wetting | | Heart disease | | Stomach ulcers | |
| Birth defects | | Hay Fever | | Stroke | |
| Bleeding disorder | | High Blood Pressure | | Tuberculosis | |
| Cancer | | Hyperactivity | | Yeast infection | |
| Celiac disease | | Juvenile Arthritis | | Venereal disease | |
| Colitis | | Kidney Disease | | Other:____________ | |

I don't know the family medical history

Please fill in the following chart, based on the child's relatives:

| Relation | Age (if living) | If deceased, at what age & cause of death? |
|---|---|---|
| Mother | | |
| Father | | |
| Sibling(s) | | |
| Sibling(s) | | |
| Sibling(s) | | |
| Sibling(s) | | |
| Sibling(s) | | |
| | | |
| Maternal grandmother | | |
| Maternal grandfather | | |
| Paternal grandmother | | |
| Paternal grandfather | | |

Do either of the parents have a chronic illness? *Y / N* Please describe.___________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

**Home Environment:**

Are there any pets in the home? *Y / N* What type and how many?____________________________

______________________________________________________________________________

Does anyone in the child's household smoke? *Y / N*

Age of home ______ Carpet (age, type):___________ How is the child's home heated?___________

Lead paint (old home, age):_______ Is home located near a power line and/or cell phone tower? *Y / N*

Do you know of any toxins or other hazards that the child is regularly exposed to (home, hobbies, school, etc.)? Please describe.____________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

How would you describe the emotional climate of the child's home?_________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Does your child have any known environmental or chemical sensitivities (e.g., perfumes, detergents, odors, soaps, etc.)?______________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**General Info:**

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

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Thank-you for your time and effort.**
**I look forward to working with you on your journey to health and well-being.**

***"Those who do not find time every day for health***
***must sacrifice a lot of time one day for illness."***
**-Father Sebastian Kneipp**

# CONSENT FORM

Welcome to the Natural Terrain Naturopathic Clinic! This clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body, mind and spirit in its own inherent healing power. Our practitioners will take a full case history and may perform a complaint oriented physical exam, as well as blood, urinary or saliva testing to assist in diagnosis and treatment. Please **read and initial** the following statements:

_______ Initials — A confidential record will be kept of health services provided. This record will not be released to others unless directed by yourself or unless law requires it. You understand that you may look at your medical record at anytime and can request a copy of it by paying the document fee of $25. You understand that information from your medical record may be analyzed for research purposes and that your identity will be protected and kept confidential.

_______ Initials — Treatment results are not guaranteed and we will answer questions as best as we can. You do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. With this knowledge, you voluntarily consent to diagnostic and therapeutic procedures, except for (please list any exceptions): __________________

_______ Initials — You intend this consent form to cover the entire course of treatment for you or your child's chief health concerns. You confirm that you have free will and choice regarding suggested care. You acknowledge that you are not representing an agency (private, governmental or otherwise) attempting to gather information without so stating.

_______ Initials — All fees are due at the time of the visit (ie consultation, prescriptions and lab testing). The clinic does direct bill to some insurance providers, but not all, as such a receipt is provided to submit your claim to insurance providers. Reminder: When a test is performed through a private lab (ie heavy mental testing, food intolerance testing, DUTCH hormone testing, organic acid testing, neurotransmitter testing, blood work, etc) the fee for the test **does not** include the follow up visit. The fee for these tests is to cover the laboratory cost in performing the test. As such, you will require a follow up visit consultation with your ND to discuss, interpret and explain the treatment steps required to address the test deficiencies.

_______ Initials — You will be charged for the first appointment if it is missed or if you cancel with less than 2 business days notice. For follow-up visits a missed appointment fee of $50 will be charged for any appointments that are missed or late cancellations (less than 2 business days).

_______ Initials — Please refrain from wearing scents/perfume due to the sensitivity of other clients.

_______ Initials — There may be times when you may be required to wait as we are providing needed attention to a current patient – we appreciate your cooperation, patience and understanding.

_______ Initials — I agree to receive newsletters, health information handouts and updates from the clinic by email. I am aware I can withdraw my consent at any time.

Patient Name: (Please Print) ________________________________ Date: ________________

Patient Signature (parent/guardian if patient under 18 years of age): ________________________

Name of parent/guardian if patient is under 18 years old (please print): ______________________