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	$ 40.00 $ 70.00 $ 95.00
Missed appointment fee		$ 40.00

We offer direct billing for most insurance providers, please ask for more details.

Otherwise payment is due at time of service, payable by Debit, Mastercard, Visa or cash.

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
- Microbiology test (including Candida)
- Comprehensive stool analysis
- Heavy metal test (hair and urine tests)
- Organic Acid test
- Blood tests

Please note we cannot bill directly to insurance companies for laboratory expenses.

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: _____