TouchStone Health

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Pediatric Naturopathic Intake Form

Naturopathic and preventative health care is only possible when the Doctor has a complete picture of the client physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire and bring to your first appointment.
Please note that all information disclosed is confidential and will not be released without your permission.

Child's Name: _____ Date: _____

Age: _____ Sex: _____ Birth date: _____

Address: _____

Tel, Home: _____ Other: _____

Email contact: _____

Who is filling out this form? (name and relation)? _____

Who does the child live with? _____

May we leave messages relating to your visits? Yes No (please circle)

EMERGENCY CONTACT:
Name: _____ Relation: _____

Address: _____

Tel: _____ Email: _____

Other Health Care Providers your child is seeing:
1. _____ 2. _____
_____ _____
_____ _____
Tel: _____ Tel: _____

How did you hear about this clinic? _____

List reason(s) for your child's visit in order of importance (include date of onset with each concern):

1. _____ Onset Date: _____

2. _____ Onset Date: _____

3. _____ Onset Date: _____

4. _____ Onset Date: _____

5. _____ Onset Date: _____

Are you currently receiving any treatment for these concerns? Have they been effective?

_____

List any medication he/she is taking or has taken in the past (include duration, dosage and frequency):_____

_____

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

List any vitamin, mineral, or herbal supplements he/she is taking or has taken in the past (include duration, dosage and frequency): _____

_____

List any screening tests done recently (blood work, X-rays, etc.; include year and results):

_____

List any hospitalizations, accidents, trauma or serious injuries: _____

_____

List any known allergies or intolerances: _____

_____

PRENATAL HISTORY	**poor**	**fair**	**good**	**excellent**
Health of father at conception:	☐	☐	☐	☐
Health of mother at conception:	☐	☐	☐	☐
Physical health of mother during pregnancy:	☐	☐	☐	☐
Emotional health of mother during pregnancy:	☐	☐	☐	☐
Emotional health of mother after pregnancy:	☐	☐	☐	☐
Relationship with partner:	☐	☐	☐	☐
Mother's diet during pregnancy:	☐	☐	☐	☐

Number of pregnancies: _____ Number of miscarriages: _____

Mother's age at birth of child: _____ Was it a planned pregnancy?_____

Indicate any drug or alcohol consumption or cigarette smoking during pregnancy. (circle)

List any medication, supplements or herbal remedies taken during pregnancy: _____

_____

Did the mother experience any of the following during the pregnancy:

☐ Bleeding ☐ Nausea ☐ High Blood Pressure ☐ Vomiting

☐ Diabetes ☐ Thyroid Problems ☐ Physical or emotional trauma ☐ Other_____

LABOUR AND DELIVERY

Location of birth: _____ Duration of labour: _____

Birth weight: _____ Birth length: _____ Head circumference: _____

Description of birth:

☐ Induced ☐ Forceps ☐ C-section ☐ Late ☐ Premature

☐ Spontaneous ☐ Epidural ☐ Medications ☐ Water birth ☐Other_____

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

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth Injuries ☐ Birth Defects_____

☐ Other _____

IMMUNIZATIONS

☐ MMR: Measles, mumps, rubella ☐ Haemophilus influenza B ☐ Hepatitis A
☐ DPT: Diphtheria, pertussis, tetanus ☐ "Flu" ☐ Hepatitis B
☐ Tetanus booster; when? ____ ☐ Polio ☐ Chicken Pox
☐ Other: _____ Has he/she had any adverse reactions to any immunizations? _____

CHILDHOOD ILLNESSES

Has he/she ever had any of the following?

☐ Chicken Pox ☐ Ear infections ☐ Frequent colds ☐ Impetigo
☐ Measles ☐ Mumps ☐ Pneumonia ☐ Mono
☐ Polio ☐ Rheumatic fever ☐ Rubella ☐ Strep Throat
☐ Scarlet fever ☐ Tonsillitis ☐ Whooping cough ☐ Other_____

NUTRITION

Infant feeding: ☐ Breast fed? How long? _____☐ Formula? Describe: _____
☐ Milk? ☐ cow ☐ goat ☐ soy ☐ nut ☐ other
Age of introduction to solid foods: _____ What foods were introduced first? _____
_____
Was/is the child colicky? Explain: _____

Typical Day's Diet

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages _____
Dietary restrictions (religious, vegetarian/vegan, etc.)? _____
Food allergies intolerances: _____
Favorite foods: _____

Does he/she consume any of the following at least once a week?

☐ Sweets ☐ Fried foods ☐ Luncheon meats ☐ Artificial sweetener
☐ Excess salt ☐ Margarine ☐ Soft Drinks

GROWTH AND DEVELOPMENT

Current weight: _____ Current height:_____
Age he/she began:

Sitting _____ Crawling _____ Teething _____
Walking alone _____ Saying first words _____ Toilet training _____
Any concerns (by parents and/or teachers) in regards to his/her physical, social or mental development?
_____

SLEEP

Bedtime? _____ Hours of sleep per night? _____ Quality of sleep? _____
Sleep position? ☐ Stomach ☐ Side ☐ Back ☐ Restless ☐ Bedwetting ☐ Nightmares
How long does it take for him/her to fall asleep? _____Is he/she rested upon waking: _____

LIFESTYLE / ENVIRONMENTAL FACTORS

Is he/she exposed to any chemicals at home or at school? Explain: _____
What are his/her hobbies?_____
How is his/her energy level? Rate on scale of 1 to 10 (1=very low; 10=excellent) _____
Emotional climate at home: ☐*very stable* ☐ *stable* ☐ *stressful* ☐*very stressful*
How old is his/her residence: _____ Type of heating:_____
Any pets?___ _____ Type of flooring (hardwood, linoleum, carpets, rugs, etc.):_____
How much screen time does your child have? _____ (hrs per day) Second hand smoke exposure? YES NO

FAMILY HISTORY

Have any family members (including immediate family, grandparents, aunts and uncles) had any of the following conditions:

☐ Allergies
☐ Asthma
☐ Epilepsy
☐ Mental illness
☐ Alcoholism
☐ Drug addiction
☐ Anemia
☐ Diabetes
☐ Arthritis
☐ Kidney disease
☐ Tuberculosis
☐ Cancer
☐ Headaches
☐ Hypertension
☐ Heart disease
☐ Stroke
☐ Birth defects
☐ Other? _____

REVIEW OF SYSTEMS

Please check off any conditions you currently have (indicate with ☑) or have had in the past (indicate with ☒):

General

☐ Poor appetite
☐ Intolerance to heat / cold
☐ Change in thirst
☐ Sleep difficulties
☐ Fever / chills
☐ Other _____
☐ Fatigue / weakness
☐ Significant weight change
☐ Other _____

Skin

☐ Rashes / Hives
☐ Itching
☐ Eczema
☐ Other _____
☐ Easy Bruising
☐ Nail problems / changes
☐ Jaundice
☐ Lumps
☐ Hair problems / changes
☐ Birthmarks

Head

☐ Abnormal head shape
☐ Headaches
☐ Hearing problems
☐ Cradle cap
☐ Frequent nasal discharge
☐ Dizziness
☐ Vision problems
☐ Ear infections
☐ Nosebleeds
☐ Injuries
☐ Abnormal head size
☐ Crossed eyes
☐ Ringing/buzzing in ear(s)
☐ Nasal congestion
☐ Other _____

Mouth, throat & neck

☐ Frequent sore throats
☐ Dental cavities
☐ Swollen glands
☐ Sore tongue/mouth
☐ Speech difficulties
☐ Sore Gums
☐ Chronic bad breath
☐ Cold sores
☐ Other _____

Respiratory system

☐ Chronic cough
☐ Breathing noises
☐ Other_____
☐ Sputum / phlegm
☐ Shortness of breath /difficulty breathing
☐ Chest pain

Abdomen & gastrointestinal systems

☐ Change in appetite
☐ Blood in stool
☐ Diarrhea
☐ Food allergies
☐ Change in stool color
☐ Other_____
☐ Change in thirst
☐ Belching / flatus
☐ Constipation
☐ Abdominal pain
☐ Change in stool odor
☐ Nausea / vomiting
☐ Colic or indigestion
☐ Hernias
☐ Hepatitis
☐ Change in bowel habit

Cardiovascular

☐Murmurs
☐Cold Extremities
☐Other_____

Urinary system

☐ Urinary frequency
☐ Pain on urination
☐ Difficulty passing urine
☐ Change in color
☐ Bed wetting
☐ Dribbling
☐ Blood in urine
☐ Other_____
☐ Sense of urgency
☐ Hesitancy (difficulty starting)
☐ Urinary tract infections

Musculoskeletal

☐ Broken bones
☐ Bone pain
☐ Muscle cramps
☐ Back pain
☐ Weakness
☐ Other_____

Nervous system

☐ Fainting
☐ Loss of balance
☐ Other _____
☐ Seizures / convulsions
☐ Paralysis
☐ Other _____
☐ Numbness / tingling
☐ Tremors
☐ Other _____

Please attach an extra sheet to include any further information regarding your child's personal health history, family history, past medical history or lifestyle / environmental factors that may be of relevance to your naturopathic doctor.

Privacy Policy

I understand that a confidential record will be kept of the health services provided to me. This record will be kept confidential but if required, I understand that my naturopathic doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record at any time and can request a copy of my file with a fee of $0.20 per page.

Consent Regarding Personal Information
Our privacy policy outlines what our clinic is doing to ensure that:
• Only necessary information is collected about you;
• We only share your information with your consent;
• Storage, retention and destruction of your personal information complies with the existing legislation, and privacy protection protocols;
• Our privacy protocols comply with privacy legislation and standards of our regulatory body, The College of Naturopaths of Ontario.

How our clinic collects, uses and discloses patients' personal information:
To help you understand how we protect your personal information, we have outlined here how our clinic is using and disclosing your information:
• To assess your health concerns and provide health care.
• To advise you of treatment options.
• To establish & 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 comply with legal and regulatory requirements of our regulatory body, the Board of Directors of Drugless Therapy – Naturopathy acting under the authority of the Drugless Practitioners Act.
• To invoice for goods and services.
• To process credit card payments.
• To collect unpaid accounts.
• To assist this clinic to comply with all regulatory requirements.
• To comply generally with the law.
• To allow potential purchasers, practice brokers or advisors to conduct and audit in preparation for a practice sale.

☐ I would like to receive newsletters and other information mailings

By signing the consent section of 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.

Patient Name: (Please print name):_____

Signature of Patient or Guardian:_____

Date:_____ Naturopathic Doctor: _____

ND Signature: _____

Informed Consent

Consent Regarding Treatment

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Your ND will take a thorough case history and perform a relevant physical examination.

It is very important that you inform your naturopathic doctor of any medical concerns or medication and supplements you may be taking. Please advise your ND if you are pregnant, suspect you are pregnant or if you are breastfeeding. As a patient you will receive information about your diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.
As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine including acupuncture. By signing this sheet, you acknowledge your understanding of the associated risk and grant permission to proceed.

Possible side effects of naturopathic medical care include:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles

I understand that the results are not guaranteed. I do not expect the naturopathic doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to Naturopathic care. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to discontinue participation in these procedures at any time.

I declare that I have received a full and complete explanation of the treatment or services that I may receive at TouchStone Health and hereby authorize and consent to treatment.

I agree to pay my full account at the time of each visit or treatment, including fees for services as well as other applicable fees.

Parents/Guardians
I agree that I am solely responsible for the safety of my child/children while on the premise of TouchStone Health. Children are to be supervised at all times and never left unattended by the parent.

Cancellation Policy
I agree that if I am unable to make my appointment, I must provide advance notification within 2 business days. Failure to provide notice will result in a charge equivalent to the cost of the appointment that was missed.

Patient Name: (Please print name):_____

Signature of Patient or Guardian:_____

Date:_____ Naturopathic Doctor: _____

ND Signature: _____

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