Pediatric Intake Form (Under 12)

Dr. Mike Baker, ND

Thank you for taking the time to complete the following new patient forms to the best of your ability. If possible, it can be fun to do this with your child. This form is an important step towards defining your child's health care needs and achieving his or her health goals.

Please bring this completed form to your child's first appointment or drop it off in advance for review. Please also bring any relevant blood work or health reports. All the answers on this form will be held **absolutely confidential.**

Child's Name: _____ Birthdate:_____
Address: _____ City: _____Prov_____ PC:_____
Family Doctor: _____Phone #:_____
Referring Professional: _____Phone #: _____
Care Card #: _____

Guardian Information:
Name:_____Relationship:_____
Phone (Home): _____Cell: _____Work:_____
Email: _____ Occupation:_____
Preferred method of communication: _____Spouses name _____
Other children's names and ages _____
Emergency Contact (name, relationship): _____
Phone: _____
Why did you choose to come to this clinic?:_____
Have you seen a Naturopathic Doctor before? Y/N When: _____ Dr_____
Are you aware of the fees for the initial consultation and follow up visits? Y/N

PRESENT HEALTH CONCERNS:

	Please list most important health concerns in their order of significance.	Please list any prior diagnosis including when and by whom.
1		
2		

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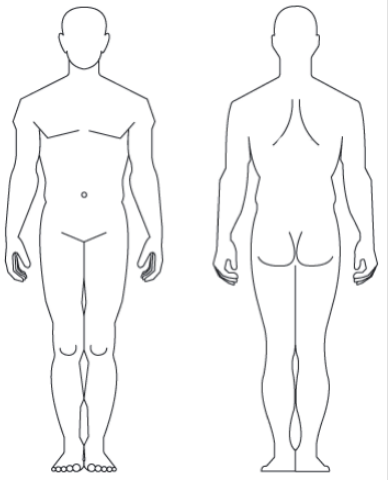
3		
4		
5		

ALLERGIES: (please list your child's allergy, their reaction and severity on a scale of 1-10)
Medications: _____
Food: _____
Environmental: _____

PAST MEDICAL HISTORY:
Has your child ever been hospitalized Y/N, Why and dates?
_____
_____
Has your child ever had any major accidents, traumas or surgeries? Y/N explain, dates:
_____
_____

PHYSICAL CONDITION:

Please indicate on the diagram the nature of your child's symptoms using the provided symbols.



Aching	**O**
Stabbing	**X**
Rashes	**=**
Burning	**~**
Numbness or Tingling	**^**

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If you have indicated pain above, please use the next 2 lines to explain the onset, duration and frequency with which your child experiences this pain:

_____

_____

_____

Please describe your child's current physical condition (Truth please) **:**

_____

_____

Exercise: Daily 5x Week 3x Week Weekly Monthly or Never

Type (length, aerobic, strength, intensity):

_____

FAMILY HEALTH HISTORY: identify all family members who have had any of the following				
MEDICAL CONDITION	RELATION		MEDICAL CONDITION	RELATION
Alcoholism			Heart disease	
Allergies			Hearing loss	
Anemia			Hypoglycemia	
Arthritis			Mental illness	
Asthma			Obesity	
Diabetes			Stroke	
Eczema			Thyroid disorder	
Epilepsy			Other(s)	

PRENATAL / BIRTH / NEONATAL HISTORY			
Birth weight _____	Premature	Late	Full term

CHILDHOOD ILLNESSES					
	Chicken pox		Scarlet fever		Mononucleosis
	Red measles		Rheumatic fever		Ear infection(s)
	Mumps		Strep throat		Tonsillitis
	Rubella		Pneumonia		other

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IMMUNIZATION HISTORY			
AGE	IMMUNIZATION	DOSE	DATE / REACTIONS?
2 months	DTaP	1 of 3	
	Hib (Haemophilus influenza type b)		
	Polio (IPV)		
	Hepatitis B		
	Pneumococcal (PCV)	1 of 3	
	Meningococcal (Men-C)	1 of 3	
4 months	DTap / Hib / Polio (IPV)	2 of 3	
	Hepatitis B		
	Pneumococcal (PCV)	2 of 3	
6 months	DTap / Hib / Polio (IPV)	3 of 3	
	Hepatitis B		
	Flu (Influenza)	yearly	
12 months	Chicken pox (varicella)	1 dose	
	MMR	1 of 2	
	Meningococcal (Men-C)	2 of 3	
	Pneumococcal (PCV)	3 of 3	
18 months	DTap / Hib / Polio (IPV) booster	1 of 1	
	MMR	2 of 2	
4-6 years	DTap / Polio (IPV)	1 of 1	
	Chicken pox (varicella) (Catch up dose if not previously given & no exposure)	1 dose	
Grade 6	Hepatitis B (if not previously given)	2-3 doses	
	Human Papillomavirus (HPV)	3 doses	
	Meningococcal (Men-C)	3 of 3	
	Chicken pox (varicella) (Catch up dose if not previously given & no exposure)	1 dose	
Grade 9	Human Papillomavirus (HPV) (if not previously given)	3 doses	
	TdaP (adult formulation; for age 7 & older)	1 dose	

OTHER SHOTS	AGE OR DATE GIVEN
H1N1	
Hepatitis A	
Pneumococcal (PPV)	

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Seasonal Flu

MOTHER'S HEALTH DURING PREGNANCY

☐ Age	☐ Drugs	☐ Stress
☐ Alcohol	☐ Extreme nausea	☐ Toxemia
☐ Bleeding	☐ High blood pressure	☐ Trauma / injury
☐ Cigarettes	☐ Illness	☐ x-rays
☐ Diabetes	☐ Medications	☐ other

Details: _____

INFANT DIET

☐ Breast fed – how long? _____ ☐ Formula fed – how long & type? _____

Age solids began? _____ What foods? _____

Food Allergies / Intolerances? _____

Favourite foods? _____

Sample daily diet (choose a typical day, include liquids) _____

Has your child tried any previous treatment? :

_____

_____

On a scale of 1 (low) to 10 (high) how would you rate your child's:
Sleep quality: ____Eating habits: ____Stress level: _____Exercise habits: _____
How many hours of sleep a night do you get? : _____

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Best Possible Medication History

(Include all your child's current and relevant past prescription medications, OTCs, and complementary medicines)

MEDICATIONS

Start Date	Name of Medication	Strength	How to take this medication				Purpose	Comment	Prescribed By
dd/mm/yy	Brand and Generic name (If available)		Quantity ?	Route ?	Frequency ?	Food?			

Name: _____

Pharmacy: _____

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DIET:
Please describe you child's typical daily diet:
Breakfast: _____
Lunch: _____
Dinner:_____
Snacks: _____Beverages: _____

How many hours does your child spend watching TV a day: _____
on the computer: _____ Texting: _____ Talking on the phone:_____

SETTING THE STAGE:
(Please ask these questions to your child if appropriate and allow for as candid of response as possible)

-What is your main expectation from this visit?: _____

-What would you like to see the future of your health look like? :
_____

-What would your ideal doctor be like? _____

-If things in your life needed to change, like what you eat, or exercise or listening how likely would you be to be able to make these changes?: (1(low)- 10 (high):
_____

-What do you do that is healthy? _____

-What do you do that you don't think is healthy?: _____

-What do you think would be the hardest part to making changes in your life?:
_____

-Who do you know that will sincerely support you and help you out?
_____

-What do you <u>LOVE</u> to do?
_____

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Informed Consent For Treatment

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honor to take your care and health seriously. The following document is an agreement between you and I that states that you are entitled to understand any detail you wish about your health condition, treatment and diagnosis. It states that you are aware of the costs of naturopathic medicine (including late cancellation policies), the benefits and potential risks and side effects. Your health is ultimately up to you, therefore you also have the right to refuse any suggested treatment. We are in this together, so be sure to ask any questions you have, no matter what they are, at anytime and I will do my best to fulfill the meaning of doctor (docere) "To Teach".

STATEMENT OF ACKNOWLEDGEMENT

I, _____as a patient of Dr. Mike Baker, ND understand that I am being treated under the practice philosophy and scope of naturopathic principles and practices. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my naturopathic doctor because I understand that safe care requires that I truthfully and completely disclose this information. I also will inform my naturopathic doctor if I am pregnant or breastfeeding so that he can take proper precautions for treatment.

I am aware and understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative treatments that may be applicable. I am encouraged to take an active role in my care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that he has answered all of my questions to the best of his ability.

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

I understand that my naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at anytime. I accept full responsibility for any fees incurred during care and treatment, including a 50% late cancellation fee if providing less than 24 hours notice for cancellation of any appointments. I am aware that I am always at liberty to seek or continue care form another healthcare provider.

Signature (of patient, or legal guardian):
_____ Date: _____

Witness: _____ Printed: _____

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