

Child Intake Form

Child's name _____ Date of birth _____ Sex M F O

Who is filling out this form? Name _____ Relationship _____

How did you hear about our clinic? Friend or family Who? _____

Advertisement: Collingwood *Life* On The Bay Health Pages (EB) body magazine Yellow Pages

Other: _____

Contacts (in order of preference)

1. Name _____	Phone (H) _____
Address _____	(W) _____
_____	(e) _____
Relationship to child _____	

2. Name _____	Phone (H) _____
Address _____	(W) _____
_____	(e) _____
Relationship to child _____	

With whom does the child live? _____

Other health care providers

1. _____ 2. _____ 3. _____

Phone # _____ Phone # _____ Phone # _____

What are the child's health concerns, in order of importance:

1. _____

2. _____

3. _____

4. _____

Child's Medical History

Which of the following conditions has the child had?

Rubella (German measles)

Roseola

Impetigo

Measles

Scarlet Fever

Mononucleosis

Chicken pox

Strep throat

Ear Infections

Whooping cough

Mumps

Other: _____

Please indicate any serious conditions, illness or injuries, and any hospitalizations or emotional upsets, next to the corresponding age:

Age years	Event
0-12 months	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

Does the child have any allergies (medicines, environmental, etc.)?

Please list all CURRENT medication; prescription, over-the-counter, vitamins, herbs, homeopathics...

Please list all PAST PRESCRIPTION medications.

How many times has the child been treated with ANTIBIOTICS? _____

Which of the following immunizations has the child had?

DPT(diphtheria, pertussis, tetanus)	Haemophilus influenza	Hepatitis B
Tetanus booster: when? _____	"Flu"	Hepatitis A
MMR(measles, mumps, rubella)	Polio	Chicken Pox
Other _____		

Please indicate if any of the above have caused an adverse reaction:

Has the child had any screening test (i.e. blood, hearing, vision)? Yes No

If yes, please list:

Child's Diet

How was the child fed as an infant?

Breast-fed: how long? _____

Formula: Milk Soy Other

Other: _____

Were foods introduced before 6 months? Yes No

If yes, please list:

What foods were introduced between 6-12 months?

Did the child ever experience colic? Yes No

Quality of colic: Mild Moderate Severe

Does the child have any food allergies or intolerances? Yes No

If yes, please list:

Does the child have any dietary restrictions (i.e. religious, vegetarian/vegan)? Yes No

If yes, please list:

Describe a typical day's diet for the child

Breakfast _____

Snacks _____

Lunch _____

Beverage type _____

Dinner _____

#Beverages _____

Health and Development

How was the child's health in the first year? Poor Fair Good

Excellent Unknown

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe the child's sleep pattern:

Describe the child's temperament:

Describe the child's behaviour and performance at school:

Prenatal Health

What was the health of the parents at conception?

Mother:	Poor	Fair	Good	Excellent	Unknown
Father:	Poor	Fair	Good	Excellent	Unknown

What was the health of the mother during the pregnancy?

Poor	Fair	Good	Excellent	Unknown
------	------	------	-----------	---------

How was the mother's diet during pregnancy ?

Poor	Fair	Good	Excellent	Unknown
------	------	------	-----------	---------

What was the mother's age at the time of this child's birth? _____

Did the mother receive prenatal medical care? Yes No Unknown

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

Bleeding	High Blood Pressure	Nausea	Vomiting
Diabetes	Thyroid Problems	Physical Trauma	Emotional trauma
Other: _____			

Did the mother use any of the following substances during the pregnancy?

Recreational drugs: Type? _____
Prescription Medications: List? _____
Over-the-counter Medications: List? _____
Supplements: List? _____
Tobacco Alcohol Other: _____

Birth History

Term Length: Full Premature: _____ wks. Late: _____ wks.

Length of labour: _____ Child's weight at birth: _____

Was the birth: Vaginal C-section Induced Forceps Anaesthesia used

Were there any complications? Yes No

If yes, please explain:

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

Jaundice	Rashes	Seizures
Birth injuries: _____	Birth defects: _____	
Other: _____		

Family History

Do you know the family medical history? Yes No

Indicate if a close relatives (i.e. parent, sibling) has had any of the following:

Symptoms	Relationship to Child	Symptoms	Relationship to Child
Allergies		Birth defects	
Asthma		Juvenile arthritis	
Diabetes		Other	
Kidney disease		Other	
		Other	

Do either of the parents have a chronic illness? Yes No

If yes, please describe.

Child's Environment

Is the child in: School Daycare Home care Other

What are the child's favourite activities?

Does the child exercise regularly? Yes No

How much? _____

How often? _____

How much television does the child watch? _____ hours per day/week

How often does the child read, or is read to (not for school)?

Daily Several times a week Weekly Less than weekly Never

Does anyone in the child's household smoke? Yes No

Are there any animals in the home? Yes No

What kind? _____

How is the child's home heated? _____

Do you know of any toxins or hazards the child is regularly exposed to (home, school, hobbies)?

Please describe: _____

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

What else would you like to share with me about this child?

*I look forward to our first meeting together.
Shelby*

DECLARATION AND CONSENT TO TREAT

This is to acknowledge that I (or parent/legal guardian) have been informed and understand that:

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. A number of different approaches are used: Diet and nutritional supplements, botanical medicine, homeopathy, Chinese medicine and acupuncture, hydrotherapy, physical medicine and lifestyle counselling.

Shelby Worts, BSc, ND, will take a thorough case history, do a screening physical exam and if your case requires, do more specific physical examinations including breast exams, gynecological exams and genital exams. Certain laboratory assessments may also be required on a case specific basis.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those on multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform Shelby Worts, BSc, ND, of any disease process that you are suffering from or if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise Shelby Worts, BSc, ND immediately.

There is some slight health risks to treatment by Naturopathic Medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of skin from the use of moxa.
- Muscle strains and sprains, disc injuries from spinal manipulation

As a patient of Shelby Worts, BSc, ND, I am at liberty to seek or continue medical care from a medical doctor or other care providers licensed to practice in Ontario. No employee, agent, board member, student, instructor or anyone else under the direction or control of Shelby Worts, BSc, ND, has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.

The Treatment and therapies rendered or recommended by Shelby Worts, BSc, ND, may be different than those usually offered by a medical doctor or other licensed health care providers.

As a patient of Shelby Worts, BSc, ND, I understand that results are not guaranteed.

I agree to pay my full account at the time of each visit or treatment, including fee for services, cost of supplements and remedies, cost of laboratory tests and other fees unless otherwise discussed with Shelby Worts, BSc, ND. Payment can be made in cash, personal cheque, Debit Card, Visa or MasterCard.

I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during intake of my case.

I understand that a 24-hour cancellation policy is in effect. To avoid a visit charge I will notify the office of Shelby Worts, BSc., ND, 24-hours before a scheduled appointment.

I will be given a full and complete explanation of the present and future treatments and/or services that I will receive.

OVER →

Privacy of your personal information is an important part of our practice, while providing you with quality naturopathic care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibly. We will try to be as open and transparent as possible about the way we handle your personal information. For more detailed information ask the Privacy Information Officer for a copy of our privacy policy.

In this office Elizabeth Hansford acts as the Privacy Information Officer.

This consent form is intended to cover the entire course of treatments in this office. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Date _____

Patient's printed name _____

Parent's/legal guardian's signature _____