



Naturopathy Child (Ages 7-17) Intake Form

			Date: / /	
First Name:	Last Name:	Birthdate (D/M/Y): / /	Age:	Sex:
Address:	City/Province:	Postal Code:	Ph(H):	
How did you hear about us?			Ph(W):	
Name of parents/guardians: /			Ph(C):	
E-mail of parents/guardians:		Main Contact Person:		

Would you like to receive a copy of our newsletter via email? ☐ Yes ☐ No

Health Overview

Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during the visit.

Height: Weight: Weight (1 year ago):

Please Rank your Health Goals/Concerns by Importance:

1	
2	
3	
4	
5	

List all current vitamins and herbal supplements, prescription medications and over-the-counter remedies that you are taking:

Medicine/Vitamin (include brand)	Purpose of Treatment	Date Started	Dosage

What hospitalizations or surgeries have you had? _____

What accidents/traumas have you had? _____

Do you have any known contagious diseases at this time? ☐ No ☐ Yes Explain: _____

LifeStyle

How often do you consume:

Caffeine _____ Pop _____ Sugar _____ Alcohol _____ Added salt _____

Artificial sweeteners _____ Recreational drugs _____ Tobacco _____

Any past addictions (alcohol, drugs, tobacco)? _____

What exercise do you do and how often? _____

List known allergies or sensitivities:

Foods:

Medications:

Environmental factors:

Chemicals:

Systems Review

Please Check ALL continuing or recurrent problems

Head

- ☐ Headache
- ☐ Migraines
- ☐ Jaw/TMJ problems

Neurologic

- ☐ Seizures/epilepsy
- ☐ Paralysis
- ☐ Muscle weakness
- ☐ Numbness or tingling
- ☐ Vertigo or dizziness
- ☐ Loss of balance
- ☐ Fainting

Neck

- ☐ Lumps
- ☐ Swollen glands/Tonsilitis
- ☐ Goiter

Eyes

- ☐ Glasses or contacts
- ☐ Recent change in vision
- ☐ Double vision
- ☐ Spots in eyes
- ☐ Eye pain/strain
- ☐ Sensitive to light
- ☐ Eyes water excessively
- ☐ Dryness

Ears

- ☐ Hearing loss
- ☐ Ringing
- ☐ Frequent ear infections

Nose and Sinuses

- ☐ Frequent colds
- ☐ Frequent nose bleeds
- ☐ Hayfever, allergies or stuffiness
- ☐ Sinus problems (including infection)
- ☐ Loss of smell

Mouth and Throat

- ☐ Hoarseness
- ☐ Snoring
- ☐ Teeth grinding
- ☐ Dental cavities/Mercury fillings
- ☐ Mouth ulcers (canker sores)
- ☐ Cold sores
- ☐ Loss/change of taste

Cardiovascular

- ☐ Palpitations/Fluttering
- ☐ Murmurs
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart condition
- ☐ Chest pain
- ☐ Blood clots

Respiratory

- ☐ Cough
- ☐ Spitting up blood
- ☐ Wheezing
- ☐ Asthma
- ☐ Shortness of breath

Gastrointestinal

- ☐ Change in thirst
- ☐ Change in appetite
- ☐ Nausea/vomiting
- ☐ Trouble swallowing
- ☐ Heartburn
- ☐ Abdominal pain or cramps
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Blood or mucus in stool
- ☐ Gallstones

Skin

- ☐ Eczema
- ☐ Hives
- ☐ Psoriasis
- ☐ Acne
- ☐ Itching
- ☐ Color change/loss of pigment
- ☐ Hair loss
- ☐ Night sweats
- ☐ Jaundice (yellow skin)

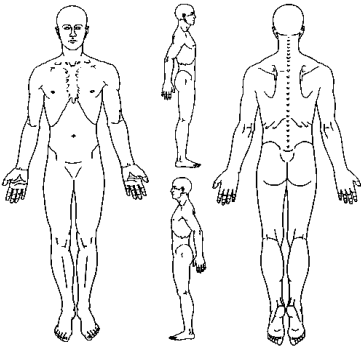
Endocrine

- ☐ Thyroid problem
- ☐ Heat or cold intolerance
- ☐ Hypoglycemia (low blood sugar)
- ☐ Diabetes
- ☐ Excessive thirst
- ☐ Seasonal depression

Musculoskeletal

- ☐ Joint pain or stiffness
- ☐ Osteoporosis
- ☐ Arthritis
- ☐ Muscle weakness
- ☐ Muscle spasms or cramps
- ☐ Sciatica

Mark areas you currently feel pain:



Blood / Peripheral Vascular

- ☐ Easy bleeding or bruising
- ☐ Anemia
- ☐ Deep leg pain
- ☐ Cold hands/feet
- ☐ Varicose veins
- ☐ Raynaud’s
- ☐ Fluid retention

Mental / Emotional

- ☐ Depression
- ☐ Mood Swings
- ☐ Anxiety or nervousness
- ☐ Issues with body image
- ☐ Eating disorder
- ☐ Thoughts of harming self

Urinary

- ☐ Pain on urination
- ☐ Increased frequency
- ☐ Inability to hold urine
- ☐ Blood in urine
- ☐ Difficulty starting to urinate
- ☐ Frequent urinary/bladder infections
- ☐ Kidney stones

Systems Review

Female Reproduction / Breasts

- ☐ Do you do breast self-exams?
- ☐ Breast lump
- ☐ Breast pain/tenderness
- ☐ Nipple discharge
- ☐ Date of last annual exam/PAP
- ☐ Abnormal PAPs
- ☐ Birth control? ☐ Yes ☐ No
- Type: _____
- ☐ Sexually transmitted infection
- ☐ Vaginal itching or discharge
- ☐ Frequent yeast infections
- ☐ Fibroids or cysts

Fill in this section if menstruating:

- ☐ Age of first menses? _____
- ☐ Irregular or no cycle _____
- ☐ Duration of period: _____ days
- ☐ Length of cycle: _____ days
- ☐ Bleeding/spotting between cycles
- ☐ Abnormal bleeding
- ☐ PMS
- ☐ Cramping
- ☐ Clotting
- ☐ Heavy or excessive flow

Male Reproduction

- ☐ Hernias
- ☐ Testicular masses or pain
- ☐ Do you do testicular self-exam?
- ☐ Prostate problems
- ☐ Discharge or sores
- ☐ Birth control? ☐ Yes ☐ No
- Type: _____
- ☐ Sexually transmitted infection

Other (symptoms not listed above)

Childhood illnesses (Check all that apply)

- ☐ Chicken pox ☐ Mumps
- ☐ Diphtheria ☐ Measles
- ☐ Scarlet fever ☐ Rubella
- ☐ Whooping cough ☐ Asthma

Others: _____

Immunization (Check all that apply)

- ☐ Diphtheria/pertussis/tetanus
- ☐ Measles/mumps/rubella
- ☐ Chicken Pox ☐ Hepatitis A
- ☐ Hepatitis B ☐ Polio
- ☐ Flu shot ☐ HPV

Others: _____

Any reactions to a vaccination?

The Doctor of the future will give no medicine, but will interest his patients in the care of the *human frame, in diet, and in the cause and prevention of disease.*

Thomas Edison

Family History

Please check all that apply

	Mother	Father	Sibling(s)	Maternal Grandparent	Paternal Grandparent	Other
Diabetes						
Stroke						
Heart disease						
High blood pressure						
High cholesterol						
Asthma						
Allergies						
Thyroid problems						
Osteoporosis						
IBS, Crohn's, Colitis						
Depression/Anxiety						
Cancer (list type)						
Other (please list)						

Current health care providers

Family Physician: _____ Phone number: _____ () _____

Other health care providers (chiropractor, massage therapist, physiotherapist, etc.)

Name	Profession	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

Living with

☐ Alone ☐ Partner ☐ Parents ☐ Friends ☐ Children ☐ Relatives

Context of Care

What long term expectations do you have?

What is your current level of commitment to addressing your health issues?

- ☐ I am willing to make any changes and do whatever is necessary
☐ I am willing to make some changes in my lifestyle to feel better
☐ I am specifically looking for a medication/surgical alternative
☐ I am here to learn more about my healthcare options and what you offer

Informed Consent

Naturopathic medicine is the treatment and prevention of diseases and disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used to stimulate the body's inherent healing capacity. A variety of treatment modalities may be used.

Traditional Chinese Medicine (TCM) includes acupuncture, as well as, the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of disposable, sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes moxa (a compressed herb), cupping therapy, or guasha is used over the skin at or near specific points on the body in order to stimulate the body's energy. Botanical formulas may be given in the form of pills, tinctures, herbal extract powders, or decoctions (strong teas) to be taken internally or used externally as a wash, poultice, salve, or fomentation.

Diet and Nutrition: Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.

Botanical Medicine: Botanical Medicine is a plant-based medicine using herbal teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. These compounds are also used to boost the body's immune system and prevent disease.

Homeopathic Medicine: Based on the principle of "like cures like." A remedy is selected, which in its crude form would produce in a healthy individual the same symptoms found in a sick person suffering from the specific disease. Minute amounts of natural substances (plant, animal, mineral) are used to stimulate the body's innate ability to heal, as the aim is to change the body's energy levels that lie at the root of disease. Homeopathy is a powerful tool and effects healing on a physical and emotional level.

Physical Medicine: This includes the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation, therapeutic ultrasound, or heating lamps for the purpose of treating musculoskeletal and neurological problems. Hydrotherapy refers to the use of hot and cold-water applications to improve circulation and stimulate the immune system.

As Naturopathic Medicine is a holistic approach to health, lifestyle is considered relevant to most health problems. Your naturopathic doctor will help you identify risk factors and make recommendations to help you optimize your physical, mental and emotional environment. Your naturopathic doctor will take a thorough case history, do a screening physical examination and urine samples if necessary. If your case requires, the physical may include more specific examinations such as gynecological, breast, rectal, prostate or genital exams.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform your naturopath immediately of:

- Any disease process that you are suffering from
- If you are on any medication or over the counter drugs
- Any existing nutritional supplements, herbs, or health food products
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or you are breast-feeding

There are 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, acupuncture or cupping
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa or cupping
- Muscle strains and sprains, disc injuries from spinal manipulation.
- The potential for stroke is a concern in neck manipulation, but tests will be done to screen for this possibility. Clinical research has shown that stroke-like occurrences are rare – approximately 1 in 1.5 million manipulations.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my naturopathic doctor will answer any questions that I have to the best of his/her ability. 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. I will rely on the naturopathic doctor to exercise judgement during the course of the procedure which they feel at that time is in my best interests, based on the facts then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for:
(please list exceptions below): _____

I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

If I am unable to make my appointment I must provide advance notification at least 24 hours before my scheduled appointment in which case no charge will be applied. Otherwise, a \$50 cancellation fee will be applied and may only be waived in cases of emergency at the discretion of the clinic.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

- I. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future from another licensed health care provider;
- II. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Alberta;
- III. No employee, student or anyone else under the clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;
- IV. The treatment and therapies rendered or recommended by this clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

I **DECLARE** that I have received a full and complete explanation of the treatment or services that I may receive from Dr. Jennifer Yee, Doctor of Naturopathic Medicine, 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, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as other applicable fees. I understand that these fees are non-refundable.

PRINTED NAME OF PATIENT

PRINTED NAME OF PARENT/GUARDIAN

DATE

SIGNATURE OF PARENT/GUARDIAN