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PEDIATRIC INTAKE FORM

Please note that all information disclosed is confidential and will not be released without your permission.

DATE:_________________

Child's name: _______________________________ age: _____ Date of Birth: __/__/__
Last, First d/ m/year

Address: ____

Name of parents or guardians: ____
____

Home Phone: (___)________ Work Phone: (___)_________ Mobile: (____)___________

Email address of Parent or guardian: __________________________

Preferred method of contact? ________________________________

Would you like to receive email reminders for future appointments? _______

Emergency Contact: ___________________ Relationship ___________Tel(___)__________

How did you hear about my practice? ___________________________

CONCERNS IN ORDER OF IMPORTANCE TO YOU:

____
____
____
____
____
____

HEALTH HISTORY:

PLEASE CIRCLE THE FOLLOWING CONDITIONS THAT YOUR CHILD HAS HAD

Tonsillitis	Cold sores	Scarlet Fever	Eczema
Frequent colds	Asthma	Whooping Cough	Strep throat
Ear infections	Allergies	Chicken Pox	Rubella
Pneumonia	Sinusitis	Mumps	Measles

IMMUNIZATIONS: (Copy of immunization record)

Has your child had all vaccines as recommended by the public health schedule? ________________

If not, which vaccine has your child had?

Has your child had any unusual reactions to vaccinations?
____

Any Traumatic events, Accidents, Injuries or Hospitalisations? __________________________

____

Mother's age at child's birth: ___________

Previous pregnancies by birth mother, miscarriages or complications?
____

Mother's health during pregnancy:____

Birth History:
Term: Premature___ Full ___ Late___ Birth Weight__________ Length of labour_______

Complications: ____

FOOD
Feeding: breast-fed? _____ How Long? _________ Formula: Dairy______ Soy______

Age began solid food_________ Age began Dairy products_______________

Any problems associated with solid food introduction? ______________________________

PLEASE CIRCLE THE FOLLOWING CONDITIONS WHICH HAVE AFFECTED YOUR RELATIVES (i.e. siblings, parents, grandparents)

Psychiatric Disorders High Blood pressure Allergic Reactions	Respiratory Alzheimer's Hepatitis	Thyroid Asthma Heart Disease	Tuberculosis Cancer Kidney Disease	Diabetes Birth defects Stroke

CURRENT HEALTH HISTORY:

ALLERGIES: Medications: ____
Food: ____
Environment: ____
Other: ____

DIET
INTOLERANCES: ____

Diet Restrictions: ____

Any symptoms experienced after eating: ____
____

Recent Weight Gain or Loss? ____

Environmental Hazards? At Home _________________ Other ________________________

MEDICATIONS and SUPPLEMENTS:

MEDICATIONS:
Current use: ____

Past use: ____

Supplements, Herbal remedies and Homeopathic remedies: ______________________________
____
Over the counter medications: ____

SLEEP PATTERN:

1. Hours per night __________
2. Quality: Excellent ( ), Good ( ), Fair ( ), Poor ( )

PERSONAL / SOCIAL HISTORY

FAMILY STRUCTURE: ____
____
____

IS YOUR CHILD CURRENTLY UNDER THE CARE OF ANOTHER PHYSICIAN(S)?

Physician	For what condition?	Treatment(s)

Consent Form

In order to clarify my position as your child's health care practitioner, and our mutual responsibilities in their health care, I ask for your cooperation in signing this statement of acknowledgement. In doing so you understand that:

- You are at liberty to seek or continue medical care from a physician or surgeon or other health care provider.
- Cathleen MacDonald ND is not suggesting or recommending that you refrain from seeking or following the advice of another licensed health care provider.
- The treatment and therapies rendered or recommended by Dr MacDonald may be different than those usually offered by a medical doctor or other licensed health care provider.
- The ultimate responsibility for your child's health care is your own, and that Dr MacDonald is here to support you in this.
- While changes in dietary habits are not an absolute pre-requisite for treatment, failure to follow sound nutritional, exercise and lifestyle programs could undermine the expected results.
- If any explanation of proposed treatment or therapy is not clearly understood, you are responsible to seek clarification.
- All information you give regarding your child's health history is true to the best of your knowledge.
- The office privacy policy is available on the website and on the bulletin board at the office.
- Payment is made by cash, debit, cheque, mastercard or visa at the time of the visit.
    - The initial consultation is 60 minutes and is $ 135.00
    - Subsequent consultations are 30-45 minutes and are $90.00
    - $50 fee for NSF cheques.
    - Phone consultations are rounded to the nearest 15 minutes and are based on $135.00/ hour
- Notice of 24 hours is required for appointment cancellation.

I have read, understood and acknowledged the above consent to treatment. I hereby authorize and consent to naturopathic treatment for my child by Cathleen MacDonald, N.D.

______________________________ ____________________

Signed by parent or guardian Date