HAWTHORNE NATUROPATHIC CENTRE

PEDIATRIC INTAKE FORM

PATIENT INFORMATION DATE: _____

First name _____ Last name: _____ Nickname _____
Date of birth (mm/dd/yy) _____ Age _____ Gender: _____

MSP Care Card Number _____ Do you have extended coverage? Y / N

Address: _____

City _____ Prov _____ Postal Code _____

Phone (home)_____(cell) _____ (work) _____

Would you like an email reminder for your child's appointments? **Y / N** Email _____

Name of Parent(s)/Guardian:_____

Name of **current medical doctor (MD)** _____ Phone _____

Emergency Contact _____Relation to child _____ Phone _____

Where did you hear about Hawthorne Naturopathic Centre? _____

HEALTH INFORMATION

Main concern(s):

_____

_____

Please list any other health concerns

1) _____

2) _____

3) _____

Please list **other current health professionals** the child is seeing and why

_____ Phone _____

_____ Phone _____

_____ Phone _____

ALLERGIES/SENSITIVITIES Please list any allergies or sensitivities in the following categories:

Medications _____

Foods _____

Environmental/chemical _____

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MEDICATIONS

Please list all current medications (prescription and over the counter):

Medication(s)	Dose	Used for how long and for what?
1)		
2)		
3)		
4)		

How many times has your child taken antibiotics (approximately?) _____ For what? _____
Please list past medications: _____

SUPPLEMENTS

Please list all current supplements/herbals/homeopathics, ect

Supplement(s)	
1)	5)
2)	6)
3)	7)
4)	8)

IMMUNIZATIONS
Check any other vaccinations taken. Please indicate any adverse reaction(s): _____

□ DTaP
□ H.influenza B
□ Flu shot
□ Hepatitis A
□ Hepatitis B
□ Meningococcal C
□ MMR
□ Polio
□ Pneumococcal
□ Rotovirus
□ Other _____

Please list (with approximate dates) any serious illnesses, injuries, surgeries or hospitalizations
_____
_____
_____

FAMILY HISTORY Please check if you have a family history of any of the following:

☐ Arthritis
☐ Asthma/allergies
☐ Bleeding disorders
☐ Cancer:_____
☐ Celiac disease
☐ Depression
☐ Diabetes: Type 1 / Type 2
☐ Drug/alcohol abuse
☐ Epilepsy/seizures
☐ High blood pressure/cholesterol
☐ IBD (Crohns or colitis)
☐ Kidney disease
☐ Mental illness
☐ SIDS
☐ Thyroid disease
☐ Unknown family history
☐ Other: _____
_____

DEVELOPMENTAL MILESTONES Please indicate approximate ages, if applicable:

Age began: sitting _____ crawling _____ walking _____ talking _____ First tooth _____
first words _____ toilet training _____

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BIRTH HISTORY

Birth weight: _____ Term (circle): PREMATURE / TO TERM / LATE / INDUCED
Type of birth (circle): Vaginal / Caesarean Any interventions used? (ie forceps)_____
Length of labor _____Complications (mother or baby): _____

BIRTH MOTHERS PRENATAL HISTORY

Age of mother at birth _____Mothers health during pregnancy: _____
Were any of the following experienced during pregnancy?

- ☐ Bleeding
- ☐ Nausea/vomiting
- ☐ Illness
- ☐ Physical or emotional trauma
- ☐ Medications
- ☐ High blood pressure
- ☐ Gestational Diabetes
- ☐ Thyroid issues
- ☐ Alcohol/drug/cigarette use

HOME LIFE

Are parents divorced/separated? Y / N If yes, with whom does the child live? _____
Occupation of parents: _____
Any siblings? Y / N If yes, please indicate ages: _____
Any pets? Y / N If yes, what type(s)? _____
How old is the home? _____ Any recent renovations? _____
Does the home contain any (circle): MOLD / EXCESS DUST / FUNGUS / CARPETS / CIGARRETE SMOKE
Is the home close to any (circle): POWER LINES / AIRPORT / HIGHWAY / TREES / INDUSTRY: _____

HABITS

Temperament (please describe): _____
Child's sleep patterns _____
How many hours/day does you child get exercise? _____ play outdoors? _____ watch TV/videogames? _____
Any issues at school, if applicable: _____

NUTRITION

Was your child breastfed? Y / N If yes, for how long? _____ Formula? Y / N If yes, what kind? _____
At what age were foods introduced? _____ 1st foods? _____
Any reactions? _____
Does your child have a good appetite? Y / N How many meals per day? _____
Typical 24 hour diet: Please list a normal day's food and liquid intake for your child.

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Fluids (and amount/day): _____

What are their favourite foods? _____
Do they have any dietary restrictions? _____

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Patient Name: _____

EXPECTATIONS AND GOALS

What are your expectations from this visit? _____

Please list any long-term goals pertaining to the health of your child

_____

_____

_____

REVIEW OF SYMPTOMS:

Please check the appropriate box for any of the following symptoms **Key:** P=Past N=Now B=Both

P N B

General
- ☐☐☐ Insomnia
- ☐☐☐ Fatigue
- ☐☐☐ Weight loss
- ☐☐☐ Weight gain

Neurological
- ☐☐☐ Seizures/ epilepsy
- ☐☐☐ Speech problems
- ☐☐☐ Difficulty walking

Head/Eyes/Nose/Throat
- ☐☐☐ Headache
- ☐☐☐ Head trauma
- ☐☐☐ Migraine
- ☐☐☐ Needs glasses
- ☐☐☐ Dark under eyes
- ☐☐☐ Itching/redness
- ☐☐☐ Canker sores
- ☐☐☐ Cold sores
- ☐☐☐ Tonsilittis
- ☐☐☐ Frequent sore throat
- ☐☐☐ Frequent cavities
- ☐☐☐ Hay-fever
- ☐☐☐ Loss of smell
- ☐☐☐ Chronic runny nose
- ☐☐☐ Nosebleeds
- ☐☐☐ Frequent ear aches
- ☐☐☐ Loss of hearing
- ☐☐☐ Ringing in ears

P N B

Mental/ Emotional
- ☐☐☐ Depression
- ☐☐☐ Mood swings
- ☐☐☐ Anxous/nervous
- ☐☐☐ Phobia
- ☐☐☐ Weeps easily
- ☐☐☐ Easily angered
- ☐☐☐ Poor concentration
- ☐☐☐ Nightmares/terrors
- ☐☐☐ Memory issues

Gastrointestinal
- ☐☐☐ Bloating/gas
- ☐☐☐ Belching
- ☐☐☐ Poor digestion
- ☐☐☐ Reflux/ heartburn
- ☐☐☐ Stomach-aches
- ☐☐☐ Vomiting/nausea
- ☐☐☐ Diarrhea
- ☐☐☐ Constipation
- ☐☐☐ Blood in stool
- ☐☐☐ Hemorrhoids
- ☐☐☐ Hernias

Bladder/Kidneys
- ☐☐☐ Bed-wetting
- ☐☐☐ Frequent urination
- ☐☐☐ Frequent infections
- ☐☐☐ Kidney stones

P N B

Skin
- ☐☐☐ Rash
- ☐☐☐ Itching/ dry skin
- ☐☐☐ Hives
- ☐☐☐ Diaper rash
- ☐☐☐ Lice / nits
- ☐☐☐ Hair loss
- ☐☐☐ Change in moles
- ☐☐☐ Acne
- ☐☐☐ Eczema

Muscle and Bone
- ☐☐☐ Joint pain
- ☐☐☐ Swollen joints
- ☐☐☐ Stiffness
- ☐☐☐ Muscle ache/cramps
- ☐☐☐ Bone pain
- ☐☐☐ Fractures
- ☐☐☐ Growing pains

Lungs / Heart
- ☐☐☐ Asthma
- ☐☐☐ Shortness of breath
- ☐☐☐ Persistent cough
- ☐☐☐ Frequent cough
- ☐☐☐ Bronchitis
- ☐☐☐ Wheezing
- ☐☐☐ Pneumonia
- ☐☐☐ Chest pain
- ☐☐☐ Murmurs

P N B

Endocrine
- ☐☐☐ Diabetes
- ☐☐☐ Hypoglycemia
- ☐☐☐ Thyroid issues
- ☐☐☐ Heat intolerance
- ☐☐☐ Cold intolerance
- ☐☐☐ Excessive thirst
- ☐☐☐ Excessive hunger
- ☐☐☐ Excessive sweating
- ☐☐☐ Night sweats

Conditions
- ☐☐☐ Chicken pox
- ☐☐☐ Eating disorders
- ☐☐☐ Scarlet fever
- ☐☐☐ Strep throat
- ☐☐☐ Mononucleosis
- ☐☐☐ Measles
- ☐☐☐ Pnuemonia
- ☐☐☐ Anemia
- ☐☐☐ Impetigo
- ☐☐☐ Mumps
- ☐☐☐ Whooping cough
- ☐☐☐ Fibromyalgia
- ☐☐☐ Chronic Fatigue
- ☐☐☐ Rubella
- ☐☐☐ Roseola
- ☐☐☐ Other: _____
- ☐☐☐ Other: _____
- ☐☐☐ Other: _____

HAWTHORNE
NATUROPATHIC CENTRE

Patient Name: _____

Confidentiality Agreement and Informed Consent to Treatment

Naturopathic doctors (ND's) assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual and how they affect health and well being. Your doctor will take a thorough case history and may conduct physical exam when needed or requested, including a breast exam, a pelvic/PAP exam or prostate exam. We realize these tests may provoke discomfort in some people. Please feel free to discuss your concerns in advance so that we may do what we can to make all procedures as comfortable as possible. Lab tests, when deemed appropriate, may be ordered. The purpose of the testing and costs will be discussed in advance. Treatment may involve botanical medicine, acupuncture, nutrition, massage, craniosacral therapy, allergy testing and desensitization, lifestyle counseling, vitamin supplementation and intravenous therapies. If you have any known allergies or have had reactions in the past to any natural medicines, please advise the doctor. Procedures will be discussed briefly and questions answered. The doctors will do their best to assist you in reaching your health goals but cannot guarantee results.

The physicians at Hawthorne Naturopathic Centre are trained in the use of pharmacognosy (medicinal drugs obtained from plants or other natural sources) and pharmacology (prescription drugs). It is important that we are aware of all prescription drugs and supplements you are currently taking and any changes to your medication or supplementation program. If you are pregnant or become pregnant or are breast-feeding, please inform us.

Your identity will be protected at all times. A record will be kept of the health services that are provided to you. This record will be kept confidential and will not be released to others unless directed by yourself or unless the law requires it. Confidentiality will be superseded if we become aware of child abuse, neglect, threats to harm others or yourself. A copy of your record can be requested at any time with an appropriate fee charged for this service.

Fees are payable at the time of the appointment, including fees for services, prescriptions, and laboratory tests.

The clinic requires at least 24 hours notice for appointment cancellation. The full cost of the appointment may be charged if no notice is given. We do understand there are extenuating circumstances at times.

I certify that I have read and understand the above Confidentiality and Informed Consent for Treatment and that, unless withdrawn, will prevail over the entire course of treatment at the clinic.

Patient Name: (Please print)

_____

Name of guardian if patient is a child:

_____

Signature of patient or guardian:

_____

Date:

_____

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