Dr. Chris Ford and Dr. Darcie Pawlick – Naturopathic Physicians

Although this form may seem long, please note that completion of each section of this intake form is optional, however, it is beneficial for us to have a full history in order to gain a better understanding of your health and how it may be affected by all aspects of your life. All answers are fully confidential. If you have any questions please mark them with a question mark. Thank you.

Child's Name ________________________________ **Date** __________________________

Date of birth __________________________ (M/D/Y) **Age**_______ **Gender**_____________

Who is filling out this form (name and relation)?___________________________________

Contacts (in order of preference):

Name ________________________________ **Relationship to child**____________________

Address____

City__________________ **Prov./State**___________________ **Postal/Zip Code**___________

Home Telephone Number ____________________ **Alternate** ________________________

Name ________________________________ **Relationship to child**____________________

Address____

City__________________ **Prov./State**___________________ **Postal/Zip Code**___________

Home Telephone Number ____________________ **Alternate** ________________________

Name ________________________________ **Relationship to child**____________________

Address____

City__________________ **Prov./State**___________________ **Postal/Zip Code**___________

Home Telephone Number ____________________ **Alternate** ________________________

May we leave messages relating to your visits? Yes__ / No__ Which Number?_________

With whom does the child live?____

Occupation_______________________________________ **Hours/week**_________

Married____ **Separated**____ **Divorced**____ **Widowed**____ **Single**____ **Partnership**____

Names of Other Healthcare Providers: M.D. _______________________________________

Naturopaths_____________________ **Chiropractors**________________________________

Others____

Emergency contact: Name ____

Phone number ____________________ **Relation**______________________________

How did you hear about our Clinic? Please check one of the following:

Media (Newspaper, radio) ____
Health/Wellness Event____
Website____

Clinic patient____
Other _______________________

Referred by________________________

Please list the child's health concerns, in order of importance:

1. ____
2. ____
3. ____
4. ____
5. ____

<u>Medical History</u> (Indicate dates when possible)

Please describe the child's general state of health? Excellent___ Good___ Fair___ Poor___

Surgeries/Hospitalizations____

____

Diagnostic Testing (X-ray, CAT Scan, MRI, EEG, EKG, Ultrasound)_____________________

____

What screening tests has the child had (blood, hearing, vision, etc.)?

____

____

____

Significant physical trauma (car accidents, falls, injuries, broken bones, etc.)

____

____

Significant emotional trauma (divorce of parents, death of a loved one, etc.)

____

____

Conditions (N=never, M=mild, A=average, S=severe):

Rubella (german measles)____
Roseola____
Impetigo____
Measles____
Scarlet Fever____
Mononucleosis____
Chicken Pox____
Whooping Cough____
Ear Infections____
Mumps____
Strep Throat____
Rheutmatic Fever____
Diptheria_____
Other___________________

Family History (Please indicate if on father's (F) or mother's (M) side of family)

Cancer___ Diabetes___ Heart Disease___ High Blood Pressure___ High Cholesterol___

Stroke___ Seizures___ Asthma___ Allergies___ Anemia___ Kidney Disease___

Tuberculosis___ Depression___ Schizophrenia___ Dementia___ Arthritis___

Alcoholism/Drug Use___ Autoimmune Disease___ Suicide___ Other________________

Do either of the parents have a chronic illness? If yes, please describe:

____

____

Current History

Height______ Weight______ 1 year ago______ Allergies (food, drugs)_________________

____

Sleep (Hours/Night)____ Quality___________________ Mood on Waking?________________

Typical daily food intake (Please specify amounts):

Breakfast ____

Lunch ____

Dinner ____

Snacks____

Water/Herbal Tea ____

Soft drinks/Juice—amount/day____

Dietary Restrictions____

Medications

Current medications (prescription, over-the-counter, etc.)

____

____

Past prescription medications.

____

____

Supplements (Vitamins, minerals, herbs, etc.)

____

____

How many times has the child been treated with antibiotics? ____________________

Please indicate what immunizations the child has had:

DPT (diphtheria, pertussis, tetanus)____ Haemophilus influenza B____ Hepatitis B____

Tetanus booster; when? _____________ **"Flu"** ____ **Hepatitis A____**

MMR (measles, mumps, rubella) ____ **Polio____**

Other ____

Please indicate if any caused adverse reactions

____

____

____

Prenatal health

What was the health of the mother during the pregnancy?

Poor____ Fair____ Good____ Excellent____ Unknown____

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

How was the mother's diet during pregnancy?

Poor____ Fair____ Good____ Excellent____ Unknown____

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 or emotional trauma

Other____

____

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

Tobacco_________ Alcohol___________ Recreational drugs_________________

Prescription medications____

Over-the-counter medications____

Supplements____

Other____

Birth History

Term length:

Full____ Premature___________ wks_______ Late____________ wks________

Length of labour:_________________________ Weight at birth_____________________

Any complications?____

Was the birth: Vaginal___ C-section___ Induced___ Forceps___ Anesthesia used___

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

Jaundice____ Rashes____ Seizures____ Birth injuries__________________________

Birth defects____

Other ____

Diet

How was the infant fed? Breast fed____ How long? ______________

Formula____ Milk/Soy: ______________ Other: ____________________________________

What foods were introduced before 6 months? (Please list approximate month as well.)

____

____

6–12 months?

____

____

____

Did the child ever experience colic? Yes____ No____

If yes, how severe? mild____ moderate____ severe____

Does the child have any food allergies or intolerances? Please list. _________________

____

____

Health and Development

How was the child's health in the first year?

Poor____ Fair____ Good____ Excellent____ Unknown____

At what age did the child first:

Sit up ________________________ Crawl ________________________

Walk ________________________ Talk ________________________

Describe the child's sleep pattern

____

____

How would you describe the child's temperament? ___________________________________

How would you describe the child's behaviour and performance at school?

____

____

____

Environment

Is the child in: school____ daycare____ home care____ other_____________________

What are the child's favorite activities?

____

____

____

Does the child exercise regularly? How much, how often?

____

____

____

How much television does the child watch? ________ hrs a day/week

Does anyone in the child's household smoke? Yes____ No____

Are there animals in the home? Yes____ No____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? If so, please describe.

____

____

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

____

____

Review of Systems: Please check if the child has experienced any of the following symptoms now (N) or in the past (P).

General

Poor sleep____	Night sweats____	Sudden energy drop____
Poor appetite____	Sweat easily____	Peculiar tastes/smells____
Chills____	Strong thirst____	Fatigue____
Fevers____	Weight gain____	Change in appetite____
Cravings____	Weight loss____	

Neuropsychological

Depression____	Anxiety/nervousness____	Tension____
Mood swings____	Loss of balance____	Quick temper____
Poor memory____	Dizziness____	Concussion____
Seizures____	Numbness/tingling____	Lack of co-ordination____

Endocrine

Heat/cold intolerance____	Excess thirst____	Hypoglycemia____
Diabetes____	Excess hunger____	

Immune

Slow wound healing____	Swollen glands____	Chronic infections____
	Muscle weakness____	Frequent colds/flus____

Skin and Hair

Rashes ____	Itching____	Eczema/hives____
Acne____	Colour change____	Lumps____
Hair loss____	Dandruff____	Changing moles____
Ulcerations____		

Musculoskeletal

Joint pain/stiffness____	Broken bones____	Hand/wrist pain____
Muscle cramps/spasm____	Weakness____	Hip pain____
Neck pain____	Back pain____	Foot/ankle pain____
Shoulder pain____	Knee pain____	

Gastrointestinal

Indigestion____	Gas____	Bad breath____
Constipation____	Abdominal pain/cramps____	Nausea____
Vomiting____	Blood in stool____	Rectal pain____
Difficulty swallowing____	Black stools____	Diarrhea____
	Heartburn____	Jaundice (yellow skin) ____
	Ulcer____	Change in appetite____

Head/Eyes/Ears/Nose/Throat

Headaches____
Head/Neck problems____
Migraines____
Head injuries____
Spots in vision____
Blurry vision____
Glasses/contacts____
Double vision____
Eye pain____
Colour blindness____
Tearing/dryness____
Poor hearing____
Ringing in ears____
Earaches____
Sinus problems____
Nose bleeds____
Stuffiness____
Chronic sore throat____
Teeth grinding____
Loss of smell____
Dental cavities____
Goiter____
Facial pain____
Lumps____
Jaw/TMJ problems____
Swollen glands____
Pain/stiff neck____

Cardiovascular

High/low blood pressure____
Heart disease____
Blood clots____
Fainting____
Irregular heart beat____
Dizziness____
Swollen feet____
Cold hands/feet____
Chest pain____
Murmurs____
Palpitations____

Respiratory

Cough____
Difficult breathing____
Bronchitis____
Asthma____
Pneumonia____
Coughing of blood____
Wheezing____
Pain on breathing____
Phlegm (colour) ____
Shortness of breath____

Peripheral Vascular

Anemia____
Cold hands/feet____
Bleed/bruise easily____

Genito-Urinary

Frequent urination____
Unable to hold urine____
Pain on urination____
Wake to urinate____
Blood in urine____
Decrease in flow____
Kidney stones____
Urgency to urinate____

Male Only

Hernias____
Testicular pain____
Testicular mass____
Discharge____

Female Only (if applicable)

Age of first menses____
Duration of menses____
Menstrual cramps____
Heavy menses____
Length of cycle____
Irregular periods____
Vaginal discharge____
Light menses____
Bleeding between cycles____
Ovarian cysts____
Vaginal sores____
PMS____
Nipple discharge____
Breast lumps____

General Questions

Why did you choose to bring the child to our clinic?________________________________
____

What do you know about our approach to healthcare?______________________________
____

What are three expectations that you have from this visit to our clinic?

1. ____
2. ____
3. ____

What long term expectations do you have from working with us?____________________
____

What expectations do you have of me personally as the child's physician?____________
____

What is your current level of commitment to support the child regarding lifestyle changes that may be required? (Please rate for 1-10 with 10 being most committed)

1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___ 10___

What behaviours or lifestyle habits does the child currently engage in that you believe are beneficial to their health?____
____

What behaviours or lifestyle habits does the child currently engage in that you believe have a negative impact on their health?____
____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining The child's health and in following the treatment plans which we will be sharing with you?____
____

Is there anything that you feel we have missed that is important to you?_____________
____
____
____
____

All fees for services and supplements are the responsibility of the patient, payable in full at the end of the appointment. Payment can be made in the form of cash, personal cheque, Interac or credit card. Please note that MSP *does not cover Naturopathic services (except those on Premium Assistance at a rate of $23 per visit).* Many extended health care plans cover Naturopathic medical services; please check the specifics of your plan. You will be supplied with the necessary receipts to submit to your insurance company.

Important – Cancellation Policy

If you need to cancel or reschedule your appointment, 24 HOURS NOTICE *by phone* is required or there will be a cancellation fee incurred. This fee is equivalent to the cost of the appointment missed. This helps cover clinic operation costs and avoids the need to increase consultation fees.

Read and understood by:

Signature: ________________________________ **Date:** __________________________