be well
COLLINGWOOD

CHILD INTAKE FORM

Child's Name:_____ Date of Birth: _____ Age: _____ Gender: M / F

Who is filling out this form? Name: _____ Relationship to child: _____

Contacts (in order of preference):

1. Name: _____ Home Phone: _____ Work: _____

Address:_____ City:_____ Postal Code:_____

Email:_____ Relationship to Child: _____

2. Name: _____ Home Phone: _____ Work: _____

Address (if different than above):_____City:_____ Postal Code:_____

Relationship to Child: _____

Who does the child live with? _____

Other health care providers:

Name:_____ Designation:_____ Phone:_____

Name:_____ Designation:_____ Phone:_____

Name:_____ Designation:_____ Phone:_____

How did you hear about our Naturopathic medical services? _____

THIS IS A CONFIDENTIAL MEDICAL RECORD AND WILL BE KEPT IN SECURE ELECTRONIC FORM. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON, EXCEPT FOLLOWING APPROPRIATE WRITTEN AUTHORIZATION. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

What are your child's primary health concerns (in order of importance)?

1. _____

2. _____

3. _____

4. _____

Has your child seen any specialists? Yes No If yes, please indicate name of the doctor and year of visit:

_____

_____

_____

_____

MEDICAL HISTORY:
Please list all **CURRENT prescription and non-prescription medications** (vitamins, herbs, homeopathics, etc) your child is taking. Please indicate the name, dosage, duration of use and reason for use:

_____

_____

_____

_____

Has your child ever had an adverse reaction to a medication? Indicate the drug and the reaction experienced:

_____

How many times has your child been treated with antibiotics? _____

Immunizations (please check):

- Flu Shot ☐ Diptheria/Pertussis/Tetanus ☐ Measles/Mumps/Rubella
- Haemophilus Influenza ☐ Chicken Pox ☐ Polio
- Hepatitis A ☐ Hepatitis B ☐Bacterial Meningitis and Otitis Media

Describe any adverse reactions: _____

List all known allergies (food, medicines, environmental, seasonal, etc.): _____

_____

Which of the following diseases has your child had?

- Measles ☐ Roseola ☐ Impetigo
- Mumps ☐ Scarlet Fever ☐ Mononucleosis
- Rubella ☐ Whooping Cough ☐ Ear Infections
- Chicken Pox ☐ Strep throat

Please indicate any serious conditions, illnesses, injuries, and/or any hospitalizations you child has experienced, with approximate dates (if possible): _____

_____

_____

FAMILY MEDICAL HISTORY:

Relation	Current Age	Health problems	Cause, if deceased
Father			
Mother			
Grandparents			
Siblings			

PRENATAL HEALTH:

What was the health of the parents at conception (please circle)?

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

What was the mother's age at the 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 pregnancy?

☐ Bleeding ☐ Diabetes ☐ High Blood Pressure ☐Nausea

☐ Vomiting ☐ Thyroid Problems ☐ Physical/ emotional trauma

Other: _____

Did the mother use any of the following during pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational Drugs:

_____

☐ Prescription medications: _____

☐ Over-the-counter medications: _____

☐ Supplements:_____

BIRTH HISTORY:

Pregnancy Length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Location of birth: ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other: _____

Type of birth: ☐ Vaginal ☐ C-section

Types of Intervention Used: ☐ Induced labour ☐ Use of forceps ☐ Epidural/anaesthesia
☐ Other:_____

Length of Labour: _____ Birth Weight: _____

Did the child experience any of the following at, or shortly after, birth?
☐ Jaundice ☐ Seizures ☐ Colic ☐ Respiratory Difficulties: _____
☐ Birth injuries: _____ ☐ Birth defects:
_____
☐ Skin Disorders: _____ ☐ Other:
_____

FEEDING HISTORY:

How was your child fed as an infant?
☐ Breast fed: How long? _____ ☐ Formula: Milk/Soy/Other:
_____

Please describe any reactions you observed: _____
When was your child first introduced to solid foods, and in what order? _____
_____

If any adverse reactions were noticed, what were they? _____

Please describe a typical day's diet:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages (and total quantity): _____
What are your child's favourite foods? _____

Does your child drink caffeine (i.e. pop, tea)? YES NO Type: _____ Frequency: _____

HEALTH AND DEVELOPMENT:

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

At what age did your child first:
Sit up: _____ Crawl: _____ Walk: _____ Talk: _____

Is your child in: ☐ school ☐ daycare ☐ homecare ☐ other:

_____

What are your child's favourite activities? _____
_____

How many hours of sleep does your child get per night? _____

Does your child have any problems associated with sleeping (e.g., trouble falling asleep, waking up throughout the night, etc.)? _____

Does your child exercise regularly? YES NO How much and how often? _____

How much television does your child watch? _____ (hrs per day)

Is your child exposed to second hand smoke? YES NO Where? _____

Is your child frequently exposed to animals? YES NO What type? _____

Do you know of any toxins or other hazards that your child is regularly exposed to (home renovations, chemicals, older home/school)?_____

Please list any other relevant health/personal information that you feel is missing:
_____
_____

Lia Sonnenburg- Naturopathic Doctor

INFORMED CONSENT TO TREATMENT OF A MINOR

This is to acknowledge that I, _____, parent/legal guardian of _____, whose relationship to me is as a _____, have been informed and understand that:

I would like to take this opportunity to welcome you and your child to the services of Lia Sonnenburg, Naturopathic Doctor. You acknowledge that you are indeed the legal parent or guardian of the above-mentioned child.

This practice utilizes the principles of Naturopathic Medicine to assist the body's own ability to heal and thrive. A number of different approaches may be used such as: Clinical nutrition and Nutritional supplements, Botanical/Herbal Medicine, Homeopathy, Traditional Chinese Medicine, Physical Medicine, Intravenous/Injection Therapy and Lifestyle Counseling.

The slight health risks of some Naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms or conditions, allergic reaction to supplements or herbs and pain, fainting, bruising or injury from acupuncture.

Your practitioner will conduct a thorough case history. As part of a naturopathic intake assessment, a physical exam and/or specific laboratory tests (blood and/or urinary) may be required and used as part of the treatment work-up (as deemed necessary after a comprehensive intake).

Although Naturopathic Medicine uses very gentle therapies, even these may induce complications in certain physiological including but not limited to diabetes, liver, autoimmune, gastrointestinal, heart or kidney disease. It is therefore important to inform your Nathuropathic Doctor of any illnesses your child suffers from or medications he/she may be taking (prescription or over-the- counter).

As the legal guardian of the patient seeing Lia Sonnenburg, ND, I am at liberty to seek or continue medical care from a medical doctor or other health care provider for my child. This consent form is intended to cover the entire course of treatment for his/her present condition.

- I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
- 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 without my consent unless required by law.
- I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.
- I understand that the Naturopathic Doctor will answer any questions I have to the best of her ability.
- I understand that the results are not guaranteed. With this knowledge, I voluntarily agree to the diagnostic and therapeutic treatments recommended to me.
- I understand that treatment advice will not be given over the phone or via e-mail unless directly relating to specifics discussed during a clinic visit.
- I understand that I need to book a follow-up visit in order to discuss changes to my case or new symptoms that may arise. I will also notify my ND when I have an adverse reaction to a treatment recommended to me.
- I understand that I may receive emails and newsletters from time-to-time with information about clinic ongoings and health tips, I have the right to unsubscribe at anytime
- I accept full responsibility for any fees incurred during care and treatment.
- I understand that charges are to be paid at the time of the visit unless previous arrangements have been made prior to my scheduled appointment.

- I also understand that the Cancellation policy requires me to cancel and/or reschedule a booked appointment 24 hours prior to a given, scheduled appointment. Cancellations with less than 24 hours notice will incur a charge of 100% of the scheduled office visit fee that must be paid prior to the next visit.

With this knowledge, as parent/legal guardian, I voluntarily consent to the examination and administration of Naturopathic Medical care and treatment mentioned above, except for:

_____

_____

Dated in _____, ON this_____ day of _____, _____

Guardian's Name: _____

Signature of Guardian: _____

Signature of Naturopathic Doctor: _____