LONSDALE NATUROPATHIC CLINIC

# Confidential Pediatric Case History

Please help me to understand your child's health needs by carefully completing this intake form.
All information is strictly confidential.

## Patient Information:

**Child's Name:** _____ **Age:** _____ **Gender:** _____

**Date of Birth:** _____ _____ _____ **Care Card # (PHN):** _____
(Month) (Day) (Year)

## Parent/Guardian Information:

**Name:** _____ **Relationship:** _____ **Phone:** _____
**Name:** _____ **Relationship:** _____ **Phone:** _____
**Address:** _____ **City:** _____
**Province:** _____ **Postal Code:** _____ **Phone:** _____

**Contact in case of emergency:** _____ **Phone:** _____
**Child's GP or Pediatrician:** _____
**How did you hear about the clinic?** _____

**Please list all of your child's known allergies (medications, foods, airborne, etc):** _____
_____
_____

## Current Health:

**Please list the reasons for your child's visit:**

**1.** _____ **3.** _____
**2.** _____ **4.** _____

**Please list any medications or natural supplements your child is presently taking:** _____
_____

**Current weight:** _____ **Current height:** _____
**How often does your child have a bowel movement?** _____
**How is your child's energy?** ☐**Extremely Low** ☐**Barely Enough** ☐**Good** ☐**Excellent** ☐**Too High**

**Please describe a typical day of eating for your child:**
**Breakfast:** _____
**Lunch:** _____
**Dinner:** _____
**Snacks/Beverages:** _____

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## Medical History:

**Please list any serious injuries/hospitalizations/illness/trauma, with brief details:**

_____ **Year:** _____ _____ **Year:** _____

_____ **Year:** _____ _____ **Year:** _____

**History of antibiotic use? Yes ☐ No ☐ Approximate dates:** _____

**IMMUNIZATIONS** – What vaccines has your child had?

| | | | | |
|---|---|---|---|---|
| ☐ **MMR** | ☐ **Polio** | ☐ **Hep A** | ☐ **Pneumo** | ☐ **Rotavirus** |
| ☐ **DTaP** | ☐ **HiB** | ☐ **Hep B** | ☐ **Men-c** | ☐ **Chicken pox** |

**Any adverse reactions to vaccinations? Yes ☐ No ☐ If yes, please describe:** _____

## Mother's Health During Pregnancy

☐ **Diabetes** ☐ **High blood pressure** ☐ **Severe morning sickness** ☐ **Smoking/alcohol/drug use**

☐ **Thyroid condition** ☐ **Other** _____ ☐ **Mother's age at birth:** ____

## Birth History:

**Term:** ☐**Full** ☐**Premature** ☐**Late** ☐ **Birth weight:** _____

**Birth:** ☐**Vaginal** ☐**C-Section**

**Birth complications or interventions:** _____

**Feeding: Breastfed? Yes ☐ No ☐ How long:** _____

**When was food introduced?** _____

**First foods:** _____

## Family History:

Has anyone in your child's immediate family been diagnosed with any of the following?

☐ **Autoimmune condition** ☐ **Diabetes** ☐ **Heart Disease** ☐ **Cancer: type(s)** _____

☐ **Mental illness** ☐ **Thyroid disease** ☐ **Other** _____

## Overview of Body Systems:

Has your child had any of the following conditions in the past or currently:

| | | | | |
|---|---|---|---|---|
| ☐ **Allergies** | ☐ **Colic** | ☐ **Dry skin** | ☐ **Heart murmur** | ☐ **Stuffy nose** |
| ☐ **Anemia** | ☐ **Cough/Wheeze** | ☐ **Earache(s)** | ☐ **High fever** | ☐ **Thrush** |
| ☐ **Asthma** | ☐ **Croup** | ☐ **Eczema/rashes** | ☐ **Insomnia** | ☐ **Vomiting spells** |
| ☐ **Bedwetting** | ☐ **Depression** | ☐ **Frequent infections** | ☐ **Jaundice** | ☐ **Other** _____ |
| ☐ **Birth defects** | ☐ **Diarrhea** | ☐ **Headaches** | ☐ **Learning problem(s)** | |

Is there any other information that I should know about your child?

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# Consent to Naturopathic Treatment

Dear patients:

Naturopathic examination includes: physical and clinical diagnosis, traditional Chinese medical diagnosis and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, manual muscle therapy, cranio-sacral therapy, clinical nutrition, lifestyle counselling and Inter-Muscular Injection Therapy.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure result.

I understand the visit costs for Naturopathic treatment are as follows:

Initial Pediatric Consultation $140.00
The Initial visit is 40 minutes with Dr. Dayal

Subsequent Pediatric Consultation $70.00
Subsequent visits are 20 minutes with Dr. Dayal

I understand that if I miss an appointment or cancel on short notice (less than 24 hours), I may be charged a fee for the missed appointment.

| | |
|---|---|
| Patient Name | Guardian Signature |
| Guardian Signature | Date |
| Doctor's Signature | Doctor's Name |

## Welcome!

Thank you for taking the time to fill out this extensive questionnaire. Your time and care is appreciated.