

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: _____

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?



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 \$170.00

The Initial visit is 40 minutes with Dr. Dayal

Subsequent Pediatric Consultation \$85.00

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.