www.monctonnaturopathic.com
12 Fifth Street, Moncton, NB, E1E 3G9
Ph: 506-382-1329 Fax: 506-382-1828

Pediatric Intake Form (6-12 years)

Last Name:________________First:____________Middle:__________ Date: _____________

Age: ____ Date of Birth: _____/_____/_____ Gender (circle one): female or male
Mother's name: ______________________ Father's name:______________________
Address: ____
City: ___________________________ Province: ______ Postal Code: ___________
Phone # (home): (_____)______________ Parent's # (work): (____)_____________
NB Medicare #: ____
Parent's email address: ____

Which is your preferred contact method for visit reminders (circle one)?
email or phone
Which is your preferred spoken language during office visits (circle one)?
English or Français

How did you hear about our clinic (be as specific as you can)? _______________
____

HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in **order of importance**:

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

Does your child have a contagious disease at this time? Y N
If yes, what? ____

Previous Illnesses

Rheumatic fever	Y N	German measles	Y N
Chicken pox	Y N	Measles	Y N

Tonsillitis	Y N	approx. number ____________________
Ear infections	Y N	approx. number ____________________
Other	Y N	list ________________________________

Has your child had any of the following tests? <u>When</u> <u>Where</u>

Electroencephalogram (EEG)

....

Psychological evaluation

....

Hearing tests

....

Speech/Language tests

....

Hospitalizations/ Surgeries/ Injuries

What hospitalizations, surgeries or injuries has your child had?

____

____

Immunizations

Polio	Y N	Pertussis	Y N
Tetanus shot	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N

Any adverse reactions? Y N If yes, what ? ______________________________

Allergies

Is your child hypersensitive or allergic to:

Any drugs?____

Any foods? ____

Any environmental?____

Typical Food Intake

Breakfast:____

Lunch: ____

Dinner: ____

Snacks: ____

To Drink: ____

Please list **any** prescription medications, over the counter medications, <u>vitamins</u> or other <u>supplements</u> your child is taking:

1) ______________________________ 5) ______________________________

2) ______________________________ 6) ______________________________

3) ______________________________ 7) ______________________________

4) ______________________________ 8) ______________________________

REVIEW OF SYSTEMS

Y = a condition now **P** = <u>significant</u> problem in the past **N** = never had

MENTAL/ EMOTIONAL

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N

ENDOCRINE

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

SKIN

Rashes	Y	P	N	Eczema, Hives	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N

HEAD

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

EYES

Glasses or contacts	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N				

EARS

Earaches	Y	P	N	Impaired hearing	Y	P	N

NOSE AND SINUSES

Frequent colds	Y	P	N	Nose Bleeds	Y	P	N
Stuffiness	Y	P	N	Hayfever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

MOUTH AND THROAT

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N				

RESPIRATORY

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

CARDIOVASCULAR

Heart disease	Y	P	N	Murmurs	Y	P	N

URINARY

Frequent urination	Y	P	N	Bed wetting	Y	P	N

GASTROINTESTINAL

Belching/passing gas	Y	P	N	Stomach aches	Y	P	N
Constipation	Y	P	N	Diarrhea	Y	P	N

Bowel Movements How often ____________________________________

Breastfed? ____how long? ______Formula?____________ milk / soy/ other _____

MUSCULOSKELETAL

Joint pain/stiffness	Y	P	N	Muscle spasms/cramps	Y	P	N
Broken bones	Y	P	N				

BLOOD/PERIPHERAL VASCULAR

Anemia	Y	P	N	Easy bleeding/bruising	Y	P	N

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

Welcome! We're honored to be of service for you and your child!

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Statement of Acknowledgement of Visit Fees Schedule:

Printed name of patient: ________________________

FEE SCHEDULE

Initial visits:

Pediatrics (12 & under)	*$160 (if a 60min visit)*
- if extends longer	*$200*
Oncology:	*$250 (1hour 15-30min visits)*

Return visits:

Visit fees are based on time spent with the doctor: $13.50 per 5 minutes.

30 min. shorter visits:	*$80*
40 min. visits:	*$107*
45 min. typical visits:	*$120.50*
50 min. visits:	*$134*
Phone/email consults:	Based on time required as per visit fees.

Please note:

Our doctors try their best to be as efficient as possible and keep visits length within proposed time frames: e.g. 1 hour & 15 minutes for pediatric initial visits ($160) and 45 minutes for typical return visits ($120.50). Because of the complexity of each person's health issues this can be challenging and may require longer consults. Children with a complex medical condition, the initial visit may have taken longer than 60 minutes in which case an extended visit fee of $200 would have been applied. Oncology (cancer) patient visits are $250 to allow the doctor the extra time needed to review labs/imaging studies after your appointment.

For upcoming return visits, the length of the appointment may take longer than 45 minutes (should extra time be needed to fully address your health concerns), in which case visit fees will reflect the additional time taken per 5 minutes increments (e.g. 50 minutes return visits = $134; 60 minutes return visits = $160). Likewise, should less time be needed, the shorter appointment will be based on your time spent with the doctor (e.g. 30 minutes return visits = $80).

Please let your doctor know at the start of the appointment should you have timing/financial restrictions and prefer a shorter or longer appointment.

I consent to receive naturopathic treatment. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: ______________________ Date: _____________

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Declaration and Informed Consent for Naturopathic Care

We would like to take this opportunity to welcome you. Your naturopathic doctor will conduct a thorough case history, physical examinations (when indicated) and may recommend specific blood, urinary or other laboratory reports as part of the treatment work-up. Your naturopathic doctor integrates supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

Statement of Acknowledgement

Printed name of patient: _________________________

As a patient, I have read this information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided in this intake form is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms;
- allergic reactions and other adverse effects to supplements, homeopathics or herbs;
- pain, fainting, bruising or injury from acupuncture, venipuncture or intramuscular vitamin injections; and
- muscle strains, sprains and spasms, disc injuries from spinal manipulations.

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. It is highly recommended that I update my health care providers of any new treatments.
- I also confirm that I have the ability to accept or reject this care of my own free will and choice. I understand results are not guaranteed. I accept full responsibility for any fees incurred during care and treatment.
- I understand that a record will be kept of my visits. This record will be kept confidential and **will not be released** without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- No recording devices shall be used during a consultation without the express permission of both parties.
- I am responsible for **payment at the time services are rendered.** Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.
- I understand that your naturopathic doctor reserves the right to determine which cases fall outside of his scope of practice, in which case the **appropriate referral will be recommended.**
- I have read and understand the **Privacy Policy** which is available on the clinics website at www.monctonnaturopathic.com (see Forms).

I consent to receive naturopathic treatment. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: ______________________ Date: _____________