Moncton Naturopathic
Medical Clinic - Clinique Médicale

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

Pediatric Intake Form (Birth - 5 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): (___)_____Parents # (work): (___)_____
NB Medicare #: _____
Parents e-mail address: _____
Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept: _____
_____
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 this clinic (be as specific as you can)? _____

Reason for referral or presenting problems: _____

MEDICATIONS	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Anti-histamine	_____	_____
Decongestant	_____	_____	Other	_____	_____
Ibuprofin	_____	_____	Allergies to medicines	_____	

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is *currently* taking:
1) _____ 3) _____
2) _____ 4) _____

MEDICAL HISTORY (Y/N)

_____ Chicken pox	_____ Scarlet fever	_____ Tonsillitis, approx. no. _____
_____ Measles	_____ Pneumonia	_____ Ear infections, no. _____
_____ Mumps	_____ Frequent colds	_____ other (please list) _____
_____ Rubella	_____ Rheumatic fever	

Has your child had any of the following tests?	When	Where	Results
Electroencephalogram	.....		
Psychological evaluation	.....		
Hearing	.....		
Speech/Language	.....		

Injuries/Surgeries/Hospitalizations (please list): _____
_____

IMMUNIZATIONS

_____ Measles	_____ Polio	_____ MMR	_____ Smallpox	_____ Diphtheria
_____ Mumps	_____ DPT	_____ Tetanus	_____ Influenza	

Others (list) _____

Any adverse reactions? Y N What ? _____

FAMILY HISTORY

_____ Heart disease	_____ Diabetes	_____ Birth defects
_____ Hypertension	_____ Arthritis	_____ Tuberculosis
_____ Cancer	_____ Allergies	_____ Mental illness

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____

_____

Mother's health during pregnancy?

_____ Bleeding _____ Physical or emotional trauma
_____ Nausea _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid problems _____ Diabetes

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____ Weight at birth_____
Length of labor _____ Complications? _____
Did your child have any of the following problems shortly after birth?

_____ Birth defects _____ Birth injuries _____ Blue baby
_____ Cerebral palsy _____ Seizures _____ Jaundice
_____ Colic _____ Fever _____ Rashes

Other (explain) _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breastfed? _____ how long? _____ Formula? ___ milk / soy / other_____

Age began solids _____ Which foods? _____

Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

_____ Hives _____ Burning of urine _____ Bloody urine
_____ Eczema _____ Frequent urination _____ Cries easily
_____ Bleeding gums _____ Heart murmur _____ Nervous
_____ Nose bleeds _____ Vomiting spells _____ Sleep problems
_____ Acne _____ Anemia _____ Night sweats
_____ High fevers _____ Stomach aches _____ Sensitive to light
_____ Chronic rash _____ Jaundice _____ Body/breath odor
_____ Hearing loss _____ Easy bruising _____ Motion/car sickness
_____ Diarrhea _____ Flat feet _____ No appetite
_____ Sore throats _____ Constipation _____ Nightmares
_____ Headaches _____ Gas _____ Canker sores
_____ Frequent colds _____ Bleeding tendency _____ Unusual fears
_____ Wheezing _____ Joint pains _____ Excessive fatigue
_____ Cough _____ Dizzy spells _____ Hair loss

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Thank you. We look forward to helping your child in any way we can.

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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: _____