CHILD INTAKE FORM **Dr Nadia Tymoshenko ND, Naturopathic Doctor**

Name _____ Age_____ Birthdate _____ Sex: M F

Address_____City_____ Postal code_____

Email (for appointment reminders)_____ How did you hear about me?_____

If Internet, how specifically did you find me (certain search terms, Glenbourne website, Nadia-ND website, FB):

_____

Parents/Guardians: (include any phone numbers at which we may phone you or leave messages):

Name _____ Relationship to Child_____

Phone (Home) _____ (Work) _____ (Cell)_____

Name _____ Relationship to Child_____

Phone (Home) _____ (Work) _____ (Cell)_____

Who does the child live with? _____

What are your child's health concerns, in order of importance?

_____

_____

_____

Other health care providers: indicate their name and title (i.e., MD, Chiropractor, Counsellor):

_____

Child's Medical History: Please indicate any health conditions, illnesses, injuries, surgeries and hospitalizations, along with approximate dates:

Current and past illnesses or conditions:_____

_____

Injuries, surgeries and hospitalizations:_____

_____

Please list all known allergies: _____Have an EpiPen?____

Please list all prescription and over-the-counter medications your child is taking
(Include the name, dose, duration of use, and reason for taking each one):

_____

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

Please list all supplements your child is taking (i.e., vitamins, herbs, homeopathics):

_____

_____

Which vaccinations has your child had?_____

Any adverse reactions to any vaccinations?_____

Family History

Indicate if a close relative (parent, sibling, grandparent) has had any of the following:

	Which relative(s):		Which relative(s):		Which relative(s):
Allergies	_____	Heart disease	_____	Diabetes	_____
Asthma	_____	Autoimmune disease	_____	Cancer	_____
Eczema	_____	Kidney disease	_____	Arthritis	_____
Depression	_____	Mental illness	_____	Epilepsy	_____

Other_____

Do either of the parents have a chronic illness? If yes please describe:

_____

Prenatal Health (if known)

How was the health of the parents at *conception*?
Mother: □Poor □Fair □Good □Excellent Father: □Poor □Fair □Good □Excellent
How was the mother's physical health during pregnancy? □Poor □Fair □Good □Excellent
How was the mother's emotional health during pregnancy?□Poor □Fair □Good □Excellent
How was the mother's diet during pregnancy ? □Poor □Fair □Good □Excellent
What was the mother's age at the child's birth? _____

Did the mother experience any of the following during pregnancy:
□Nausea □Vomiting □Bleeding □High blood pressure □Diabetes □Toxemia
□Thyroid problems □Physical stress/trauma □Emotional stress/trauma
Other:_____
Did the mother use any of the following during pregnancy?
□Supplements: (Please list) _____
□Prescription Medications: (Please list) _____
□Over-the-counter Medications: (Please list) _____
□Tobacco □Alcohol □Recreational drugs Other: _____

Birth History

Pregnancy Length: □Full term □Premature: _____weeks □Late: _____weeks
Length of labour: _____ Child's birth weight: _____
Was the birth: □Vaginal □C-section □Induced □Forceps □Epidural/anaesthesia
Was the mother given Intravenous antibiotics during labour? _____

Any complications for mom or baby during labour or delivery?_____
Did the child experience any of the following at birth or soon after?
□Jaundice □Rashes □Seizures □ Respiratory difficulties □Birth injuries □Other_____
Did the mother experience post-partum depression?_____ Was it: □Mild □Moderate □Severe

How was your child fed as an infant?
□Breast-fed: how long? _____ □ Formula-fed: □Milk □Soy □Other_____
□Other _____ Any reactions to any of these (i.e. rashes, constipation)? _____
At what age was your child first introduced to foods (other than breast milk or formula)? _____
What foods were introduced first? _____
Did your child ever experience colic? □Yes □No Was it: □Mild □Moderate □Severe

Please describe child's current diet in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____ Beverages_____

Please list any food allergies or sensitivities _____
Please list any dietary restrictions (i.e., religious, vegetarian/vegan) _____

General Health
How often does your child have a bowel movement?_____
Any problems associated with digestion? _____
How many hours of sleep does your child typically get per night?_____
Any problems associated with sleep? _____
For girls – has menstruation begun?_____ If yes, since when_____
Is your child in: □School (grade:_____) □Daycare □Home care □Other_____
Any concerns with your child's behaviour or performance at school/daycare:
_____
Rate your child's typical stress level None Minimal Average High Very high Unbearable
Any concerns with your child's moods or emotional health?_____
Does your child exercise regularly? □Yes □No Are there any pets in the home? □Yes □No _____
Are there any chemicals or toxins your child is regularly exposed to? (cigarette smoke, mould, home renos)

_____

How would you describe the emotional climate of your child's home?

_____

Please provide any other relevant health/personal information that you feel is important:

_____

Thank you. All information will be kept confidential. I look forward to helping you any way I can.

dr.nadia.nd
Nadia Tymoshenko|Naturopathic Doctor
Nadia-ND.com

Pediatric Consent Form **(Please read and sign this page)**

Naturopathic medicine is the treatment and prevention of disease by natural means. Gentle, non- invasive techniques are used in order to support and stimulate the body's inherent healing capacity. Naturopathic therapies include: diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, naturopathic bodywork, and lifestyle counselling. Your Naturopathic Doctor will take a thorough case history, perform a physical examination as is pertinent to your child's case, and make recommendations based on the history, findings and assessment.

Statement of Acknowledgement & Consent to Treatment

I understand that Nadia Tymoshenko ND provides naturopathic medical care based on the practices mentioned in the previous paragraph. I understand that it is my responsibility to provide complete information of all health concerns including but not limited to: any illness, diagnosis, and all prescription & over the counter medications the child is taking. I understand that results cannot be guaranteed. As with any form of medicine, there is a potential for aggravation of pre-existing symptoms or allergic reactions (i.e., to herbs or supplements). I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I understand that any questions I have will be answered by Nadia to the best of her ability.

I understand that a record will be kept of the health services provided. This record will be kept confidential and will not be released to others unless directed by me in writing or unless required by law. I understand that I am at liberty to seek or continue care from a medical doctor or other health care provider.

With this knowledge, I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I intend this consent to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures any time.

Child's name_____ Date_____

Parent/guardian's signature_____ Parent/guardian's name printed_____

Payment Policy

All payments are due in full at the time of each appointment. Our clinic accepts payment by cash, debit and credit card. First pediatric visit is $140, follow-up visits are $85.

Please provide at least 24 hours notice to change or cancel appointments. The full appointment fee will be billed if you do not give sufficient notice of cancellation or change. This fee also applies to missed appointments. Exceptions can be made for extenuating circumstances.

Many people have extended health care benefits through their own plan or another family member's plan that covers naturopathic consultations. We recommend you check with your benefit plan and familiarize yourself with their procedures. At each appointment, we provide you with an official receipt that you can submit for reimbursement.

I agree to pay for my appointments in full at each appointment. I understand the cancellation policy and agree to pay the appointment fee if I fail to give at least 24 hours notice of cancellation or change.

Parent/guardian's signature_____ Date_____