

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 we can phone 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? _____

What types of infections were the antibiotics for? _____

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 Home Birth

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 At home 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 reno's)

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

Consent Form (Please read and sign both sections of 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 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 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, pregnancy, breast-feeding, and all prescription & over the counter medications I am taking. I understand that results cannot be guaranteed. As with any form of medicine, there is a potential for aggravation of 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 to me. 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.

Signature _____ **Date** _____

If a guardian has signed, please **print guardian's name and relation** _____

Payment Information & Cancellation Policy

Our clinic accepts payment by cash, debit & credit card. Payment is due at each appointment. First visit is \$160 (**\$140 for child** 17 years old or younger & seniors age 65+), half hour follow-up visits are \$85.

Naturopathic fees are not covered by provincial health care/MSI. Most extended health insurance plans offer coverage. We provide an official receipt that you can submit for reimbursement.

Please be advised that you are responsible for appointment times you have reserved. Appointments are in high demand, and your early cancellation/reschedule will give another person the possibility to access that time. Therefore, we require at least **2 business days notice** to change or cancel your naturopathic appointment. If you miss or cancel an appointment without 2 business days notice, you will be responsible to pay a \$50 fee. Exceptions to this policy can be considered in emergency situations.

I agree to pay for my appointments in full at each appointment. I understand that I may be billed \$50 for missed or forgotten appointments or with less than 2 business days notice of cancellation or change.

Signature _____ **Date** _____