WOODBRIDGE AVENUE CHIROPRACTIC AND WELLNESS CENTRE
53 WOODBRIDGE AVENUE, UNIT 4
WOODBRIDGE, ON, L4L 9K9
P: 905-264-8107 F: 905-264-8542

Pediatric Intake Form

Child's Name: ____ Date: ____________________

Address: ____City:________________________

Postal Code: ____________ E-mail: ____

Date of birth : ________________Sex:______Age: ________ Weight: _________ Height: ___________

Parent/Guardian Name: ____Relation:____________

Phone (primary): ____________________________ other: ____________________________________

May we leave phone messages relating to child's visits? Y/N

Medical Doctor: _________________________________ Phone: _______________________________

Have your child received naturopathic care previously? ___________________________

How did you hear about us: ____

What are the child's main health concerns in order of importance to you?

1. __________________________________ 2. ______________________________________

3. __________________________________ 4. ______________________________________

Does the child have any known allergies or sensitivities ?

____

Please list all the vitamin, mineral, herbal supplement the child iscurrently taking and for how long? (include the brands)

__________________________________ ____

__________________________________ ____

__________________________________ ____

Please list all the medications that the child is taking and for how long? *Please all the medications or photo to first visit*

___________________________________ ____

___________________________________ ____

___________________________________ ____

Please list any injuries, major surgeries, major diseases or illnesses that child has had and when they occurred?

____

How many times have the child been treated with antibiotics ? _______

Does your child have any dietary restrictions: (vegetarian, vegan, religious)

____

Please check any condition that may have occurred in close relative (parent, child, sibling):

- ☐ Allergies
- ☐ Asthma
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Cardiovascular disease
- ☐ Cancer
- ☐ Mental Health Conditions
- ☐ Other: ___________________

Maternal/Prenatal Health:

Term length in weeks __________________ Birth weight _________________________

Type of Birth: ☐ Vaginal ☐ C-Section ☐ Induced ☐ Forceps ☐ Drug aided

Please list any pharmaceutical or recreational drugs taken by the mother during the pregnancy, including tobacco and alcohol:
____

____

Was the infant breast feed Y/N, How many months? _____

Was the infant bottle fed Y/N, Type of milk ? ____________

Any adverse reaction to foods?____

Vaccinations:

- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Influenza (Flu shot)
- ☐ Hep A
- ☐ Polio
- ☐ DPT (Diphtheria, Pertussis, Tetanus)
- ☐ Chickenpox
- ☐ Hep B
- ☐ Others ___________________

Is there anything you feel important that has not been covered?
____

____

Thank you for the taking your time to fill these forms out

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Please note that this form must be signed prior to child's first appointment.

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. I will conduct a thorough case history and perform any necessary physical examinations. Specific blood and/or urine laboratory samples may be used as part of treatment work-up.

It is very important that you inform your Naturopathic Doctor immediately of any disease process from which your child is suffering and any medications/over the counter drugs that he/she is currently taking.

There are some slight health risks associated with treatment by naturopathic medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Allergic reactions to certain supplements and herbs. Please advise your Naturopath of any allergies child may have.
- Pain, bruising or injury from venipuncture or acupuncture.
- Fainting or puncturing of an organ with acupuncture needles .

Supplements, remedies, botanicals, laboratory tests and other services are charged separately and are not included in the visit fee. There will be no refunds or exchanges on visit fees, supplements, remedies, botanicals, laboratory tests and other services.

Child's health records will be kept confidential and will only be released to comply with legal and regulatory requirements. It may also be used to complete claims for insurance purposes. If needed, Naturopathic doctor may communicate with other health-care providers. I may look at my child's medical record at anytime and can request a copy of it by paying $0.10 per page.

I understand:

- The clinic does not guarantee treatment results.
- I am free to withdraw my consent and to discontinue my child's treatment at any time.
- I give my informed consent to provide naturopathic medical consultation, assessment and/or treatment to my child.
- I understand that some therapies or treatments have the potential for complications
- I accept full responsibly for any fees incurred during care and treatment
- I intend this informed consent to apply to all my child's present and future naturopathic care.
- I do not expect the doctors to be able to anticipate and explain all risks and complication

Patient's Name (please print):____

Parent/Guardian Name: ____

Relationship to child:________________________________

Signature of patient or guardian:__________________________Date: __________________

ND:_________________________________