Pediatric Intake Form

General Information

Child's Name:________________Birth Date____________________Sex F M

Address____Postal Code____________

Telephone_________________________

Mother's Name_____________________Father's Name____________________________

Address (if different from child): _______________________________________

Telephone: Home___________________Work_____________May leave message? Y N

Emergency Contact:_________________Phone: ____________

How did you hear about our clinic?____

Would you like to receive our newsletter? Email Address __________________________

Primary Health Concerns

Please list health concerns order of importance to you:

Concern	When did it first occur	What makes better	What makes worse

Past/Present Medications (include supplements, antibiotics, vitamins, homeopathics)

Name	Duration

Illnesses (Past and Present)

Mumps		Ear infections		Influenza	
Measles		Frequent colds		Small pox	
Rubella		Tonsillitis		Tetanus	
Allergies		Scarlet fever		Diphtheria	
Pneumonia		Rheumatic fever		Hepatitis	
High fevers		Pertussis			
Chicken pox		Other:			

Past Medical History (surgeries, injuries, hospitalizations)

____

____

____

Symptoms Your Child has Displayed

Stomach aches		Constipation		Eczema		Tendency to bleed	
Frequent vomiting		Diarrhea		Headaches		Sore throat	
Change in appetite		Easy bruising		Cough		Bed wetting	
Body/breath odour		Nosebleeds		Wheezing		Blood in urine	
Frequent urination		Hearing loss		Fatigue		Unusual fears	
Cries easily		Hair loss		Nervousness		Dizzy spells	
Night sweats							

Suspected Allergies and Intolerances ____

____

Immunizations

Measles		Diphtheria		Hepatitis	
Mumps		Pertussis		Influenza	
Rubella		Tetanus		Small Pox	
Polio		Other			

Any adverse reactions to any of the above?

If yes, explain:____

____

Birth and Prenatal History

Term of pregnancy: __________________ Caesarean section: Y N

Birth weight: __________________ Birth length :____________

Interventions during birth (i.e. forceps, epidural):

____

If yes, explain:____

____

Mother's age at birth: ________________

Mother's health at conception (rate on scale 1 to 10): ______

Mother's health during pregnancy (rate on scale 1 to 10): ______

Symptoms or interventions during pregnancy:

Nausea		Hypertension		Rhogam Shot (Rh+/-)	
Bleeding		Physical trauma		Other illnesses (specify below)	
Thyroid problems		Diabetes		Emotional stress	
Other Ilness (list)					

Medications or drugs used during pregnancy (including alcohol, tobacco, recreational drugs):

____

____

Was infant nursed? ____________ If yes, how long? ____________________________________

If no, alternative used? ______________________________

Food reactions or intolerances (past and present): ____

____

____

Symptoms which occurred at birth or during infancy:

Colic		Rashes		Birth injuries	
Seizures		Jaundice		Birth defects	

Age the following milestones were achieved:

1st tooth		Sitting		Solid foods	
All teeth		Crawling		Toilet trained	
First words		Walking			

Child's health in the past year (1=poor, 10=excellent):____

Any significant change from the previous year: ____________________________________

If yes, explain: ____

____

Child's activity level (1=poor, 10=excellent): ______

Favourite activities or hobbies: ____

Child's temperament: ____

Behaviour and performance at school: ____

Communication with others (children and adults): ______________________________

Any pets in home:____

Urban or rural home:____

Type of heating used in home:____

Any smokers in the home:___________ If yes, how many?_________________________

How often has child moved?____

Any recent renovations to current or recent homes: ______________________________

If yes, specify: ____

____

Has child had direct exposure to any potentially harmful substances or chemicals (pesticides, herbicides, insecticides, household cleaners, lead piping, poisons etc.) Please specify:

____

What is the current parenting situation at home (both parents at home, joint custody, single parent etc.)?

____

Outside of school, about how many hours a week does the child spend at the following:

Physical activities (sports, play, etc.): _______________

Electronic activities (TV, computer, video games): _______________

Outdoor activities : _______________

Creative activities (reading, schoolwork, music, etc.): _______________

Family Health History

In the following table, please indicate which of the following ailments, have affected your relatives. Please specify any other major ailments not listed here.

Alcoholism	Asthma	Diabetes	Gout	Paralysis	Skin Disease
Allergies	Cancer	Epilepsy	Hay Fever	Pneumonia	Syphilis
Arthritis	Depression	Gonorrhea	Heart Disease		Tuberculosis

Relative	Age (If living)	Age at death	Ailments and Cause of Death
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles			

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NATURAL HEALTH CENTRE

Tom Daly BSc ND

Declaration and Consent to Treatment

Patient's Name:___________________________________ Date: ______________________
please print

Assessment and Treatment

Tom Daly practices naturopathic medicine using a combination of the following forms of treatment: standard medical techniques (i.e. physical examination and lab work), nutrition, traditional Oriental medicine, homeopathic medicine, botanical medicine (i.e. herbs), physical treatments and lifestyle counselling.

"I am here to apply the unique skills, knowledge, and principles of naturopathic medicine toward the betterment of individual and community health and well-being. I will create an accessible, family-centered practice with a special enthusiasm for pediatric care. Through ongoing personal and professional development, I will provide expert medical guidance built upon a foundation of caring and committed relationships."

I understand that Tom Daly is a licensed Naturopathic Doctor (N.D.). Any treatment or advice provided to me as a patient of Tom Daly is not exclusive from any treatment or advice that I may receive in the future from another licensed health care provider. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Ontario.

I understand that I have the right to ask any questions regarding the nature of my treatment, including foreseen risks and benefits. I understand that, as in any medical treatment, results are not guaranteed.

I understand that in the event of a medical emergency, I am advised to seek conventional medical care at a hospital or clinic if I am unable to reach my naturopathic doctor.

I understand that the products available through the clinic dispensary may also be available through retailers of natural health products in the community.

Patient Fees

Adult	$125 per hour
Senior (65+) or Student/Child (17 and under)	$100 per hour
Telephone Consultations	$1 per minute after 5 minutes; long-distance charges where applicable
Missed appointments without 24 hours cancellation notice	Billed at hourly rate

**prices subject to change*

I have read all the above and accept that these are the terms and conditions while under the naturopathic care of Tom Daly, B.Sc. N.D.

Signature: ____ Date: ____________________
Patient or Parent/Guardian