NATUROPATHIC PEDIATRIC INTAKE FORM

This information is strictly confidential and is only used in accordance with our privacy policy.

CONTACT INFORMATION

Child's Name: _____

Address: _____

Postal Code: _____ Home Tel. #: _____

Mother's Name: _____ Father's Name: _____

Mother's Contact #: _____ Father's Contact #: _____

PATIENT INFORMATION

Child's Date Of Birth: _____ Age: _____ Grade: _____ Gender: ☐ M ☐ F

Please list your child's main health concerns in order of importance to you.

1. _____
2. _____
3. _____

Please list your child's present health care provider with their designation (ie. Pediatrician).

_____

Does your child have any known contagious diseases at this time (please specify)?

_____

CHILD'S HEALTH HISTORY– Please check those that your child has experienced

Condition	Now	Past	Never	Condition	Now	Past	Never
Allergies	☐	☐	☐	Fatigue	☐	☐	☐
Anemia	☐	☐	☐	Headaches	☐	☐	☐
Asthma	☐	☐	☐	Heart murmur	☐	☐	☐
Bedwetting	☐	☐	☐	High fever	☐	☐	☐
Birth defect	☐	☐	☐	Hyperactivity	☐	☐	☐
Colic	☐	☐	☐	Insomnia	☐	☐	☐
Cough	☐	☐	☐	Jaundice	☐	☐	☐

Condition	Now	Past	Never	Condition	Now	Past	Never
Croup	☐	☐	☐	Learning problems	☐	☐	☐
Depression	☐	☐	☐	Moodiness	☐	☐	☐
Diarrhea	☐	☐	☐	Stuffy nose	☐	☐	☐
Dry skin	☐	☐	☐	Thrush	☐	☐	☐
Earache	☐	☐	☐	Vomiting	☐	☐	☐
Eczema	☐	☐	☐				

CHILDHOOD ILLNESSES – Please check those that your child has experienced

☐ Chicken pox	☐ Scarlet fever	☐ Mononucleosis
☐ Measles	☐ Rheumatic fever	☐ Ear infection
☐ Mumps	☐ Strep throat	☐ Tonsillitis
☐ Rubella	☐ Pneumonia	☐ Whooping cough

IMMUNIZATION HISTORY - Please list what, when, and any reaction

Vaccine	Yes / No	Reaction	Vaccine	Yes / No	Reaction
MMR			Hepatitis B		
DPT			Influenza		
Hepatitis A			Polio		
Tetanus			Smallpox		

CHILD'S BIRTH HISTORY AND EARLY LIFE

Term: ☐ Full ☐ Premature _____ weeks ☐ Post Date: _____ weeks

Birthweight: _____ Length Of Labour: _____

Any complications? _____

Birth: ☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps Or Suction ☐ Anesthesia

Mother's health during pregnancy and comments of labour and delivery: _____

_____

_____

Breast Fed: ☐ No ☐ Yes If yes, how long? _____

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Formula Fed: ☐ No ☐ Yes If yes, how long and what type? _____

Age solid foods were introduced: _____

What foods and in what order? _____

_____

Does the child have any food allergies or aversions? _____

_____

What screening tests has your child had (ie. Hearing, vision): _____

_____

Describe the child's sleep patterns: _____

_____

Age Child Began: Sitting: _____ Crawling: _____ Walking: _____ Talking: _____

Does your child have any environmental allergies? _____

_____

SAMPLE DAILY DIET INCLUDING LIQUIDS

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you have any concerns about your child's diet? _____

_____

MEDICATIONS & SUPPLEMENTS - Please mark "C" for current use, and "P" for past use

Antibiotics	Fluoride
Aspirin	Tylenol
Other Vitamins and Supplements:	

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Hospitalizations/surgeries/accidents/serious injuries and illnesses (please describe and date):

FAMILY HISTORY – Please identify family members who have had the following, if any:

Alcoholism	Diabetes	Hypoglycemia
Allergies	Eczema	Mental illness
Anemia	Epilepsy	Stroke
Arthritis	Heart disease	Other
Asthma	Hearing loss	

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

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CONSENT TO TREAT, COMMUNICATION & COLLABORATION

NATUROPATHIC CONSENT TO TREAT

I consent to treatment and understand that my doctor is a licensed Doctor of Naturopathic Medicine who will conduct a thorough case history with me before initiating any treatment protocols. Doctors of Naturopathic Medicine are recognized as primary care doctors in Alberta, Canada with the ability to diagnose and treat disease conditions. Naturopathic Doctors utilize principles and practices that treat the whole person and assist the body's own ability to heal.

Evaluation and diagnoses will be based on consultation, pertinent physical exam and modern laboratory techniques that may include, but are not limited to Saliva, Blood, Urine and Stool testing and reports. Evaluation of these laboratory reports may be interpreted differently from other practitioners and treatment protocols may or may not be consistent with mainstream medical tests/evaluations and are based on clinical experience and scientific/medical literature.

Treatments may include, but are not limited to, Homeopathic medicine, Botanical medicine, Nutritional advice and Supplementation, Emotional Freedom Technique (EFT), The Original Bowen Technique, Niromathe, Bio-Intolerance Elimination (BIE), Bioscan and BEMER Treatment. I understand that my doctor will inform me of the potential risks of treatment and answer any questions that I may have.

I understand that even "natural" treatments may have side effects and it is my responsibility to inform my doctor in a timely manner of any side effects or adverse effects that I may be experiencing. I will make sure to inform my doctor of all dietary supplements, non-prescriptive and prescriptive medicines that I am taking; as well as updating any changes to this list. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. I understand that the results are not guaranteed and therefore, I do not expect the Naturopath to be able to anticipate and explain all risks and complications.

COMMUNICATION CONSENT

May we leave messages by telephone relating to your visits? ☐ Yes ☐ No

Do you want to receive our newsletter? ☐ Yes ☐ No

May we have your permission to communicate with you via email? ☐ Yes ☐ No

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PERMISSION TO COLLABORATE

☐ I agree, or ☐ I do not agree to allow my Radiant Health & Wellness (RH&W) practitioner(s) to discuss with another RH&W practitioner(s) details of my health information for the purpose of collaboration in support of individual diagnoses, treatment or referral.

I acknowledge that if I have any questions or concerns about my lab evaluation and/or treatment protocol, I will address them with my doctor in a timely manner. My consent to treatment is voluntary and informed.

I have read and understand the above-stated Consent To Treat and Communication policies of Dr. Christine Perkins.

Patient Signature (or legally authorized individual/guardian)	**Patient DOB (Date of Birth)**
Patient Name – Printed	**Date Signed**
Printed Name If Signed on Behalf of Patient	**Relationship to Patient**

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FINANCIAL, CANCELLATION & CLINICAL POLICIES

EXTENDED HEALTH BENEFITS & THIRD PARTY INSURANCE COVERAGE

Extended health benefits cover many types of health care services provided at our clinic. It is your responsibility to confirm coverage for our services. We will provide all necessary documentation for you to submit to your extended health care provider.

PAYMENT

Our Financial Policy is that payment is expected when goods and/or services are rendered. If you have extended health benefits, payment is still expected at the time of service. It is the policy of Radiant Health & Wellness (RH&W) that all fees charged for services rendered and products purchased are to be paid by cash, cheque, debit, Visa, or MasterCard at the time of each visit. We charge an additional $35.00 for NSF cheques.

PAYMENT INFORMATION

Name On Card: _____

Number: _____

☐ Visa ☐ Mastercard Expiry Date: _____

CLINIC VISITS

Scheduled time with your practitioner, regardless of whether treatment is rendered or not, will be billed as a clinic visit.

CANCELLATION POLICY

In the event that a scheduled appointment with one of the RH&W practitioners is unattended, the following policy will apply:

1. We require 24-hour notice for cancellations. Please be advised that e-mail reminders are a courtesy only and appointments are the responsibility of the client.
2. A “No-show” with no notification, as in #1, will be charged the full fee for the missed visit.
3. If there is a cancellation the same day of the appointment, the full fee will be charged for the missed visit.
4. We require credit card information to be retained on file in the event of missed appointments.

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NATUROPATHIC / CHINESE HERBAL MEDICATIONS

You may be prescribed medications, which may be purchased at our clinic or elsewhere. Please be aware that most insurance companies will NOT cover the medicinary items that are prescribed or dispensed. There are no refunds or returns for purchased medicinary items as we can only guarantee potency and quality of products that have been stocked and inspected in our office at all times.

Thank you for respecting your practitioner's schedule and time in following this policy. Should you have any questions, kindly speak with one of our front desk assistants, or directly with your practitioner.

I have read and agree to my financial obligations with regards to receiving services/products at RH&W

Name: _____ Date: _____

Signature: _____ Witness: _____

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