Olivia Rose
Naturopathic Doctor

Pediatric Intake Form

Personal Information

Child's Name: First: _____Middle:_____ Last:_____ Age: _____

Birth Date: m/__d/__y/____ Gender:_____

Parent/Guardian: _____

Address: _____City: _____ Postal Code: _____

Telephone (Home): _____ (Work): _____ May we leave a message? _____

Email: _____*(Please indicate with an * the best way to contact you)*

Occupation: _____ Employer: _____

Who currently lives in the household? *Parent(s)* *Sibling(s)* *Friend(s)* *Pet(s)* *Other*_____

How did you hear about my practice? _____

What is your primary health concern?

_____

_____

_____

What are your other health concerns, and what treatment(s) have you received for them?

1) _____

_____ Onset: _____

2) _____

_____ Onset: _____

3) _____

_____ Onset: _____

Health History

Has your child ever undergone surgeries or been hospitalized? Y/N If yes, please explain:

_____

_____

Has your child ever suffered from any serious injuries? Y/N

If yes, describe extent of the injury and the age of occurrence:

_____

Has your child ever experienced any mental or emotional trauma? Y/N

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If yes, describe the condition(s) and the age of occurrence:

_____

Is your child currently on any supplements or medication? Y/N If yes, please specify:

Dose:	Dose:
Dose:	Dose:
Dose:	Dose:

Has your child ever been on antibiotics? Y/N If yes, how many times? _____

List reason(s) for antibiotic use: _____

Review of Systems

Height:	Current weight:

Have you had any of the following conditions? If yes, indicate "yes" (Y), "no" (N) or "past" (P).

Allergies		Weight Fluctuations		Stroke		STD	
Asthma		Gallstones		Cancer		Syphilis	
Canker Sores		Hepatitis		Headaches		Constipation	
Chicken Pox		Fainting		Diabetes		'Mono'	
Diphtheria		Speech Concerns		Parasites		Physical Abuse	
Ear Infections		Tonsillitis		'PMS'		Broken Bones	
Eczema		Gout		Epilepsy		Gonorrhea	
Hayfever		Anemia		Smallpox		Cold Hands/Feet	
Heart Disease		Alcoholism		HIV		Kidney Disease	
Measles		High Blood Pressure		Tuberculosis		Visual Problems	
Mumps		Rheumatic Fever		Malaria		Warts	
Pneumonia		Acne		Gas/Bloating		Varicose Veins	
Psoriasis		Arthritis		Migraine		Miscarriage	
Scarlet Fever		Ringing In Ears		Rectal Bleeding		Liver Disease	
Shingles		Balance Problems		Diarrhea		Child Abuse	
Sinusitis		Jaundice		Herpes		Emotional Abuse	
Strep Throat		Thyroid Concerns		Polio		Numbness/Tingling	

Other:

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Family History

	Father	Mother	Brothers	Sisters	Grandmother		Grandfather	
					Maternal	Paternal	Maternal	Paternal
Age								
Health (G=good, P=poor)								
Alcoholism								
Anemia								
Asthma								
Cancer								
Diabetes								
Epilepsy								
Hay fever								
Heart Disease								
High Blood Pressure								
Hives								
Kidney Disease								
Mental Illness								
Osteoarthritis								
Rheumatoid Arthritis								
Stroke								
Tuberculosis								
Other								
Age (at death)								
Cause of death								

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

_____

Vaccine History

Please enter dates of the most recent dose and any reactions following vaccination(s).

- r DPT (diphtheria, pertussis, tetanus)
- r Haemophilus influenza B
- r Hepatitis A
- r Hepatitis B
- r MMR (measles, mumps, rubella)
- r Flu

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- r Smallpox
- r Polio
- r Tetanus booster

Other: _____ Please describe any adverse reactions: _____

Prenatal History

How was the mother's general health during the pregnancy? r good r average r poor

Number of pregnancies? _____ Was this pregnancy planned? Y/N

Did the mother experience any term complications? _____

Please choose from the options below with any additional comments.

- r bleeding
- r excessive nausea or vomiting
- r unusual weight gain
- r high blood pressure
- r swelling of hands and feet
- r infections–rubella or sexually transmitted diseases
- r falls or any other severe trauma
- r mental illness (i.e. depression)
- r emotional stress
- r others: _____

List any drug allergies: _____

Alcohol use: Y/N how many drinks/week?_____

Tobacco use: Y/N how many/day? _____

2nd hand smoke exposure: Y/N how often? _____

Recreational drugs: Y/N specify:_____ how often? _____

Prenatal Nutrition

- r non-vegetarian
- r vegetarian
- r other: _____

Briefly describe the typical diet during pregnancy: _____

_____

Food cravings: _____

Exercise: How often & what type? _____

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Please list any medications or supplements taken during the pregnancy:

Dose:	Dose:
Dose:	Dose:

Labour and Delivery

Length of labour: ____ hours Induced? Y/N, if yes, why? _____

Delivery: r vaginal birth r cesarean, if cesarean, why? _____ r breech r forceps

Length of pregnancy: r premature; how early?_____weeks r full-term r post-term

Birth weight: _____ Birth length: _____ APGAR score 1 min _____ 5 min _____

Was infant discharged with mother? Y/N if no, note length of hospital stay and why? _____

_____

Please indicate any medical problems during the baby's newborn period: _____

Your Child's Nutrition

Was your child breastfed? Y/N if yes, for how long? ____

Was your child bottlefed? Y/N if yes, for how long? ____ formula type: _____

Did your child ever have any feeding problems (ie) spitting, colic, diarrhea? Y/N If yes, specify:

_____

At what age were solid foods introduced into the infant's diet? _____

Please list new foods introduced in estimated order of introduction and any reactions:

_____ _____

_____ _____

_____ _____

_____ _____

Please rate your child's appetite as: r excessive r healthy r poor

Milk intake: r cow's milk r soy milk r rice milk r other: _____

How many cups/day on average? _____ cups

Please make a list of food likes and dislikes below.

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Likes	Dislikes

As a parent, how do you perceive your child's nutrition? r very healthy r fairly healthy r poor

Developmental History

At what age did your child?

_____hold head erect

_____sit alone

_____walk alone

_____put sentences together

_____toilet train

_____tie own shoes

_____dress alone

How does your child's development compare to siblings or peers?

_____

Social History

Is the child yours by: r birth r adoption r stepchild r other: _____

Any pets? Y/N if yes, please specify: _____

What is the household stress level experienced by the child: r high r moderate r low

Does anyone at home smoke, drink or use recreational drugs? Y/N

Is the child exposed to second-hand smoke? Y/N

Is tension or violence a concern within the household? Y/N

Are any of the following behaviours of concern?

r use of security blanket or toy

r repetitive behaviour (head-banging, bed rocking)

r pica

r excessive masturbation

r nail-biting

r thumb-sucking

r twitches

r other sexual habit(s)

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Rate your child's ability to thrive in new situations (10 being excellent)? _____

How does you child deal with stress? _____

Is there any occurrence of negativity, withdrawal or aggressive behaviour? Y/N if yes, please list behaviour and age of occurrence: _____

How many hours per day does your child spend on each activity below:

TV: _____ computer: _____ videogames: _____ reading: _____

Is your child involved in any extracurricular activities? Y/N if yes, which ones and how many times per week of each?

Activity:_____ times/week: _____ **r** like doing it **r** forced to do it

Activity:_____ times/week: _____ **r** like doing it **r** forced to do it

Activity:_____ times/week: _____ **r** like doing it **r** forced to do it

Activity:_____ times/week: _____ **r** like doing it **r** forced to do it

Did/does your child attend preschool? Y/N

Current grade: _____ School: _____

Does you child like going to school? Y/N if no, please explain: _____

Are there any concerns with regards to school performance? Y/N if yes, explain? _____

_____

Has your child ever been diagnosed with a learning disability? Y/N if yes, which one?

_____

When was it first diagnosed and by whom? _____

Does your child get along with classmates at school? Y/N

Does you child make friends easily? Y/N if no, please explain: _____

_____

Does you child get along well with friends? Y/N Briefly describe interaction with friends:

_____

Sleep

Hours per night: _____

Any sleeping problems (bedwetting, sleepwalking, insomnia, light sleeper) Y/N

If yes, please specify: _____ How often? _____

Naps: Y/N if yes, how long? _____ how many per day? _____

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Olivia Rose ND, RAc

Naturopathic Doctor, Registered Acupuncturist
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INFORMED CONSENT

I would like to take this opportunity to welcome you to the care of naturopathic doctor and registered acupuncturist, Olivia Rose, ND, RAc. This clinic utilizes the principles and practices of Naturopathic Medicine and Traditional Chinese Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

The natural treatments used in this clinic include: nutrition, supplementation, homeopathy, botanical medicine, acupuncture, and lifestyle counseling. Naturopathic Doctors assess the whole person, including physical, mental, emotional and spiritual aspects of the individual. Your naturopathic consultation will consist of a thorough case history and a screening physical examination, and may include specific blood and/or urinary laboratory reports. More specific examinations such as breast, rectal or genital examinations may be included if necessary.

It is important that we are informed of any diseases that you are suffering from and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or are breast-feeding, please let us know immediately.

Statement of Acknowledgement

As a patient of this clinic I understand that Olivia Rose ND, RAc, utilizes non-invasive methods for the assessment of bodily dysfunction and supportive natural therapies. I consent to the diagnostic and therapeutic procedures outlined to me by the naturopathic doctor and registered acupuncturist, Olivia Rose, ND, RAc. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; and pain, fainting, bruising or injury from acupuncture. I further acknowledge and confirm that I will become informed of the diagnostic and therapeutic procedures and plans with respect to the financial costs, expected benefits, potential risks and side effects, the likely consequence of not having or following the procedure/plan, and what alternative course(s) of action is/are available to me. As a patient I also confirm that I have the ability to accept or reject this care of my own free will.

I accept and agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies and any other fees. I am aware that these fees are not covered by OHIP.

I, _____, consent to treatment as prescribed by my naturopathic doctor/registered acupuncturist, and have read, understood, and acknowledge the above statements.

_____ Date: _____

(Patient/Guardian's signature – Please sign in the office)

_____ Date: _____

(Witness's signature – Please sign in the office)

Olivia Rose ND, RAc

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PRIVACY POLICY CONSENT FORM

Privacy of your personal information is an important part of the business practices of Olivia Rose, ND, RAc, while at the same time providing you with quality health care. We understand the importance of protecting your personal information and we are committed to collecting, using and disclosing your personal information responsibly and only when necessary.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information. The reception staff will require your name, telephone number, and address when booking your first appointment. The health file that you create with Olivia Rose, ND, RAc is completely confidential and not shared with anyone else, unless you request otherwise by signing a consent form for the release of records.

HOW OUR CLINIC COLLECTS, USES AND DISCLOSES PATIENTS' PERSONAL INFORMATION

Olivia Rose, ND, RAc stands by the importance of protecting your personal information. Our privacy protocols comply with privacy legislation and standards of the Board of Directors of Drugless Therapy – Naturopathy and the College of Traditional Chinese Medicine Practitioners and Acupuncturists of Ontario. Olivia Rose, ND, RAc will collect, use and disclose information about you for the following purposes.

- To assess your health concerns
- To provide health care
- To establish and maintain contact with you
- To email/mail newsletters, clinic updates and other information
- To remind you of upcoming appointments
- To allow us to efficiently follow-up for treatment and billing
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

PATIENT CONSENT

I have reviewed the above information that explains how Olivia Rose, ND, RAc will use my personal information, and the steps taken to protect my information. I agree that Olivia Rose, ND, RAc can use and disclose personal information about _(Print Name)_____ as set out above.

_____ _____ _____

Signature Date