Infant Intake Form

Date_____

Child's name _____
Date of birth _____ Sex M F
Referred by_____
Who is filling out this form (name and relation)?_____

Legal Guardian

Name _____ Phone number
Address_____ home_____
_____ work_____
cell _____

Relationship to child
_____

Whom does the infant live with?_____

Other health care providers

1.	2.	3.
_____	_____	_____
_____	_____	_____

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Medical history

Birth: □ Vaginal □ C-section □ Epidural □ Vacuum
□ Forceps □ Induction □ Augmentation

Length of Labour: _____ Length of pushing: _____ Antibiotics: _____
Skin to Skin: _____ Time of latch: _____Separation of dyad: Y N

Previous Painful Procedures:_____
Has baby ever used pain relief? □N □Y_____
Voids in last 24 hours: _____
Stools in last 24 hours/color: _____

Frequency of feeds: _____
Length of feeds: _____
Feeding: □ On demand □ On schedule Offering both breast: □ Y □ N
_____
Overnight feeds: _____
Supplemental feeding: Y N Frequency of supplemental feeds:_____
Amount of supplemental feeds:_____
How would you describe your child's general state of health?
Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

_____
_____

_____

Does your child have any allergies (medicines, environmental, etc.)?

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

How many times has your child been treated with antibiotics?

_____

Please indicate what immunizations your child has had

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis B

☐ Tetanus booster; when? ☐ "Flu" ☐ Hepatitis A

_____

☐ MMR (measles, mumps, rubella) ☐ Polio

Other

_____

_____

Please indicate if any caused adverse reactions_____

Prenatal health

What was the health of the parents at conception? Please circle.

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs
☐ Prescription medications:_____
☐ Over-the-counter medications:_____
☐ Supplements:_____

Family history

Indicate if a close relative (parent, sibling) has had any of the following

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Other	
Juvenile arthritis			

☐ I don't know the family medical history

Do either of the parents have a chronic illness? Y N
Please describe:_____

Environment

Does anyone in the child's household smoke? Y N
Are there animals in the home? Y N

How would you describe the emotional climate of the child's home?

_____
_____

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

_____
_____

Dr. Melanie Jacobson, N.D
Doctor of Naturopathic Medicine #1394
melaniejacobsonnd.com

Please take a few moments to read over the office policy for Naturopathic Medicine.

Fee Schedule**

Initial Visit (or half of mother's visit if lactation consultation visit)	**$95.00**
Subsequent visit (or half of mother's visit if lactation consultation visit)	**$48.00**

****All prices are subject to change.**

Missed appointments

At least 24 hours notice is required when canceling or rescheduling any appointments. Patients are responsible for the full fee of any missed appointments without 24 hour notice.

Insurance

Many benefit plans cover some or all of our services to some extent. While the naturopathic services do not deal directly with insurance companies, we do issue official receipts that may be submitted for reimbursement.

Privacy Policy

The personal information collected is for limited and confidential use by the clinic. The information will not be release to others unless so directed by the patient themselves or unless the law requires it. We reserve the right to contact you on occasion for the following purposes: confirming appointments, clarifying your prescriptions and protocols, clarifying your account and clinic updates/promotions.

Parent or guardian of the patient:_____ **Date:**_____

Patient Informed Consent

I, Melanie Jacobson, ND utilize the principles and practices of Naturopathic Medicine and other supportive therapies including lactation support to assist the body's own ability to heal and to improve the quality of life and health through natural means.

I will always conduct a thorough case history. A physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up. The majority of treatments used by a Naturopathic Doctors fall under one or more of the following categories: clinical nutrition and diet modification, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine and counseling.

CONSENT TO TREATMENT OF A MINOR

PATIENT INFO:

First Name: _____

Age: _____

I authorize, Melanie Jacobson, ND, Doctor of Naturopathic Medicine, who has been engaged by me, to examine and administer naturopathic care, lactation support and treatment to _____whose relationship to me is _____.

As the parent/ legal guardian of_____, I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns. The slight health risks of some naturopathic treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain or bruising from acupuncture.

I also confirm that I have the ability to accept or reject this care of my own free will and choice. I accept full responsibility for any fees incurred during care and treatment.

My name, address and phone number are as follows:_____
_____
_____

_____ _____
Name of Parent or Guardian Signature
Date_____

_____ _____
Naturopathic Doctor Signature
Date_____