Naturopathic Pediatric Intake Form

PERSONAL & CONTACT INFORMATION

NAME: ____
GENDER: ____________ ASSIGNED SEX: ___________
DATE OF BIRTH (YY/MM/DD): _____________________
AGE: _________________

ADDRESS: _____________________________________
____
HEIGHT: ______________ WEIGHT: _________________

PARENT/GUARDIAN: ____________________________
PHONE 1: _______________ PHONE 2: _____________
EMAIL: ____

PARENT/GUARDIAN: ____________________________
PHONE 1: _______________ PHONE 2: _____________
EMAIL: ____

HOW DID YOU HEAR ABOUT ME?

WORD OF MOUTH ☐ FACEBOOK ☐ SIGNAGE IN CLINIC ☐ REFERRAL FROM COMPLETE HEALTH PRACTITIONER ☐
OTHER

WOULD YOU LIKE TO BE SUBSCRIBED TO RECEIVE DR. ANNIE'S BLOG POSTS AND NEWSLETTER? YES ☐ NO ☐
If yes, please be sure to include your email address above

OTHER HEALTH CARE PROVIDERS – Please put a * beside the name of the child's primary practitioner

NAME: ________________________ SPECIALTY: ________________________ PHONE: _________________________
NAME: ________________________ SPECIALTY: ________________________ PHONE: _________________________

WHAT ARE YOUR TOP CONCERNS ABOUT YOUR CHILD'S HEALTH?

1) _________________________________ 2) ______________________________ 3) ____________________________

MEDICAL HISTORY – Hospitalizations / Injuries / Major illnesses

REASON / INJURY / ILLNESS	DATE	OUTCOME

VACCINATION HISTORY

AS PER ALBERTA SCHEDULE? ☐ ALTERNATE SCHEDULE? ☐ IF YES, PLEASE DESCRIBE: _____________________

ANY VACCINES DECLINED? ☐ IF YES, PLEASE LIST: ____

ANY ADVERSE REACTIONS? ____

ALLERGIES AND SENSITIVITIES – List any known or suspected allergies, sensitivities and/or intolerances

SUBSTANCE (FOOD, DRUG, ENVIRONMENTAL / CHEMICAL)	REACTION

CURRENT MEDICATIONS & SUPPLEMENTS – Please include all prescription drugs, over the counter drugs, birth control pills, herbs, vitamins, minerals, homeopathics, etc.

NAME	DOSE	REASON FOR TAKING	DATE STARTED	SIDE EFFECTS

FAMILY HISTORY – Please list if any of the child's biological family (parents, siblings, grandparents, aunts/uncles) has or has had any of the following. If you do not have information about your biological family's medical history, please skip.

	FAMILY MEMBER		FAMILY MEMBER
ALCOHOLISM/DRUG ABUSE		DIGESTIVE CONDITION	
ALLERGIES/HAY FEVER		HEART DISEASE	
ARTHRITIS		MENTAL HEALTH CONDITION	
ASTHMA/EMPHYSEMA		OVERWEIGHT/OBESITY	
AUTO-IMMUNE CONDITION		SKIN DISEASE	
CANCER		THYROID DISEASE	
DIABETES		OTHER: ________________	

PRENATAL HISTORY – If known

PARENTS'/SURROGATE'S PHYSICAL AND EMOTIONAL HEALTH DURING PREGNANCY: ________________________
MEDICAL INTERVENTIONS (E.G. FERTILITY DRUGS/PROCEDURES, AMNIOCENTESIS): _________________________
DURATION OF PREGNANCY: ______________________________ PRENATAL CARE: __________________________
COMPLICATIONS? ______________________________________ OTHER ILLNESSES/INFECTIONS: _____________
HOW MUCH ALCOHOL? ____________________ TOBACCO? _______________ RECREATIONAL DRUGS? ________

THE BIRTH EXPERIENCE – If known

LENGTH OF LABOUR: _____________ LOCATION OF BIRTH: ______________ NATAL SUPPORT: ________________
DELIVERY: PREMATURE ☐ ON TIME ☐ LATE ☐ INDUCED ☐ VAGINAL ☐ BREECH ☐ C-SECTION ☐
MEDICATIONS/INSTRUMENTATION (E.G. FORCEPS, SUCTION) USED: ______________________________________
COMPLICATIONS DURING DELIVERY? ____

NEONATAL HISTORY

BIRTH WEIGHT: ________________________________ AGPAR SCORE (IF KNOWN): _____________________________
INTERVENTIONS AT BIRTH (E.G. VITAMIN K, ANTIBIOTIC EYE DROPS): ____
COMPLICATIONS AFTER BIRTH? ____
FEEDING: BREASTFED ☐ FORMULA FED ☐ HOW LONG (MONTHS/YEARS)? _________________________

SOCIAL HISTORY & LIFESTYLE – Please explain any concerns you or your child have in the following areas:

APPEARANCE / HEIGHT / WEIGHT ____
BEHAVIOUR / MOODS / SLEEP ____
FAMILY/FRIENDS ____
GRADES / LEARNING ABILITIES ____
COMPUTER / TV / VIDEO GAME USE ____
DIETARY RESTRICTIONS (E.G. RELIGIOUS, VEGETARIAN)? ____
DOES YOUR CHILD EXERCISE? IF YES, WHAT FORMS? HOW OFTEN? ____
DO YOU HAVE REASON TO BELIEVE THAT YOUR CHILD IS BEING OR HAS EVER BEEN PHYSICALLY, EMOTIONALLY, OR SEXUALLY ABUSED? ☐ IF YES, PLEASE PROVIDE DETAILS: ____

REVIEW OF SYSTEMS

Check the conditions that your child is currently experiencing, or has experienced often in the past.

General Symptoms

	current	previous
Loss of consciousness	☐	☐
Numbness / tingling	☐	☐
Fever	☐	☐
Sweats	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Loss of sleep/insomnia	☐	☐
Frequent colds / flus	☐	☐
Loss of weight	☐	☐

Head / Neck

	current	previous
Headaches	☐	☐
Type ____________________		
Vision problems	☐	☐
TMJ concerns	☐	☐
Earaches	☐	☐
Decreased hearing	☐	☐
Sinus problems	☐	☐
Difficulty swallowing	☐	☐

Skin

	current	previous
Rashes / Eczema	☐	☐
Itching	☐	☐
Bruise easily	☐	☐
Dryness	☐	☐
Boils / Hives	☐	☐
Contagious skin disease	☐	☐

Respiratory

	current	previous
Chronic cough	☐	☐
Shortness of breath	☐	☐
Smoking	☐	☐
Breathing problems	☐	☐
Asthma / Bronchitis	☐	☐

Cardiovascular

	current	previous
High blood pressure	☐	☐
Low blood pressure	☐	☐
Bleeding disorders	☐	☐
Chest pain	☐	☐
Stroke	☐	☐
Artery hardening	☐	☐
Varicose veins	☐	☐
Swelling of the ankles	☐	☐
Poor circulation	☐	☐
Angina	☐	☐
Heart disease	☐	☐

Genitourinary

	current	previous
Trouble urinating	☐	☐
Blood in the urine	☐	☐
Kidney infections	☐	☐
Bed wetting	☐	☐
Prostate trouble	☐	☐

Gastrointestinal

	current	previous
Poor digestion	☐	☐
Indigestion	☐	☐
Excessive hunger	☐	☐
Belching or gas	☐	☐
Nausea / Vomiting	☐	☐
Abdominal pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Hemorrhoids	☐	☐
Liver concerns	☐	☐
Gall bladder trouble	☐	☐
Bladder concerns	☐	☐
Ulcer	☐	☐
Diabetes	☐	☐

Infections / Illnesses

	current	previous
Herpes	☐	☐
Hepatitis	☐	☐
Plantar warts	☐	☐
TB	☐	☐
HIV / AIDs	☐	☐
Cancer	☐	☐
Allergies	☐	☐

Muscles and Joints

	current	previous
Stiff neck	☐	☐
Backache	☐	☐
Swollen joints	☐	☐
Painful tail bone	☐	☐
Foot trouble L / R	☐	☐
Shoulder pain L / R	☐	☐
Elbow pain L / R	☐	☐
Wrist pain L / R	☐	☐
Hip pain L / R	☐	☐
Knee pain L / R	☐	☐
Arthritis	☐	☐
Weakness / lost strength	☐	☐

Women's Health

	current	previous
Painful menstruation	☐	☐
Excessive flow	☐	☐
Irregular cycle	☐	☐
Hot flushes	☐	☐
Cramps or backache	☐	☐
Vaginal discharge	☐	☐
Swollen breasts	☐	☐
Lumps in the breast	☐	☐

Are you pregnant Yes ☐ No ☐

On birth control Yes ☐ No ☐

Breastfeeding Yes ☐ No ☐

# of pregnancies _______

# of children _________

Age of first period ________

Informed Consent for Naturopathic Medicine

I, ______________________________________, hereby request and consent to examination and treatment with Naturopathic Medicine by Dr. Annie Cannon, ND.

I understand that as a Naturopathic Doctor, Dr. Cannon may include, but is not limited to, the following examination or treatment methods:

- Physical examination (including vitals, EENT, heart and lung, abdominal, musculoskeletal, orthopedic and neurological assessments).
- Common diagnostic procedures (including laboratory evaluation of blood, urine, stool and saliva)
- Botanical/herbal medicine (prescription of therapeutic plant substances which may be given in the form of, pills, creams, tinctures [which usually contain alcohol], suppositories, pastes, plasters, or other forms)
- Clinical nutrition (including food selection, diet plans, nutritional supplements)
- Counselling (including but not limited to visualization, self-empowerment techniques, mind-body medicine and stress reduction techniques)
- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the body surface)

In addition to the procedures mentioned above, I also consent to the following advanced therapies (please initial the following):

_____ **Consent to Injections**: I consent to all injection procedures (including, but not limited to, vitamins, procaine, or other solutions) rendered by Dr. Cannon.

I understand that:

1. The procedure involves inserting a needle into various areas of the body and injecting of substances.
2. Risks of injection therapies include but are not limited to:
   a. Occasionally to commonly:
      i. Discomfort, severe pain, bruising, inflammation, injury and numbness at the site of injection.
      ii. Fatigue, dizziness, or light-headedness after the injections.
      iii. Fainting or loss of consciousness during the procedure.
   b. Extremely Rarely:
      i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.

I am aware that other unforeseeable complications could occur. I do not expect Dr. Cannon to anticipate and/or explain all risk and possible complications.

_____ **Consent to Intravenous Therapy**: I consent to all intravenous therapy procedures (including, but not limited to micronutrient intravenous therapies) rendered by Dr. Cannon.

I understand that:

1. The procedure involves inserting a needle into a vein and injecting the prescribed solution.
2. Alternatives to intravenous therapy are oral supplementation and/or dietary and lifestyle changes.
3. Risks of intravenous therapy include but are not limited to:
   a. Occasionally to commonly:
      i. Discomfort, bruising and pain at the site of injection.
   b. Rarely:
      i. Inflammation of the vein used for injection, phlebitis, metabolic disturbances, and injury.
   c. Extremely Rarely:
      i. Severe allergic reaction, anaphylaxis, infection, cardiac arrest and death.
4. Benefits of intravenous therapy include:
   i. Injectables are not affected by stomach, or intestinal absorption problems.
   ii. Total amount of infusion is available to the tissues.
   iii. Nutrients are forced into cells by means of a high concentration gradient.
   iv. Higher doses of nutrients can be given than possible by mouth without intestinal irritation.

I am aware that other unforeseeable complications could occur. I do not expect Dr. Cannon to anticipate and/or explain all risk and possible complications.

I understand that it is my responsibility to inform Dr. Cannon immediately of the following and failure to do so could result in unnecessary avoidable complications for which I take full responsibility:

- Notify of all current disease conditions and any changes to my current disease state
- Notify of any medication, over the counter drugs or supplements and any changes to any of these (including new additions)
- Notify of any known allergies to drugs or other substances or any past reactions to anaesthetics
- Notify of pregnancy, suspicion of pregnancy, or breastfeeding

I understand that it is my responsibility to request that Dr. Cannon explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services has been made to me concerning the intended results of any treatment provided to me.

Privacy Policy

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

My signature below confirms that:

1. I have been provided ample opportunity to read this form or that it has been read to me.
2. I understand the information provided on this form and the procedures have been adequately explained to me and thus give my oral and written consent to evaluation and treatment.
3. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment from Dr. Cannon
4. I release Dr. Cannon from any and all liability associated with, but not limited to, the procedures mentioned herein.
5. I authorize and consent to the performance of the procedures listed herein.
6. I understand that I may withdraw my consent, in writing, at any time.

____________________	____________________
Printed name of Patient	Printed name of Guardian
____________________	____________________
Signed name of Patient	Signed name of Guardian
____________________	____________________
Date	Date