

## PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

### **FAX / EMAIL YOUR INTAKE FORMS AHEAD OF TIME FOR BETTER INDIVIDUAL CARE**

Please note that all the information that you provide will be held absolutely confidential.  
If you have any questions, feel free to ask.

Today's Date: \_\_\_\_\_  
Patients Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Care Card Number (PHN): \_\_\_\_\_  
Age: \_\_\_\_\_ Date of Birth (M/D/Y): \_\_\_\_\_ Gender: M  F

Parent/Guardian's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Telephone (home): \_\_\_\_\_ (Parent's work): \_\_\_\_\_  
Parent's email address: \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_  
If you were referred, please indicate whom we may thank: \_\_\_\_\_

Name of doctor's office/hospital/clinic where your child's health records are kept: \_\_\_\_\_

Other types of health care: (ie. Chiropractor, massage therapy, physiotherapist) \_\_\_\_\_

Do you have extended coverage Y  N

Do you receive MSP premium assistance Y  N

Reason for referral or presenting problems: \_\_\_\_\_

## **HEALTH HISTORY QUESTIONNAIRE**

Birth city & state: \_\_\_\_\_ Birth time: \_\_\_\_\_ Birth weight: \_\_\_\_\_

What are your child's most important health problems? List as many as you can in order of importance:

1) \_\_\_\_\_  
When did this start? \_\_\_\_\_

2) \_\_\_\_\_  
When did this start? \_\_\_\_\_

3) \_\_\_\_\_  
When did this start? \_\_\_\_\_

4) \_\_\_\_\_  
When did this start? \_\_\_\_\_

Does your child have a contagious disease at this time? Y / N  
If yes, what? \_\_\_\_\_

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## MEDICATIONS / SUPPLEMENTS

NOW	PAST		NOW	PAST	
___	___	Aspirin	___	___	Decongestants
___	___	Tylenol	___	___	Anti-histamine
___	___	Antibiotics	___	___	Other _____
___	___	Ibuprofen			

Allergies to medicines: \_\_\_\_\_

Nutritional supplements your child is taking: \_\_\_\_\_

## MEDICAL HISTORY

- |                                      |  |   |
|--------------------------------------|--|---|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Scarlet fever   | <input type="checkbox"/> Tonsillitis, approx no. of times: _____    |
| <input type="checkbox"/> Measles     | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Ear infections, approx no. of times: _____ |
| <input type="checkbox"/> Mumps       | <input type="checkbox"/> Frequent colds  | <input type="checkbox"/> Strep throat, approx no. of times: _____   |
| <input type="checkbox"/> Rubella     | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Other: _____                               |

Has your child ever had any of the following? How long ago? What were the results?

Electroencephalogram (EEG): \_\_\_\_\_

Psychological evaluations: \_\_\_\_\_

Hearing test: \_\_\_\_\_

Speech/language tests: \_\_\_\_\_

Injuries/surgeries/hospitalizations (please list): \_\_\_\_\_

## IMMUNIZATIONS

- |                                  |                                     |                                       |  |
|----------------------------------|-------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> MMR     | <input type="checkbox"/> DPT        | <input type="checkbox"/> Chicken pox  | <input type="checkbox"/> Others: _____                                   |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Small pox    | Adverse reactions: Y <input type="checkbox"/> N <input type="checkbox"/> |
| <input type="checkbox"/> Mumps   | <input type="checkbox"/> Tetanus    | <input type="checkbox"/> H. influenza | If so, what? _____   |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Polio      | <input type="checkbox"/> The flu      | _____  |

## FAMILY HISTORY

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Hypertension             |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Allergies                |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Mental illness | <input type="checkbox"/> Osteoporosis  | <input type="checkbox"/> Other significant: _____ |

## PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? \_\_\_\_\_

Mother's age at child's birth: \_\_\_\_\_

Did mother receive prenatal care? Y  N  Prenatal Vitamins? Y  N

Mother's health during pregnancy:

- |                                      |                                       |  |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Bleeding    | <input type="checkbox"/> Nausea       | <input type="checkbox"/> Physical or emotional trauma          |
| <input type="checkbox"/> Illnesses   | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cigarettes, alcohol, drug consumption |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Thyroid problems                      |

## BIRTH HISTORY

Term:  Full  Premature  Late Length of labor? \_\_\_\_\_

Type of birth (home, hospital, C-section) \_\_\_\_\_

Complications: \_\_\_\_\_

Birth city & province: \_\_\_\_\_

Did your child have any of the following problems shortly after birth?

- |  |   |                                    |                                   |
|--|---|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Rashes        | <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Blue baby | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Seizures      | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Colic     | <input type="checkbox"/> Fever    |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Other: _____   |                                    |                                   |

Child's sleep patterns (1st year): \_\_\_\_\_

Breast fed: Y  N  How long: \_\_\_\_\_ Formula: Y  N  Type? (milk, soy): \_\_\_\_\_

Age began solids: \_\_\_\_\_ Which foods: \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_

## ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmental? \_\_\_\_\_

## SYMPTOMS

- |                                       |   |   |  |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Hives        | <input type="checkbox"/> Burning urine      | <input type="checkbox"/> Bloody urine       | <input type="checkbox"/> Eczema        |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Bleeding gums      | <input type="checkbox"/> Heart murmur       | <input type="checkbox"/> Nervous       |
| <input type="checkbox"/> Nose bleeds  | <input type="checkbox"/> Vomiting spells    | <input type="checkbox"/> Sleep problems     | <input type="checkbox"/> Asthma        |
| <input type="checkbox"/> Acne         | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Night sweats       | <input type="checkbox"/> High fevers   |
| <input type="checkbox"/> Jaundice     | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Chronic rash       | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> Easy bruising      | <input type="checkbox"/> Sore throats  |
| <input type="checkbox"/> Flat feet    | <input type="checkbox"/> No appetite        | <input type="checkbox"/> Body/breath odor   | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nightmares   | <input type="checkbox"/> Frequent colds     | <input type="checkbox"/> Bleeding tendency  | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing     | <input type="checkbox"/> Joint pains        | <input type="checkbox"/> Excessive fatigue  | <input type="checkbox"/> Cough         |
| <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss          | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Allergies     |

## DIET

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

*Thank you & Welcome! It is an honor to work with you and your child!*

## INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE & ACUPUNCTURE

I, \_\_\_\_\_, hereby request and consent to examination and treatment by Helena Zurekova, ND, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

**I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Zurekova, and/or with the allied health care provider, providing backup:**

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/ or nothing is done

**I understand that a Naturopathic evaluation and treatment may include, but are not limited to:**

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including pap smears, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including naturopathic/osseous manipulation of the spine and extremities)
- Dietary advice and therapeutic nutrition (including food, nutritional supplements, or intravenous injection of nutrients)
- Traditional Oriental medicine- including acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface), moxa and cupping.
- Botanical/ herbal medicines
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Lifestyle counseling (including but not limited to visualization for improved lifestyle strategies)
- Bowen therapy (gentle physical therapy)
- Prescribed medication (which are within the naturopathic scope of practice in BC)

**Potential risks:** Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat, hydrotherapies; allergic reaction to prescribed herbs, supplements and medications; soft tissue or bony injury from physical manipulation; aggravation of pre-existing symptoms.

**Potential benefits:** Restoration of the body's maximal and optimal functioning capacity, relief or pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

**Notice to pregnant women:** All female patients must alert the provider if they have confirmed or suspect pregnancy as some therapies prescribed could present a risk to the pregnancy.

**Notice to individuals with bleeding disorders, pace makers, and/or cancer:** For your safety it is vital to alert your provider, Helena Zurekova, ND, of these conditions.

I recognize that even the gentlest therapies may potentially have complications in certain conditions, in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, and all medications, including over the counter drugs and supplements.

I do not expect Helena Zurekova, ND and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Zurekova explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. 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.

I understand that I require to provide 24 hr notice for cancelling my appointment, otherwise I will be charged \$50 for late cancellation and full visit fee for missing my appointment (without prior notice).

\_\_\_\_\_  
Printed Name of Patient & Guardian

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

Confidential Information