DR. HELENA ZUREKOVA, ND

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PEDIATRIC INTAKE FORM (6 TO 12 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(s): _____
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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FAMILY HISTORY

❒ Heart disease ❒ Diabetes ❒ Birth defects ❒ Hypertension
❒ Arthritis ❒ Tuberculosis ❒ Cancer ❒ Allergies
❒ Asthma ❒ Mental illness ❒ Osteoporosis ❒ Other significant: _____

PAST MEDICAL HISTORY

❒ Chicken pox ❒ Scarlet fever ❒ Tonsillitis, approx no. of times: _____
❒ Measles ❒ Pneumonia ❒ Ear infections, approx no. of times: _____
❒ Mumps ❒ Frequent colds ❒ Strep throat, approx no. of times: _____
❒ Rubella ❒ Rheumatic fever ❒ 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

U – Up to Date P – Partial N – Not done

Pre-School	_____ HBV (Hepatitis B)	_____ HAV (Hepatitis A)
	_____ Hib (Hemophilus influenza type B)	_____ IPV (Polio)
	_____ Varicella (chicken pox)	_____ DTaP (Diphtheria, Tetanus, Pertussis)
	_____ MMR (Measles, Mumps, Rubella)	_____ PCV (Pneumococcal Bacteria)
School Age	_____ Td (Tetanus, Diphtheria)	_____ MCV4 (Meningitis)
Other	_____ Influenza	_____ Other (Please list): _____

Reactions to Immunizations? _____

ALLERGIES

Is your child hypersensitive or allergic to:
Any drugs? _____
Any foods? _____
Any environmentals? _____
Breast fed? _____ how long? _____ Formula? _____ milk / other _____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To Drink: _____

MEDICATIONS/SUPPLEMENTATION

Please list any prescription medications, over the counter medications, vitamins/other supplements your child is taking:

1) _____ dose: _____
2) _____ dose: _____
3) _____ dose: _____
4) _____ dose: _____
5) _____ dose: _____
6) _____ dose: _____
7) _____ dose: _____
8) _____ dose: _____

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HABITS

Main interests and hobbies: _____

❒ Day Care ❒ School ❒ Home school Grade Level: _____

Does your child watch TV?	Y ❒ N ❒	How many hours per day?	_____
Does your child read?	Y ❒ N ❒	How many hours per day?	_____
Does your child play video games?	Y ❒ N ❒	How many hours per day?	_____
Does your child play sports?	Y ❒ N ❒	How many hours per day?	_____
Are there any pets in the home?	Y ❒ N ❒	What kind?	_____
Anyone in the home smoke?	Y ❒ N ❒		

SOCIAL HISTORY

Whom does the child live with? _____ Are the parents divorced / separated? Y ❒ N ❒

If so, what are the arrangements made with the other parent (eg. visitation etc.)? _____

List the age and gender of siblings. Indicate half, step or deceased as applicable.

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

CONTEXT OF CARE REVIEW

What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

PLEASE CHECK IF THE FOLLOWING IS A CURRENT OR RECURRING SYMPTOM:

IMMUNE

❒ Reactions to immunizations	❒ Slow wound healing	❒ Chronic infections
❒ Chronically swollen glands	❒ Night sweats	❒ Frequent cold/flu

SKIN/HAIR

❒ Rashes	❒ Acne/b	oils

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❒ Eczema
❒ Hives
❒ Itching
❒ Dandruff

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HEAD, EYES, EARS, NOSE, THROAT

- ❒ Glasses or contacts
- ❒ Tearing or dryness
- ❒ Eye pain or strain
- ❒ Impaired hearing
- ❒ Ringing in ears
- ❒ Earaches
- ❒ Headaches
- ❒ Head injury
- ❒ High fevers
- ❒ Sinus problems
- ❒ Nose bleeds
- ❒ Hay fever
- ❒ Loss of smell
- ❒ Frequent sore throat
- ❒ Sores on tongue or lips
- ❒ canker sores
- ❒ Teeth grinding
- ❒ Gum problems
- ❒ Dental cavities
- ❒ Facial pain

RESPIRATORY

- ❒ Cough
- ❒ Sputum/Phlegm (Colour?)
- ❒ Asthma
- ❒ Wheezing
- ❒ Bronchitis

HEART AND CIRCULATION

- ❒ Heart murmur
- ❒ Heart disease
- ❒ Anemia
- ❒ Easy bleeding or bruising

ENDOCRINE

- ❒ Low blood sugar
- ❒ High blood sugar
- ❒ Excessive hunger or thirst
- ❒ Fatigue
- ❒ Heat or cold intolerance
- ❒ Diabetes

DIGESTION AND ELIMINATION

- ❒ Change in thirst
- ❒ Change in appetite
- ❒ Bad breath
- ❒ Nausea/vomiting
- ❒ Abdominal pain or cramps
- ❒ Belching or passing gas
- ❒ Constipation
- ❒ Diarrhea
- ❒ Bowel movements:
  how often?_____
  is this a change?_____

URINARY

- ❒ Frequent urination
- ❒ Bed-wetting
- ❒ Pain on urination
- ❒ Frequent UTI's

MENTAL/EMOTIONAL

- ❒ Mood swings
- ❒ Quick temper/irritable
- ❒ Hyperactivity
- ❒ introverted/extroverted
- ❒ Motion/car sickness
- ❒ Anxiety/nervousness
- ❒ Cries easily
- ❒ Unusual fears
- ❒ Sleep problems
- ❒ Nightmares

NEUROLOGIC

- ❒ Seizures
- ❒ Muscle weakness
- ❒ Vertigo or dizziness
- ❒ Numbness or tingling
- ❒ Loss of balance/coordination

MUSCULOSKELETAL

- ❒ Joint pain or stiffness
  Indicate which areas:_____
  _____
- ❒ Broken bones
- ❒ Bone pain
- ❒ Muscle weakness
- ❒ Muscle spasms or cramps
  Indicate which areas:_____

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

Confidential Information

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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)
- Intravenous/Chelation/Intramuscular therapy which may include Vitamins, Minerals, Antioxidants, Amino Acids, Chelating agents, etc)

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; pain at the injection site, fainting, fatigue, muscle cramps, nerve/tendon/ligament damage, lowering of blood sugar (hypoglycemia), mineral loss, and flu-like symptoms - And very rare risks: shock, infection, inflammation of the vein used for injection, phlebitis, circulatory overload, severe allergic reaction, anaphylaxis, cardiac arrest, kidney problems, liver problems 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 understand the information provided on this form and agree to the foregoing, and authorize and consent to the performance of the procedures.

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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