WHOLSOME WELLNESS
CHILD INTAKE FORM

Dr. Julia Gill, Bsc. (Hon), ND
Naturopathic Doctor

PATIENT INFORMATION

Child's Name: _____ Today's Date: ____/____/____ (M/D/Y)
Age: _____ Gender: □ Male □ Female Date of Birth: ____/____/____ (M/D/Y)
Address:_____
City:_____ Province:_____ Postal Code:_____
Parent or Guardian Name: _____
Cell Phone: _____ Home Phone:_____ Other/Fax:_____
Occupation:_____ Email:_____
How did you hear about our Clinic?_____
Emergency Contact
Name:_____ Relationship:_____ Phone Number:_____
Do you have extended health care insurance for Naturopathic Medicine? Y / N

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Please list the child's current health concerns (In the order of importance):

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

Please list all accidents, surgeries or hospitalizations and the year they occurred:

1. _____
2. _____
3. _____

Family Doctor's Name:_____ Phone Number:_____
Last physical exam:_____ Last blood test:_____
Is your child currently seeing any other alternative health care professionals? Y / N
Please list all medications and supplements that you are currently taking:

	Medication/Supplement	Dosage	Reason for use
1.			
2.			
3.			
4.			
5.			

Please list all allergies: _____

_____

Has there been an event or sickness that your child has never fully recovered from? Please indicate: _____

Please indicate what **immunizations** your child has had:

□ DPT (diphtheria, pertussis, tetanus)	□ Haemophilus influenza B	□Hepatitis A
□ MMR (measles, mumps, rubella)	□ Flu Vaccine	□Hepatitis B
□ Smallpox	□ Polio	□ Other: Please list

Other: _____

Please describe any adverse reaction: _____

How many times has your child been treated with antibiotics? _____

SYMPTOM CHECKLIST

Please take a moment to circle the following symptoms and childhood illnesses which your child may have experienced either in the past or presently.

Childhood illnesses

Acute Epiglottitis	Measles	Rubella (German Measles)
Allergies	Mononucleosis	Scarlet Fever
Anemia	Mumps	Sinusitis
Asthma	Pneumonia	Tonsillitis
Chicken Pox	Recurrent Ear	Whooping Cough
Fevers	Infections	Impetigo
Frequent Colds	Rheumatic Fever	

Other: _____

Symptom Checklist		Symptom Checklist
Appetite Change	Easy Bruising	Nervousness
Bad Breath	Eczema	Night Sweats
Burning Urination	Fatigue	Sore Throat
Constipation	Hair Loss	Stomach Aches
Cough	Hearing Loss	Urinary Frequency
Cries Easily	Indigestion	Visual Disturbances
Diarrhea	Insomnia	Vomiting Wheezing

LIFESTYLE PATTERNS

Does your child sleep well?	Y N	Does your child wet the bed?	Y N
Does your child go to daycare?	Y N	Does your child crave junk foods?	Y N

FAMILY HISTORY

Please indicate all family members who have any major health conditions:

_____

_____

_____

TYPICAL DIET

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages (and total quantity): _____
Cravings: _____
Aversions: _____
Any dietary restrictions (religious, vegetarian, etc)? _____

HEALTH HISTORY FROM BIRTH

Birth mother's illnesses during pregnancy (circle all that applies):

Anemia	Gestational Diabetes	Trauma
Bleeding	Hypertension	Other: _____
Excessive Vomiting	Pre-eclampsia	

Substances used during pregnancy by birth mother (circle all that applies):

Alcohol	Medications	Other: _____
Caffeine	Tobacco	

Complications after delivery (circle all that applies):

Birth Defects	Fever	Respiratory Distress
Bleeding	Jaundice	Seizures
Colic	Rash	Other: _____

Breast Fed: Y N How long: _____
Bottle Fed: Y N How long: _____ Formula/Milk/Soy/Other: _____
Introduction of Solid Foods: When? _____

Thank you for taking the time to complete this form!

WHOLSOME WELLNESS
CONSENT TO TREATMENT

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PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Your ND will take a thorough case history, perform a physical examination that may include a breast exam and take blood and urine samples. Therefore, it is very important that you inform your ND immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your ND immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

(*Initials*)_____ I understand that although all therapies are natural and non-invasive, there may be potential health risks and complications including but not limited to: aggravation of current symptoms; Allergic reactions to the supplements or herbs; Bruising from Biopuncture, Vitamin Injections or Acupuncture; Fainting from needling or at a sight of blood; Accidental burning of the skin from the use of Moxa; and Muscle strains and sprains, disc injuries from spinal manipulation.

(*Initials*)_____ I understand that charges are to be paid in full at the time of the visit. Payment for all dispensary items is due at the time of the visit.

(*Initials*)_____ I understand that a $50 fee will be charged for any missed appointments or late cancellation (less than 24 hours).

As the patient, I am responsible for the total charges incurred for each visit including costs of supplements. If I have coverage for naturopathic medicine, it is my responsibility to bill my insurance company. I understand that most insurance companies do not cover the cost of supplements. I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (Please Print): _____

Signature of Parent or Guardian: _____ Date: _____

"The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease"

-Thomas Edison –