VALLEY NATUROPATHIC CLINIC
139 Union Street, Berwick, N.S. B0P 1E0
Tel: 902-538-8733 | Fax: 902-375-3055
vnc.office@eastlink.ca

Date:_____

Pediatric Intake

Thank you for taking the time to fill out this form. The information is very important in the assessment of your child.

Patient's Name:_____ Sex:_____ Age:_____ Birth Date:_____
Parent's Name (1):_____ Phone Number: (h)_____ (c)_____
Parent's Name (2):_____ Phone Number: (h)_____ (c)_____
Address:_____ City:_____ Postal Code:_____
Main Contact Email:_____
Family Physician:_____ Phone:_____ Location:_____
Referred by (if applicable):_____
Main Health Concerns:_____
Medications/Supplements:_____
_____
_____
_____

MEDICAL HISTORY

Childhood Illnesses *(Please check all that apply)*

___ Chicken Pox
___ Measles
___ Mumps
___ Rubella
___ Scarlet Fever
___ Pneumonia
___ Frequent Colds
___ Rheumatic Fever
___ Tonsillitis, approx. no.___
___ Ear Infections, approx. no.___
___ Other *(Please list)*: _____
_____

Has your child had any of the following tests?

	When	Where	Results
Psychological Evaluation			
Electroencephalogram (EEG)			
Hearing			
Speech/Language			

Injuries/Surgeries/Hospitalizations *(Please list)*:_____
_____
_____

IMMUNIZATIONS *(Please check all that apply)*

___ DPaP-IPV-Hib (Diphtheria, tetanus, acellular pertussis, polio, and Haemophilus influenzae type B)
___ RV (Rotavirus)
___ Men C Conj. (Meningococcal group C conjugate)
___ Tdap-IPV (Tetanus, diphtheria, acellular pertussis and polio)
___ Hepatitis B
___ Pneumo Conj. (Pneumococcal conjugate)
___ MMRV (Measles, mumps, rubella, and varicella)
___ HPV (Human papillomavirus)
___ Meningococcal Quadrivalent

Did your child have a reaction to any of these vaccinations (e.g. fever)? **Y** **N**
If yes, what type of reaction?_____

FAMILY HISTORY (*Please check all that apply)*

___ Heart Disease
___ Hypertension
___ Cancer
___ Diabetes
___ Arthritis
___ Allergies
___ Birth Defects
___ Tuberculosis
___ Mental Illness

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MOTHER'S HISTORY

Previous pregnancies by birth mother, miscarriages or complications:_____
_____
_____

Mother's Age at Child's Birth: _____

Mother's Health During Pregnancy *(Please check all that apply):*

___ Bleeding ___ Thyroid Problems ___ Diabetes
___ Illness ___ Physical/Emotional Trauma ___ Nausea
___ Hypertension ___ Medications ___ Cigarettes, Alcohol or Drug Use

BIRTH HISTORY

Term: ___ Full ___ Premature ___ Late Weight at birth:_____
Length of Labour: _____ Complications:_____

Did your baby have any of the following problems *(Please check all that apply)*:

___ Jaundice ___ Diarrhea ___ Birth Defects
___ Rashes ___ Colic ___ Fever
___ Cerebral Palsy ___ Allergies ___ Blue Baby
___ Seizures ___ Birth injuries ___ Other:_____

Child's Sleeping Patterns (1st year):_____
Allergies:_____
Food Intolerances:_____
Breastfed? **Y** **N** How Long?_____ Formula? **Y** **N** Milk/Soy_____
At what age did your baby begin solid food?_____
At what age did your baby begin:
Sitting _____ Crawling _____ Walking _____ 1st Words _____

SYMPTOMS *(Please mark **Y** for current symptoms, **P** for past symptoms)*

___ Hives ___ Burning of Urine ___ Bloody Urine
___ Eczema ___ Frequent Urination ___ Cries Easily
___ Bleeding Gums ___ Heart Murmur ___ Sleep Problems
___ Nose Bleeds ___ Vomiting Spells ___ Nervous
___ Acne ___ Anemia ___ Night Sweats
___ High Fever ___ Stomach Aches ___ Sensitive to Light
___ Chronic Rash ___ Jaundice ___ Body/Breath Odour
___ Hearing Loss ___ Easy Bruising ___ Motion/Car Sickness
___ Diarrhea ___ Flat Feet ___ No Appetite
___ Sore Throats ___ Constipation ___ Nightmares
___ Frequent Headaches ___ Gas ___ Canker Sores
___ Frequent Colds ___ Bleeding Tendency ___ Unusual Fears
___ Wheezing ___ Joint Pains ___ Excessive Fatigue
___ Cough ___ Dizzy Spells ___ Hair Loss

DIET

Please describe your child's typical diet: _____
_____
_____
_____
_____

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Statement of Acknowledgement

Each person seeking care in this clinic should understand that the practitioner is a naturopath, not a medical doctor. If medical diagnosis or treatment is required, it must be obtained from a licensed medical doctor.

Naturopathy uses non-invasive methods for the assessment of bodily dysfunctions and natural therapeutics for correction. The methods used in this clinic for assessment and therapeutics include: nutrition, homeopathy, botanical medicine, hydrotherapy, detoxification techniques, and lifestyle modification techniques.

Each person must sign this document before any treatment will be rendered.

My signature acknowledges that:

(1) I am in agreement with the commitments of this office and I agree to abide by the office and the financial policies outlined.
(2) I understand that the practitioner in this clinic works within the Naturopathic scope of practice, is not a medical doctor, and employs some methods which are not considered orthodox medical practice.
(3) I understand that treatment here and/or referral to other health practitioners is based upon the assessment of the conditions revealed through personal history and interview, physical examination, and laboratory testing.
(4) I understand that failure to follow the recommended nutritional, exercise, and treatment programs will undermine the expected results.
(5) I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without so stating my intentions.
(6) I am accepting or rejecting this care of my own free will and choice.
(7) I accept full responsibilities for any fees incurred during care and treatment and I agree to fully discharge this responsibility at the time of my visit, unless prior arrangements have been made.

I, _____ have read, understood, and acknowledge the above statements.
(Please print)

_____ Date: _____
(Signature)