

## Child Intake

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: M F Age: \_\_\_\_\_  
 Date: \_\_\_\_\_ Referred by: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_  
 Who is filling out this form (name and relation)? \_\_\_\_\_  
 Who does the child live with? \_\_\_\_\_

### Contacts

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (work)  
 Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Relationship to the child : \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ (home) \_\_\_\_\_ (work)  
 Address: \_\_\_\_\_  
 Relationship to the child : \_\_\_\_\_

### Other health care providers

Name: _____	Name: _____	Name: _____
Address: _____	Address: _____	Address: _____
Phone number: ( ) _____	Phone number: ( ) _____	Phone number: ( ) _____

### Child's health concerns (in order of importance)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

### Prenatal health

What was the health of the parents at conception?

Mother	Poor	Fair	Good	Excellent	Unknown
Father	Poor	Fair	Good	Excellent	Unknown

What was the physical health of the mother during the pregnancy?

Poor	Fair	Good	Excellent	Unknown
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What was the mother's age at child's birth? \_\_\_\_\_

How was the mother's diet during pregnancy?

Poor	Fair	Good	Excellent	Unknown
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Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

<input type="checkbox"/> Bleeding	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Physical or emotional trauma	<input type="checkbox"/> Other

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_

Number of births? \_\_\_\_\_

Did the mother use any of the following during the pregnancy?

Tobacco       Alcohol       Recreational drugs:

Prescription medications:

Over the counter medications:

Supplements:

Other:

Lifestyle during pregnancy:       Exercise       Exposure to chemicals

Interventions used:       Ultrasound       Amniocentesis       Other: \_\_\_\_\_

### Birth history

Term length:       Full       Premature: \_\_\_\_\_ wks       Late: \_\_\_\_\_ wks

Length of labor: \_\_\_\_\_      Weight at birth: \_\_\_\_\_

Any complications?

Was the birth:      Vaginal/C-section      Induced      Forceps      Anesthesia used      Epidural

Did the child experience any of the following at or shortly after birth?

Jaundice       Rashes       Seizures       Birth injuries

Birth defects

Other

### Diet

How was your infant fed?

Breast fed. How long? \_\_\_\_\_       Formula. Milk/Soy/Other: \_\_\_\_\_       Other: \_\_\_\_\_

When were the solid foods introduced? \_\_\_\_\_

What foods were introduced before 6 months? (Please list approximate month as well.)

\_\_\_\_\_

What foods were introduced between 6-12 months?

\_\_\_\_\_

\_\_\_\_\_

Did your child ever experience colic?      Y      N      How severe?      Mild      Moderate      Severe

Does your child have any allergies or intolerances? Please list.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)

\_\_\_\_\_  
\_\_\_\_\_

Describe a typical day's diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages (and total quantity) \_\_\_\_\_

### Health and Development

How was your child's health in the first year?      Poor                  Fair                  Good                  Excellent                  Unknown

At what age did your child first:

Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_

Describe your child's sleep pattern: \_\_\_\_\_

\_\_\_\_\_

How would you describe your child's temperament: \_\_\_\_\_

How would you describe your child's behavior and performance at school: \_\_\_\_\_

\_\_\_\_\_

What social activities does your child like to do: \_\_\_\_\_

\_\_\_\_\_

### Family History

Please indicate if a close relative (parent, sibling) has had any of the following?

Condition	Who?	Condition	Who?
Allergies		Diabetes	
Birth defects		Kidney disease	
Asthma		Tuberculosis	
Juvenile arthritis		Cancer	
Other:			

I do not know the family medical history

Do either of the parents have a chronic illness?      Y                  N                  If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Childhood illnesses:       Measles                   Rubella                   Roseola                   Chicken pox                   Mumps

Number of ear infections: \_\_\_\_\_      Other: \_\_\_\_\_

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Name: \_\_\_\_\_

Date: \_\_\_\_\_

How much television does your child watch? \_\_\_\_\_ Hrs a day/week

How often does your child read (not for school), or how often does someone read to your child?

Daily       Several times a week       Weekly       Less than a weekly

Does anyone in the child's household smoke?      Y      N

Are there animals in the home?      Y      N

How is the child's home heated? \_\_\_\_\_

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.). Please describe.

\_\_\_\_\_  
\_\_\_\_\_

How would you describe the emotional climate of the child's home?

\_\_\_\_\_  
\_\_\_\_\_

### Review of systems

**General:** Any weight changes? Please describe. \_\_\_\_\_  
Any fatigue, weakness, fever? \_\_\_\_\_

**Skin:**     rashes     lumps     itching     dryness     color change     changes in hair or nails  
 other \_\_\_\_\_

**Head:**     headaches                       head injury                       dizziness                       lightheadedness

**Eyes:**     glasses or contact lenses     pain     redness     dryness     discharge     impaired vision  
 other \_\_\_\_\_

**Ears:**     infection                       pain                       discharge                       impaired hearing  
 other \_\_\_\_\_

**Nose and Sinuses:**     infection                       pain                       discharge                       nose bleeds  
 other \_\_\_\_\_

**Mouth and Throat:**     condition of teeth and gums     pain     redness     dryness     discharge     hoarseness  
 other \_\_\_\_\_

**Neck:**     lumps                       goiter                       pain                       stiffness

**Respiratory:**     cough                       sputum                       pain                       frequent infections

**Cardiac:**     developmental abnormalities     rheumatic fever                       murmurs                       chest pain

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Gastrointestinal:**    appetite    pain    bowel habits    indigestion    vomiting    hepatitis  
Please elaborate on any of these symptoms and list ones that were not mentioned:

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**Urinary:**    urinary incontinence    urgency    pain    stones

Is there anything that you feel is important that has not been covered?

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**Margaret Balajewicz B.Sc., ND**

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## INFORMED CONSENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Naturopathic medicine uses a variety of approaches. The main modalities used by Naturopaths are: diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, hydrotherapy, physical medicine, lifestyle counseling and intravenous therapy.

**Individual diets and nutritional supplements** are recommended to address deficiencies, treat diseases and promote health. The benefits include increased energy, increased gastrointestinal function, improved immunity and general well being.

**Botanical medicine** is a plant based medicine using herbals teas, tinctures, capsules and other forms of herbal preparations to assist in the recovery from injury and disease. Herbal preparations are used in the treatment as well as prevention of diseases.

**Homeopathy** is a form of medicine based on the Laws of Similars – that is the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses of plant, animal or mineral origins are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool and effects healing on a physical and emotional level.

**Chinese medicine** includes acupuncture, as well as the use of botanical formulas and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized needles through the skin into underlying tissues at specific points on the surface of the body. Sometimes moxa (a compressed herb in the form of a stick) is burned over an acupuncture point to help relieve symptoms. Botanical formulas may be given in the form of pills, tinctures or decoctions (strong teas) to be taken internally or used externally as a wash. Herbal formulas may include shell, mineral and animal materials as well as plants. Dietary advice is based on traditional Chinese medical theory.

**Physical medicine** refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

**Intravenous therapy** refers to injection of vitamins, minerals, specific amino acids and botanical extracts into the vein. This therapy ensures 100% absorption rate and allows high dosage administration without intestinal irritation.

The Naturopathic Doctor will take a thorough case history, do a screening physical examination, including a breast exam and urine sample analysis. If your case requires, the physical may include more specific examinations such as gynecological, rectal, prostate or genital exams.

Even the gentlest therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your ND immediately.

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

There is some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions (anaphylaxis) to supplements, injectables or herbs
- Inflammation of the vein used for injection, phlebitis
- Pain, bruising or injury from injections or acupuncture
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa
- Muscle strains and sprains, disc injures from spinal manipulation

With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list exceptions below):

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I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended therapeutic and diagnostic procedures and have discussed to my satisfaction this and any requests for related information with the Naturopathic Doctor and/or with her office or clinical assistant(s). I further acknowledge and confirm that I have been informed of and understand the therapeutic and diagnostic procedures with respect to the financial costs, expected benefits, potential risks and side effects; the likely consequences of not having/following the therapeutic and diagnostic procedure(s), and what alternative course(s) of action are available to me.

As a result, I so hereby voluntarily consent my informed consent for the recommended therapeutic and diagnostic procedure(s) as specified above. I also understand that I may change the status of my voluntary informed consent at any time.

**Patient Name: (Please print):** \_\_\_\_\_

**Signature of Patient or Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature of ND:** \_\_\_\_\_

Margaret Balajewicz B.Sc., ND

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## DIET DIARY

**Please complete this diet report five days prior to your first appointment.** Be sure to list all food and beverages consumed each day, indicating type of grains and breads and whether foods are raw or cooked, and how they were cooked. (For example, cod-poached, zucchini-steamed, raw salad-romaine lettuce, cabbage, peppers and cauliflower.)

### DAY 1

Breakfast
Lunch
Dinner

### DAY 2

Breakfast
Lunch
Dinner

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

**DAY 3**

Breakfast
Lunch
Dinner

**DAY 4**

Breakfast
Lunch
Dinner

**DAY 5**

Breakfast
Lunch
Dinner