# Naturopathic Child Intake Form

Dr. Tiffany Sahakian Heikkila, Naturopathic Doctor

Child's Full Name _____

Parent/Guardian's Full Name _____

Childs's Date of Birth: _____/_____/_____ (mm/dd/yyyy) Age_____

Gender: Male ☐ Female ☐ Weight_____ Height_____

Complete Address _____

_____

Postal Code _____

| Type | Phone Number | OK to leave a message on answering machine or voicemail? | OK to leave a message with other people at this number? |
|---|---|---|---|
| Home | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Cell | | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Work | | ☐ Yes ☐ No | ☐ Yes ☐ No |

Parent/Guardian's Email Address _____

Emergency Contact: _____

Relation _____ Phone number _____

## Fee Schedule

Patients are responsible for the total charges incurred (visit fees plus any medicines) for each visit.

| 15-minute Follow up | 30-minute Follow up | 45-minute Follow up | 60-minute Follow up | 60-minute Initial Visit |
|---|---|---|---|---|
| $45.00 | $85.00 | $130.00 | $160.00 | $170.00 |

Missed appointments and cancellations made with less than 24 hours notice will be charged 100% of the Naturopathic visit fee. In case of lateness, your treatment time will be reduced appropriately, and the full treatment charge will apply.

Initial _____

**All information provided to your Naturopathic Doctor will remain confidential and will not be released unless you have authorized us to do so**

**Please list your child's main health concerns below:**

1._____

2._____

3._____

**Please list the supplements &/or medications your child is currently taking:**

| Supplement/Medication | Dosage | Taken since | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Please list the supplements &/or medications your child has taken in the past:**

| Supplement/Medication | Dosage | Taken since | Reason for taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Please list any surgeries, hospitalizations, injuries or medications that your child has used in the past:**

| History | Date |
|---|---|
| | |
| | |

**Please list any known allergies or sensitivities to food, medications, environmental or other:**

1._____ 3._____

2._____ 4._____

**Please indicate which vaccines your child has received:**

- ☐ Diphtheria
- ☐ Tetanus
- ☐ Polio
- ☐ Haemophilus Influenza B
- ☐ Pertussis (whooping cough)
- ☐ MMR (measles, mumps, rubella)
- ☐ Rotavirus
- ☐ Pneumococcal conjugate (Pneu-C-13)
- ☐ Varicella (chicken pox)
- ☐ Meningitis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ HPV
- ☐ Flu vaccine

**Has your child experienced any adverse reactions from vaccines?**_____

**Please indicate if your child has previously experienced any of the following:**

- ☐ Measles
- ☐ Roseola
- ☐ Rubella
- ☐ Skin infections
- ☐ Learning difficulties
- ☐ Varicella (chicken pox)
- ☐ Strep throat
- ☐ Rashes
- ☐ Hearing issues
- ☐ Headaches
- ☐ Mumps
- ☐ Pertussis
- ☐ Breathing issues
- ☐ Cavities
- ☐ Neurological issues
- ☐ Ear Infections
- ☐ Mononucleosis
- ☐ Jaundice
- ☐ UTI
- ☐ Heart issues

**How would you rate the current health status of your child on a scale of 1 (worst) to 10 (best)? _____**

**Please describe the emotional disposition of your child _____**

**Prenatal Health & Birth History**

**Please indicate if mom experienced any of the following symptoms during pregnancy &/or delivery:**

- ☐ Nausea
- ☐ High blood pressure
- ☐ Cravings
- ☐ Thyroid issues
- ☐ Diabetes
- ☐ Vomiting
- ☐ Bleeding
- ☐ Stress/anxiety
- ☐ Physical trauma (forceps, vacuum)
- ☐ Toxemia
- ☐ Epidural
- ☐ Emergency C-section

**Please indicate if mom used any of the following during pregnancy:**

- ☐ Cigarettes
- ☐ Recreational drugs
- ☐ Alcohol
- ☐ Prescription medication
- ☐ Supplements

**How would you rate the health of the mom at delivery on a scale of 1(worst) to 10 (best)?_____**

**Baby was delivered at _____weeks Length of labour _____hours**

**Please list any complications experienced by mom and/or baby during labour & delivery:**

_____

_____

**Diet**

**Was your child breastfed? ☐ Yes ☐ No For how long?_____**

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

| Breakfast | Lunch | Dinner | Snacks | Water/Milk/Juice |
|---|---|---|---|---|
| | | | | |

**Family History**

| | Age | Medical Conditions |
|---|---|---|
| Mother | | |
| Father | | |
| Siblings | | |
| | | |

**Any other major health concerns experienced by a close relative?_____**

_____