Dr. Megan Parker, ND
It Starts With Nature Health Clinic

# Pediatric Intake Form

Our professional association requires us to maintain contact information for our patient records. No information will be shared with any other individual or group without your expressed permission. E-mail will only be used by our office to inform you of our office events and will not be distributed for any other use.

First Name _____ Last Name _____

Date of Birth(MM/DD/YY) _____ Age_____ Sex _____

Address _____

City _____ Province _____ Postal Code _____

Parent/Guardian's Name(s): _____

Telephone (H) _____ (W) _____ (C) _____

E-mail _____

Address (if not same as above):_____

How did you hear about our clinic? If referred please indicate from whom_____

Name of Medical Doctor _____ Clinic _____

Telephone(___) _____

Saskatchewan Health Number:_____

Has your child previously been treated by a Naturopathic Doctor? Yes _☐_ No_☐_

Name _____ When?_____

Other health practitioners your child is seeing (including conventional & complementary practitioners).

_____

_____

**Health Concerns**

What are your child's health concerns, in order of importance?

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

How would you describe your child's general state of health? Poor

List any **Medications**, Herbs, Vitamins, etc. your child is taking and dose:

_____

_____

_____

**Medical History**

How was your child's health in the first year of life? Poor

Has your child ever taken antibiotics? Yes☐ No ☐

If yes, for how long and for what condition?

_____

_____

Please list any illnesses, injuries and hospitalizations your child has sustained:

_____

_____

_____

Does your child have any allergies? Yes☐ No ☐ If yes, please indicate: _____

_____

_____

Indicate which of the following your child has had, including year:

| | | | |
|---|---|---|---|
| ☐ | Rubella (German Measles) | ☐ | Whooping Cough |
| ☐ | Measles | ☐ | Strep Throat |
| ☐ | Chicken Pox | ☐ | Impetigo |
| ☐ | Roseola | ☐ | Mononucleosis |
| ☐ | Mumps | ☐ | Ear Infections |
| ☐ | Scarlet Fever | | |

Indicate which immunizations your child has had:

| | | | |
|---|---|---|---|
| ☐ | DPT (diphtheria, pertussis, tetanus) | ☐ | Prevnar |
| ☐ | Tetanus booster; When? | ☐ | H1N1 |
| ☐ | MMR (measles, mumps, rubella | ☐ | Polio |
| ☐ | Chicken Pox | ☐ | Hepatitis A |
| ☐ | HPV (Guardasil) | ☐ | Mennigococcal |
| ☐ | Haemophilus Influenza B | ☐ | Rotavirus |
| ☐ | Hepatitis B | ☐ | Other: |
| ☐ | Influenza | ☐ | |

Did your child experience any adverse reactions to any of the above immunizations? If so, please list to which immunization and reaction._____

_____

_____

**Family History**

Please list any diseases or conditions suffered by family members.

If deceased, please include cause and age at death.

Mother _____

Father _____

Brother(s) _____

Sister(s) _____

Paternal grandmother _____

Paternal grandfather _____

Maternal grandmother _____

Maternal grandfather _____

Please consider any of these:

Diabetes, hypoglycemia, heart disease, kidney disease, cancer, TB, allergies, bleeding disorders, glaucoma, seizures, mental illness, sickle cell anemia.

**Prenatal History**

What was the health of the parents at conception?

Mother: Unknown

Father: Unknown

How was the health of the mother during pregnancy?

Did the mother receive prenatal medical care? Yes☐ No☐ If yes, list what medical care she received: _____

Please indicate if the mother experienced any of the following during the pregnancy:

| | | | |
|---|---|---|---|
| ☐ | Bleeding | ☐ | Nausea |
| ☐ | Diabetes | ☐ | Vomiting |
| ☐ | High Blood Pressure | ☐ | Physical or Emotional Trauma |
| ☐ | Thyroid Problems | ☐ | Other: |

Please indicate if the mother used any of the following during pregnancy:

| | |
|---|---|
| ☐ | Alcohol |
| ☐ | Tobacco |
| ☐ | Recreational drugs: |
| ☐ | Prescription Medications: |
| ☐ | Over-the-counter Medications: |
| ☐ | Supplements: |
| ☐ | Other: |

**Birth History**

Type of Birth: ☐ Vaginal / ☐ C-Section ☐ Induced ☐ Forceps ☐ Anesthesia used

Term Length: ☐ Full Premature:____ wks Late:_____wks

Length of Labour: _____ Weight at Birth: _____

Please list any complications during the birthing process: _____

_____

Indicate if your child experienced any of the following at or shortly after birth:

| | | | |
|---|---|---|---|
| ☐ | Jaundice | ☐ | Birth Injuries: |
| ☐ | Rashes | ☐ | Birth Defects: |
| ☐ | Seizures | ☐ | Other: |

**Nutrition**

How was your infant fed?

☐ Breast Fed. How long? _____ ☐ Formula. Mild/Soy/Other: _____

Other: _____

Please indicate which foods were introduced before 6 months of age with approximate month. _____

_____

6-12 months?

_____

_____

_____

Did your child have colic? Yes ☐ No ☐

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

_____

_____

**What does your child typically eat for:**

Breakfast? _____

Lunch? _____

Supper? _____

What does your child snack on? _____

_____

What beverages does your child consume (including total quantity)?

Water _____ Juice _____ Milk _____ Pop _____ Other: _____

**Environment**

Is your child in: ☐ School ☐ Daycare ☐ Home Care ☐ Other: _____

What are your child's favorite activities? _____

_____

Does your child exercise regularly? Yes ☐ No ☐

If yes, how much and how often? _____

Does anyone in your child's household smoke? Yes ☐ No ☐

Are there animals in the home? Yes ☐ No ☐ If yes, what kind? _____

How is the child's home heated? _____

List any toxins or other hazards your child is regularly exposed to:

_____

_____

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

_____

_____

How is your child's ability to concentrate and focus on tasks at home?

_____

_____

At school?

_____

_____

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

_____

_____

_____

**Appointment Policy**

Appointment times missed without notification will be charged half the price of the appointment fee if prior notice of cancellation is not given. We often have patients on standby lists that may need that appointment time. **Please allow 24 hours notice to cancel a follow up appointment.**

# CONSENT TO TREATMENT OF A MINOR

**Patient Information:**

**First Name _____ Last Name _____**
**Age: _____ Sex _____**

I, _____, authorize Megan Parker, Doctor of Naturopathic Medicine, to examine and administer Naturopathic care and treatment to _____, whose relationship to me is as a _____. I have been given an explanation of and understand the nature of Naturopathic medical care and treatment. I authorize Megan Parker, Naturopathic Doctor, to take whatever measures she considers necessary or desirable in connection with such Naturopathic care and treatment.

This consent is modified as follows:_____
_____

My name, address, and telephone number, or that of another contact person for the patient (whichever is appropriate) is as follows:
_____
_____

Dated at _____, in the province of Saskatchewan, this _____ day of _____ 201_____

_____ _____
Parent or Guardian of Minor – Print Name Signature