Child Intake Form (ages 1 to 12)

Child's Name ________________________________ **Date:**__________________
Date of Birth: M:_____ D:_____ Y:_____ **Sex**: M F

How did you learn of St. Albert Naturopathic Clinic? ___________________________

Parent/Guardian Information:

Mother's Name _____________________ Father's Name _____________________
Contact Email ____

Address _____________________________ Phone ___________________(home)
_____________________________ ___________________(work)
_____________________________ ___________________(cell)

Please list your child's health concerns, in order of importance:

1. ____
2. ____
3. ____
4. ____

What are the goals or outcomes you hope to achieve by using Naturopathic Medicine?
____
____
____

Medical History
How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates
____
____
____

Which of the following has your child had?

rubella (german measles)	_____	roseola	_____	impetigo	_____
measles	_____	scarlet fever	_____	mononucleosis	_____
chicken pox	_____	whooping cough	_____	ear infections	_____
mumps	_____	strep throat	_____		

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Phone: 780-459-5601 Fax: 780-459-5621
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Does your child have any allergies (medications, environmental)?

____

____

Please list all current medications *(prescription, over the counter, vitamins, herbs, homeopathics, etc.)*

____

____

____

Please list past prescription medications (within last 2 years).

____

____

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

Has your child been immunized? Yes No

Diet

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

____

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

____

Family History

Indicate if a close relative (parent, sibling) has had any of the following:

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Other	
Juvenile arthritis		Other	

___ I don't know the family medical history.

Do either of the parent have a chronic illness? Yes No (*Please describe.*)

____

Environment

Is the child in: school daycare home care

What are your child's favourite activities? ____________________________________

Does the child exercise regularly? Yes No

How much television does your child watch? __________ hours per day / week

How often does someone read to your child? __ Daily __Several times/week __Weekly

Does anyone in the child's household smoke? Yes No

Are there animals in the house? Yes No

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

____

How would you describe the emotional climate of the home? _____________________

Is there anything that you feel is important that has not been covered? Yes No

____

____

____

ST. ALBERT NATUROPATHIC CLINIC

Welcome to the clinic. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please **read and initial** the following statements.

Initial

_____ Turn off your cellphones during your visit or refrain from answering unless an emergency.
_____ In winter, please remove your outdoor shoes at the front door. You may use slippers that are provided or bring your own indoor shoes to help us eliminate wet/dirt in the clinic
_____ Refrain from wearing scents for the health of our clients as some of our patients are highly sensitive to scents/perfumes.
_____ **There may be times when you may be required to wait as the Doctor is providing needed attention to a current patient.**
_____ If you have not seen the doctor in 6 years or longer, you will need to fill in the new patient intake forms and be scheduled for a 1 hour visit in order to fully address your health concerns.
_____ From time to time, the clinic may email you updates, newsletters, information about upcoming events, or similar communications. You agree to be contacted at the email provided. You may opt out of such emails at any time.
_____ Payment of services, dispensary items, and other fees are due in full at each visit. The clinic does not directly bill insurance providers, but will provide you with a receipt to submit your own claim.
_____ **Cancellations of less than 24 business hours or missed appointments will be charged a Missed Appointment Fee of $50**

Informed Consent

I have read the information and understand that the care I will receive is based on the principles of Naturopathic Medicine.

I confirm that the information I provided is complete and inclusive of all health concerns including risk of pregnancy; breastfeeding; and all medications, including over-the-counter drugs and supplements.

I understand that naturopathic medicine carries a risk of complications in certain physiological conditions and that resolution of symptoms is not guaranteed.

I acknowledge that the doctors and/or practitioners in the clinic may enhance my care periodically by discussing my case with each other. I will inform my naturopathic doctor if this is a concern to me.

I understand that I have the ability to accept or reject this care of my own free will and choice. I am here as a patient seeking naturopathic medical care and am not attending the clinic for any other reason or misrepresenting myself in any way to the practitioner without making my intention known to the practitioner and/or staff.

____ _________________
Patient Name (Please print) **Date**

____
Parent/guardian name (if minor – under 18yo)

____ _____________________
Patient Signature or parent/guardian (if minor – under 18yo)

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