ST. ALBERT NATUROPATHIC CLINIC

# Infant Intake Form (ages 0 to 12 months)

**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:**

Name _____ Relationship to child _____
Email _____ Other Parent's Name _____
Address _____ Phone _____(home)
_____ _____(cell)
_____

Other health care providers

1. _____ 2. _____ 3. _____
_____ _____ _____
_____ _____ _____
(___) _____ (___) _____ (___) _____

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

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

**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? (n=never, m=mild, a=average, s=severe)

| | | |
|---|---|---|
| n m a s – rubella (german measles) | n m a s – roseola | n m a s – impetigo |
| n m a s – measles | n m a s – scarlet fever | n m a s – mononucleosis |
| n m a s – chicken pox | n m a s – whooping cough | n m a s – ear infections |
| n m a s – mumps | n m a s – strep throat | |

Does your child have any allergies (medications, environmental)?

_____

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_____

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

_____

_____

Please list past prescription medications.

_____

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

Please indicate what immunizations your child has had: (check off)

___ DPT (diptheria, pertussis, tetanus) ___ Haemophilus influenza B ___ Hepatitis B
___ Tetanus booster; what?_____ ___ Flu shot ___ Hepatitis A
___ MMR (measles, mumps, rubella) ___ Polio ___ other _____

Please indicate if any caused adverse reactions:

_____

What screening tests has your child had (blood, hearing, vision, etc.) _____

_____

**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 health of the mother during pregnancy? Poor Fair Good Excellent
What was the mother's age at child's birth? _____
Did the mother receive prenatal medical care? Y N Unknown

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

___ Bleeding ___ High blood pressure ___ Nausea ___ Vomiting
___ Diabetes ___ Thyroid problems ___ Physical or emotional trauma
Other _____

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

___ Tobacco ___ Alcohol ___ Recreational drugs :_____
___ Prescription medications:_____
___ Over-the-counter medications: _____
___ Supplements: _____
___ Other: _____

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**Birth History**

Term length: ___ Full ___ Premature ___ Late
Length of labour: _____ Weight at birth: _____
Any complications? _____

Was the birth: (circle) Vaginal / C-section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth? (check off)
___ Jaundice ___ Rashes ___ Seizures ___ Birth injuries: _____
___ Birth defects: _____
___ Other: _____

**Diet**

How was your infant fed?
___ Breast fed. (How long? _____) ___ Formula. Milk / Soy / Other: _____

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

Between 6 –12 months? _____
_____

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

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

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

**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? Y N Please describe _____

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**Environment**

How often does someone read to your child?

___ Daily ___ Several times a week ___ Weekly ___ Less than weekly

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

Are there animals in the house? Y N

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 home? _____

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

_____

_____

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*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.

_____ _____
**Childs Name (Please print)** **Date**

_____
**Parent/guardian Name (Please print)**

_____
**Parent/guardian Signature**

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