NURTURING HEALTH
Naturopathic Clinic

Dear New Patient,

Thank you for taking the time to fill out the following form. The information you are providing is extremely valuable, in that it allows me to offer the best treatment options possible. Please bring this form to your initial appointment. Please know that the information gathered on this form will be treated in a strictly confidential manner.

What to expect at your first visit:

- Your first visit will be approximately 75 minutes long. During the first visit, I will review and discuss your patient intake form in more detail, answer any questions that you may have, perform any relevant physical exams, and discuss treatment options.
- Some additional testing may be suggested during this visit (these tests are not included in the cost of the initial visit).

What to bring to your first visit:

- All the medications and supplements that you are currently taking
- Any recent blood work, imaging, or test results

Please feel free to call **905-372-2369** if you have any questions or concerns.

I look forward to meeting you!

Yours in Health,

Dr. Kristi Prince, ND, IBCLC
Naturopathic Doctor, Lic #2073

Dr. Alison Cockerill, ND
Naturopathic Doctor, Lic #3311

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Child Patient Intake Form

Last name:	First Name:		Middle Name:
Date of Birth (mm/dd/yy):	Age:	Sex: F / M / Other	Who is filling in this form? (name, relation)
Contact Information			
Full Address:			City, Province:
Postal Code:	Primary phone number:		Secondary phone number:
Email:			
Emergency Contact Information			
Last name:	First Name:		Relationship:
Primary phone number:		Secondary phone number:	
Other Healthcare Providers			
Name: Specialty/Focus: Phone number: Fax: Permission to contact? Y / N	Name: Specialty/Focus: Phone number: Fax: Permission to contact? Y / N		Name: Specialty/Focus: Phone number: Fax: Permission to contact? Y / N
Date of last visit to medical doctor:		Date of last physical exam:	
Have you been treated by a Naturopathic Doctor before?			
If yes, by whom?		Date of last visit to ND:	
How did you hear about this clinic?			
If referred, please state by whom:			

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Child Health Assessment Questionnaire

Please list your child's health concerns (in order of importance):
1.
2.
3.
4.
5.

Medical History			
Was your child adopted?		Does your child receive regular age-specific screening exams?	
Height:	Current Weight:	Past Min Weight:	Past Max Weight:

Vaccination/Immunization Record (please check all that apply):		
○ DPT (Diptheria, Pertussis, Tetanus)	○ MMR (measles, mumps, rubella)	○ H. Influenza B
○ BCG (Tuberculosis)	○ Polio Vaccine	○ Pneumococcal (Meningitis/Pneumonia)
○ Varicax/Varilirix (Chicken Pox)	○ RSV Vaccine	○ Meningococcal C Conjugate (Meningitis)
○ Hepatitis A	○ Hepatitis B	○ Gardasil/Cervarix (HPV Vaccine)
Did you child experience any adverse reactions to any of these vaccines?		
Please list any previously diagnosed medical conditions (including childhood illnesses):		
1.		
2.		
3.		
4.		
Please list any allergies or sensitivities (food/environmental/medications):		

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1.
2.
3.

Please list all hospitalizations, surgeries, and/or major injuries your child has experienced:

Description	Year	Outcome/complications?

Please list all medications (prescription, over-the-counter, oral contraceptive) & natural products (vitamins, herbs, oils) that your child is currently taking:

Medication or NHP (please indicate brand if possible):	Dose/quantity per day	Why are you taking this product?

Have you ever experienced any adverse effects or an allergic reaction to any of the above products/therapies?

- ○ No
- ○ Yes, please specify _____

Family Health History		
	Age (or age at death)	Health Concerns
Mother		
Father		
Siblings		
Grandparents		

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Prenatal History	
Pregnancy weight gain (lbs):	Was your child conceived naturally?
If fertility interventions were used, please indicate what type:	
Mother's age at conception:	Father's age at conception:

Did you experience or use any of the following during pregnancy (check all that apply):

○ Excessive bleeding	○ Nausea or vomiting	○ High blood pressure
○ Diabetes	○ Thyroid concerns	○ Infections (UTI,yeast)
○ STI/STDs	○ Depression or anxiety	○ Measles
○ Tobacco or 2nd hand smoke exposure	○ Alcohol use	○ Caffeine use

○ Recreational drugs (please specify):

List all prescription drugs, OTC medications, supplements, & herbs taken during pregnancy:

Medication	Dosage	Reason for taking

Natal History	
Term length:	Birth Wt:
What type of delivery (circle one): Vaginal / C-section / Hospital / Home	Duration of labor:
If there were difficulties, please describe:	Were delivery interventions used? Y / N If yes, which ones?
Was mom Strep B positive? Y / N Were antibiotics used during labor? Y / N	Was special care required for your baby? If yes, please describe:
Did your baby require special care after delivery? If yes, please describe:	

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Health and Development	
At what age did your child: Sit up: Crawl: Walk: Talk: Show teeth:	
Please describe your child's: ○ Temperament: _____ ○ Sleep pattern: _____ ○ Behaviour with other children/adults: _____ ○ Performance at school: _____	
Diet and Lifestyle	
Was your child : breast-fed / formula-fed	**For how long?**
Food Introduction: ○ Before 6 months of age: _____ ○ 6-12 months of age: _____	
Does your child have any dietary restrictions:	
What are your child's favourite activities:	
How many hours/week does your child: ○ exercise: _____ ○ watch tv: _____ ○ play video games: _____ ○ read: _____	

Review of Systems:

SKIN (i.e. eczema, psoriasis, hives, rashes, acne)**:**
_____
HEAD (i.e. headaches, concussions):
_____
EYES (i.e. itching, pain, infection, corrective lenses):
_____
EARS (i.e. discharge, hearing impairment, infection):
_____
NOSE (i.e. sinus problems, congestion, nose bleeds):
_____

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MOUTH (i.e. cavities, loss of taste, problems swallowing):

_____

NECK (i.e. stiffness, tenderness, swelling, masses):

_____

HEART (i.e. rheumatic fever, murmurs, chest pain):

_____

NEUROLOGICAL (i.e. seizures, memory, speech problems):

_____

LUNGS (i.e. cough, asthma, wheeze):

_____

GI (i.e. vomiting, constipation, diarrhea):

_____

URINARY (i.e. pain, increased frequency, bed wetting):

_____

MSK (i.e. joint pain, stiffness, weakness, fractures):

_____

MALE (i.e. hernias, pain or masses in scrotum/testes):

_____

FEMALE (i.e. pregnancy, menstruation, ovaries/uterus masses):

_____

_____

MENTAL/EMOTIONAL (i.e. learning disabilities, mental illnesses, stress, anxiety):

_____

_____

Is there anything important that has not been covered in this questionnaire?

_____

_____

Complete answers to all of the questions are to your benefit for the most effective Naturopathic treatment. This is a confidential record of your medical history and will not be released to any person except when you have authorized permission to do so.