



Life 'n Balance
WELLNESS CENTRE

Pediatric Naturopathic Intake Form

Parent/Guardian, please take the time to accurately complete this questionnaire. The information you contribute is valuable in providing effective health care for your child.

Name: _____ Date: _____

Parent/Guardian: _____ Email: _____

Phone Number: _____ text reminders? Secondary Number: _____

Address: _____

Age: _____ Date of Birth: _____ Weight: _____ Height: _____

What are your chief concerns regarding your child's health? _____

If there is a specific condition, when did it start? _____

List practitioners seen for this condition: _____

Is there a family history of this condition? _____

List any other supplements, medications, homeopathic/botanical preparations your child is currently taking, including dosage and duration: _____

List any major illnesses, surgeries, hospitalizations, x-rays your child has received. Please include dates: _____

When was your child last well? _____

Has your child ever had any of the following conditions?

- | | | |
|---|--|---|
| <input type="checkbox"/> Rubella (German Measles) | <input type="checkbox"/> Measles | <input type="checkbox"/> Roseola |
| <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Strep throat | <input type="checkbox"/> Impetigo | |

Family History: Please check appropriate box and indicate which family member

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Colitis | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Mental Disease | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other |

Prenatal History:

Mother's age at child's birth: _____

Please check appropriate boxes regarding mother's pregnancy:

- | | | | |
|--|---------------------------------------|---|--|
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Illnesses | <input type="checkbox"/> Physical or emotional |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Drug use | <input type="checkbox"/> Nausea | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Cigarette Use | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Medications/trauma | |

List any supplements/vitamins taken during pregnancy _____

Did the mother smoke before the pregnancy? If so, how much? _____

Does anyone in the household currently smoke? _____

Mother's diet during pregnancy was: poor fair good excellent

Mother's emotional state during pregnancy: excellent stable stressed

Emotional climate of present household: excellent stable stressed

Birth History:

Full Term Premature: _____ weeks Late: _____ weeks

How was the birth? Please list whether home/hospital, vaginal/C-section, any interventions (forceps, epidural, etc), and any complications: _____

Child's weight: _____ Length: _____ Length of Labour: _____

Check any of the following if they occurred at birth or soon after:

- | | | |
|---|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Colic | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Birth injuries | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures |

Other: _____

General Information:

Child's sleep patterns in the first year: _____

Child's sleep patterns presently: _____

Does your child: wake early have difficulty falling asleep have nightmares/terrors

Feeding: breast-fed How long? _____ formula dairy/soy (please circle)

What solid foods were started prior to 6 months of age? _____

List your child's favourite foods: _____

List any food sensitivities/allergies: _____

Your child's appetite is: poor fair good

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Bowel movements (quantity, color, presence of blood, mucus, undigested food):

Does your child experience any gas, bloating, constipation or diarrhea?

Please describe the emotional climate of your home : _____

How many siblings does your child have (please list ages) and how do they interact :

Thank you for taking the time to complete this form.

Informed consent

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet, lifestyle counselling, clinical nutrition (primarily via supplementation), botanical medicine, homeopathy, Asian medicine and acupuncture, hydrotherapy, and physical medicine

Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved gastrointestinal function, enhanced immunity, and general well-being.

Botanical medicine is plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

Homeopathy is a form of medicine based on the Law of Similars; that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses, of plant, animal, or mineral origin, are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counselling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During your initial visits, Dr. Sweett will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples for further testing.

Even the gentlest therapies may cause complications in certain physiological conditions. This depends greatly on the individual and the extent of the illness. Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important, therefore, that you inform your naturopathic doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

Health risks associated with Naturopathic Medicine include but are not limited to:

- Aggravation of pre-existing symptoms during the healing process.
- Allergic reactions to supplements or herbs.
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles

_____ I understand that a record will be kept of the health services provided to me. This
Initials record will be kept confidential and will not be released to others without my
consent, unless required by law. I understand that I may look at my medical record at
any time and can request a copy of it by paying the appropriate fee.

_____ I understand that Dr. Sweett will answer any questions that I have to the best of her
Initials ability. I understand that the results are not guaranteed. I do not expect the doctor
to be able to anticipate and explain all risks and complications. With this knowledge,
I voluntarily consent to diagnostic and therapeutic procedures mentioned above,
except for (please list any exceptions):

_____ I understand that fees and supplements are to be paid for at the time of the
Initials consultation.

_____ I understand that a fee may be charged (Missed Appointment Fee) for any missed
Initials appointments or cancellations with less than 24 hours notice.

As the patient, you are responsible for the total charges incurred for each visit. We accept cash, debit, cheque or visa. If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company – we will provide you with all of the information necessary to send your claim for reimbursement.

Dr. Sweett may prescribe supplements that can be purchased from our in-house dispensary, or elsewhere. Most insurance companies do not cover the supplements prescribed and dispensed.

I have read and understand the above-stated policies and information. I hereby authorize and consent to naturopathic treatment and examination by Dr. Natalie Sweett, Doctor of Naturopathic Medicine. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (please print): _____

Signature of Patient or Guardian: _____

Date: _____

Welcome to Life 'n Balance Wellness Centre. We look forward to working with you to help you achieve better health.