

Naturopathic medicine aims to gather a thorough understanding of your child's physical, mental and emotional wellbeing, and embodies the use of natural modalities to promote health and prevent disease. It is a system of medicine that exemplifies the following philosophy:

1. The healing power of nature
2. First, do no harm
3. Identify and treat the cause
4. Doctor as teacher
5. Prevention
6. Treat the whole person

As a naturopathic doctor, I use nutrition, lifestyle counselling, herbs, homeopathy, physical medicine and traditional Chinese medicine, including acupuncture and Eastern herbs.

Please note the process of achieving better health is not a 'quick fix'; it takes time and dedication to change routines and habits. I am honoured to work with you and your child to find the best solutions to reach your health goals as quickly and easily as possible.

The initial visit is up to an hour in length and it will include a review of the information you have filled out below and a physical exam pertinent to your child's presenting problems. Any lab work that is required will be recommended at this time. A protocol will be put together and discussed at our second visit. Subsequent visits will vary in length, depending on the complexity of the issues and the type of treatment applied. It is my aim to not only re-establish health in your child, but to do so in a manner that teaches ways for you and your family to maintain life-long health.

Please take the time to complete this intake form as thoroughly as possible and sign the consent form that follows. If you have any questions, indicate with a question mark. All responses are kept strictly confidential.

I thank you for your interest in health and look forward to working with you and your child.

Sincerely,

Dr. Sacha Elliott, BA, ND  
*Naturopathic family physician*

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: Female / Male

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ (Parent's work): \_\_\_\_\_

Parent's email address: \_\_\_\_\_

Would you like to receive Dr. Sacha Elliott's free E-Newsletter? Yes/No

How did you hear about Canopy Integrated Health? \_\_\_\_\_

Has any other family member already been a patient at this clinic? \_\_\_\_\_

Where are your child's health records kept? (ie. MD, hospital) \_\_\_\_\_

Reason for naturopathic care: \_\_\_\_\_

What are your child's most important health problems? List in order of importance:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Does your child have a contagious disease at this time? Y/N If yes, what? \_\_\_\_\_

### MEDICATIONS / SUPPLEMENTS

NOW	PAST	NOW	PAST
_____	_____ Aspirin	_____	_____ Decongestants
_____	_____ Tylenol	_____	_____ Anti-histamine
_____	_____ Antibiotics	_____	_____ Ibuprofen

Other medications: \_\_\_\_\_

Allergies to medicines: \_\_\_\_\_

Nutritional supplements your child is taking: \_\_\_\_\_

\_\_\_\_\_



**MEDICAL HISTORY**

Chicken pox     Scarlet fever     Tonsillitis, approx. # of times: \_\_\_\_\_  
 Measles     Pneumonia     Ear infections, approx. # of times: \_\_\_\_\_  
 Mumps     Frequent colds     Strep throat, approx. # of times: \_\_\_\_\_  
 Rubella     Rheumatic fever     Other: \_\_\_\_\_

Has your child ever had any of the following? (Elaborate on when, where, and the results)

Electroencephalogram (EEG): \_\_\_\_\_

Psychological evaluations: \_\_\_\_\_

Hearing test: \_\_\_\_\_

Speech/language tests: \_\_\_\_\_

Injuries/surgeries/hospitalizations (please list): \_\_\_\_\_

**IMMUNIZATIONS**

MMR     DPT     Chicken pox    Other: \_\_\_\_\_  
 Measles     Diphtheria     Small pox    Adverse reactions: Y/N  
 Mumps     Tetanus     H. influenza    If so, what? \_\_\_\_\_  
 Rubella     Polio     Flu    \_\_\_\_\_

**FAMILY HISTORY**

Heart disease     Diabetes     Birth defects  
 Hypertension     Arthritis     Tuberculosis  
 Cancer     Allergies     Asthma  
 Mental illness     Osteoporosis     Others: \_\_\_\_\_

**PRENATAL HISTORY**

Mother: Previous pregnancies, miscarriages, or complications? \_\_\_\_\_

Mother's age at child's birth: \_\_\_\_\_ Prenatal care received? Y/N Prenatal Vitamins? Y/N

Mother's health during pregnancy:

Bleeding       Nausea       Physical or emotional trauma  
 Illnesses       Hypertension       Cigarettes, alcohol, drug consumption  
 Medications       Diabetes       Thyroid problems

### BIRTH HISTORY

Term (weeks):  Full     Premature     Late    Length of labour: \_\_\_\_\_

Type of birth (home, hospital, C-section): \_\_\_\_\_

Complications: \_\_\_\_\_

Birth time: \_\_\_\_\_ am/pm      Birth weight: \_\_\_\_\_ lb/kg

Did your child have any of the following problems shortly after birth?

Rashes       Birth injuries       Blue baby  
 Jaundice       Seizures       Cerebral palsy  
 Colic       Fever       Birth defects

Other: \_\_\_\_\_

Child's sleep patterns (1st year): \_\_\_\_\_

Food intolerances: \_\_\_\_\_

Breast fed: Y/N How long: \_\_\_\_\_ Formula: Y/N Type (milk, soy): \_\_\_\_\_

Age began solids: \_\_\_\_\_ Which foods: \_\_\_\_\_

Age began: Sitting \_\_\_\_\_ Crawling \_\_\_\_\_ Walking \_\_\_\_\_ Talking \_\_\_\_\_

### ALLERGIES

Do you suspect your child is hypersensitive or allergic to the following (list):

Medications? \_\_\_\_\_

Foods? \_\_\_\_\_

Anything in environment? \_\_\_\_\_

## SYMPTOMS

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Nightmares        | <input type="checkbox"/> Unusual fears      | <input type="checkbox"/> Night sweats  |
| <input type="checkbox"/> Nervous        | <input type="checkbox"/> Cries easily      | <input type="checkbox"/> Vomiting spells    | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> No appetite    | <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Constipation       | <input type="checkbox"/> Allergies     |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Wheezing          | <input type="checkbox"/> Excessive fatigue  | <input type="checkbox"/> Cough         |
| <input type="checkbox"/> Sore throats   | <input type="checkbox"/> Frequent colds    | <input type="checkbox"/> High fevers        | <input type="checkbox"/> Chronic rash  |
| <input type="checkbox"/> Eczema         | <input type="checkbox"/> Acne              | <input type="checkbox"/> Hives              | <input type="checkbox"/> Anemia        |
| <input type="checkbox"/> Dizzy spells   | <input type="checkbox"/> Easy bruising     | <input type="checkbox"/> Bleeding tendency  | <input type="checkbox"/> Bleeding gums |
| <input type="checkbox"/> Nose bleeds    | <input type="checkbox"/> Bloody urine      | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Burning urine |
| <input type="checkbox"/> Heart murmur   | <input type="checkbox"/> Jaundice          | <input type="checkbox"/> Body/breath odor   | <input type="checkbox"/> Hair loss     |
| <input type="checkbox"/> Hearing loss   | <input type="checkbox"/> Poor vision       | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Flat feet     |
| <input type="checkbox"/> Joint pains    | <input type="checkbox"/> Poor coordination |   |  |

## DIET

Please describe your child’s typical daily diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

*I look forward to working with you to increase your child’s health and well-being!  
Please read and sign the informed consent form that follows.  
Thank you.*

### ***Informed Consent and Request for Naturopathic Medical Care and Acupuncture***

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As the parent/guardian of my child, I have the right to be informed about his or her health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Sacha Elliott, ND, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, \_\_\_\_\_ (name), hereby request and consent my child to examination and treatment with naturopathic medicine by Dr. Elliott.

**I understand that I have the right to ask any questions and discuss satisfaction of services in regards to my child's health with Dr. Elliott. In particular, I have the right to be informed of:**

- The suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards, or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- Potential consequences if treatment or advice is not followed and/or nothing is done

**I understand that a naturopathic evaluation and treatment may include, but are not limited to:**

- Physical exam
- Common diagnostic procedures (ie. Blood work, urinalysis, etc.)
- Dietary advice and therapeutic nutrition
- Botanical/ herbal medicines
- Homeopathic remedies
- Traditional Chinese medicine and acupuncture
- Soft tissue and osseous manipulation of the spine and extremities
- Hydrotherapy (therapeutic use of hot and cold water)
- Lifestyle Counselling

**I understand that traditional Chinese medicine and acupuncture evaluation and treatment may include, but are not limited to:**

- Acupuncture
- Herbs
- Dietary and lifestyle counselling (based on traditional Chinese medicine theory)

**Potential risks:** pain, discomfort, minor bruising, infections, loss of consciousness and potential tissue injury from needle insertions, allergic reaction to prescribed herbs, supplements, soft tissue or bony injury from physical manipulation, and aggravation of pre-existing symptoms.

**Potential benefits:** Restoration of the body’s maximal and optimal functioning capacity, relief of pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or halting of its progression.

I recognize that even the gentlest therapies may potentially have complications in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns and all medications, including over-the-counter medications and supplements.

By signing below I acknowledge that I have been provided ample opportunity to read this form. I understand all of the above and give my written consent for the evaluation and treatment of my child. I intend this as a consent form to cover the entire course of treatments for my child’s present condition and any future conditions for which we seek treatment.

\_\_\_\_\_  
Printed Name of Guardian

\_\_\_\_\_  
Signature of Guardian