Pediatric Intake Form (ages 6-12)

canopy Integrated Health

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

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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

Please list any prescription medications, over-the-counter medications, vitamins or other supplements your child is taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Allergies to medicines: _____

MEDICAL HISTORY

- Frequent colds: Y/N
- Chicken pox: Y/N
- Measles: Y/N
- Rheumatic fever: Y/N
- Mumps: Y/N
- Rubella: Y/N
- Scarlet fever: Y/N
- Pneumonia: Y/N
- Tonsillitis, # of times: _____
- Strep throat, # of times: _____
- Ear infections, # of times: _____
- 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

U – Up to Date P – Partial N – Not done

- Pre-School:
  - HBV (Hepatitis B): Y/N
  - Hib (Hemophilus influenza type B): Y/N
  - DTaP (Diphtheria, Tetanus, Pertussis): Y/N
  - Varicella (chicken pox): Y/N
  - MMR (Measles, Mumps, Rubella): Y/N
  - PCV (Pneumococcal Bacteria): Y/N
  - IPV (Polio): Y/N
  - HAV (Hepatitis A): Y/N
- School Age:
  - Td (Tetanus, Diphtheria): Y/N
  - MCV4 (Meningitis): Y/N
- Other:
  - Influenza: Y/N
  - List: _____

Reactions to Immunizations? _____

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FAMILY HISTORY

____ Heart disease	____ Diabetes	____ Birth defects
____ Hypertension	____ Arthritis	____ Tuberculosis
____ Cancer	____ Allergies	____ Asthma
____ Mental illness	____ Osteoporosis	____ Other: _____

ALLERGIES

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

Medications? _____

Foods? _____

Anything in environment? _____

HABITS

Main interests and hobbies: _____

Day Care ☐ School ☐ Home school ☐ Grade: _____

Does your child read? Y/N How many hours per day? _____

Does your child play sports? Y/N How many hours per day? _____

Does your child play video games? Y/N How many hours per day? _____

Does your child watch TV? Y/N How many hours per day? _____

Are there any pets in the home? Y/N What kind? _____

How many bowel movements does your child have per day? _____

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

SOCIAL HISTORY

Does anyone in the home smoke? Y/N

When did the child last travel out of country, and where? _____

Whom does the child live with? _____ Are the parents divorced/separated? Y/N

If so, what is the visitation arrangement made with the other parent? _____

List the age and gender of siblings. Indicate half, step or deceased as applicable.

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

CONTEXT OF CARE REVIEW

What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

Is there any information about your child's health that you would like to add?

What expectations do you have for your child from working with our clinic?

REVIEW OF SYSTEMS

Y= a condition now **P**=signification problem in the past **N**= Never had **S**= Sometimes a problem

MENTAL/EMOTIONAL
- Mood Swings Y P N S
- Irritability Y P N S
- Hyperactivity Y P N S
- Introvert/extrovert Y P N S
- Motion/car sickness Y P N S
- Anxiety/nervousness Y P N S
- Cries easily Y P N S
- Unusual fears Y P N S
- Sleep problems Y P N S
- Nightmares Y P N S

ENDOCRINE
- Heat/cold intolerance Y P N S
- Fatigue Y P N S
- Excessive thirst Y P N S
- Excessive hunger Y P N S
- Low blood sugar Y P N S
- High blood sugar Y P N S

SKIN
- Rashes Y P N S
- Eczema, Hives Y P N S
- Acne, Boils Y P N S
- Itching Y P N S

HEAD
- Headaches Y P N S
- Head Injury Y P N S
- Dizzy spells Y P N S
- High fevers Y P N S

EYES
- Glasses or contacts Y P N S
- Tearing or dryness Y P N S
- Eye pain/strain Y P N S

EARS
- Earaches Y P N S
- Impaired hearing Y P N S

NOSE AND SINUSES
- Frequent colds Y P N S
- Nose Bleeds Y P N S
- Stuffiness Y P N S
- Hayfever Y P N S
- Sinus problems Y P N S
- Loss of smell Y P N S

MOUTH AND THROAT
- Frequent sore throat Y P N S
- Canker sores Y P N S
- Breath odor Y P N S

RESPIRATORY
- Cough Y P N S
- Wheezing Y P N S
- Asthma Y P N S
- Bronchitis Y P N S

CARDIOVASCULAR
- Heart disease Y P N S
- Murmurs Y P N S

URINARY
- Frequent urination Y P N S
- Bed wetting Y P N S

GASTROINTESTINAL
- Belching/passing gas Y P N S
- Stomach aches Y P N S
- Constipation Y P N S
- Diarrhea Y P N S

MUSCULOSKELETAL
- Joint pain/stiffness Y P N S
- Muscle spasms Y P N S
- Muscle cramps Y P N S
- Broken bones Y P N S

BLOOD/PERIPHERAL VASCULAR
- Anemia Y P N S
- Easy bruising Y P N S
- Easy bleeding Y P N S

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

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 Parent/Guardian Signature of Parent/Guardian