THINK Chiropractic & Wellness Centre
2-2025 William O'Connell Blvd., Burlington, ON L7M 4E4
Tel.: 905-319-2222 Fax: 905-319-2223
Email: info@thinkchiropracticandwellness.ca
Dr. Lesley D'Souza, Naturopathic Doctor, Registration Number: 1866

NATUROPATHIC CHILD INTAKE FORM

*Please complete as much of this form as possible. The form will be reviewed with you and your practitioner during your appointment. All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
*Page 1 & 2 are mandatory
*When rating 1-10, 1 is always low and 10 is always high)

Date of initial visit:			
PATIENT INFORMATION			
Last Name:	First Name:		Middle Initial:
Street Address:			City:
Postal Code:	Gender:	Preferred Pronoun:	Date of Birth: (MM/DD/YYYY)
Parent/ Guardian 1:	Phone number:		
Parent/ Guardian 2:	Phone number:		
May we leave messages relating to your visit ☐ Yes ☐ No	Email Address: Can we add you to our email list? ☐ Yes ☐ No		

EMERGENCY CONTACT INFORMATION

1. Last Name: First Name:

Phone number: Relationship:

OTHER HEALTH CARE PROVIDERS

1. Name:	2. Name:	3. Name:
Phone number:	Phone number:	Phone number:
Specialty/focus:	Specialty/focus:	Specialty/focus:

How did you hear about us?

Have they seen a naturopath before? ☐ Yes ☐ No

Health concerns in order of importance:

Health Goals, in order of importance:

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HEALTH HISTORY QUESTIONNAIRE	
Date of last visit to a medical doctor:	Date of last physical exam:
List any medical conditions that other doctors have diagnosed (ie eczema, asthma, ADHD) 1. 2. 3.	
Medications (including dose and date started) 1. 2. 3.	
Natural health products/ supplements (including dose and date started) 1. 2. 3.	
Allergies (ie medications, foods, supplements, environmental)	

BIRTH HISTORY		
G _______ P _______	Length of pregnancy:	Prenatal Care:
Birth Weight:	Birth Length:	Delivery:
Maternal Health during birth:		Concerns:
Health mother at Conception:		Health of father at conception:
Mothers age at birth:		Mothers diet during pregnancy:

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Conditions during preg: ☐ Bleeding ☐ High blood pressure ☐ Nausea/vomit ☐ Diabetes ☐ Thyroid ☐ Other	Did mother use: ☐ Tobacco ☐ Alcohol ☐ Recreational drugs ☐ Prescripotion medications ☐ Over the counter medications ☐ Supplements ☐ Other
Did child experience any of the following shortly after birth: ☐ Jaundice ☐ Rash ☐ Seizures ☐ Birth injuries ☐ Birth defects ☐ Other	How was the child's health in first year?

CHILDHOOD ILLNESSES (Check all that apply)		
☐ Antibiotic Use ☐ Strep throat ☐ Ear infections ☐ Impetigo	☐ Chicken pox ☐ Whooping cough ☐ Rubella ☐ Roseola	☐ Measles ☐ Mononucleosis ☐ Other

IMMUNIZATION HISTORY		
Any adverse reactions?		
☐ DPT (diphtheria, pertussis, tetanus) ☐ HiB (haemophilus influenza B) ☐ Hepatitis B ☐ Tetanus booster; when?	☐ "Flu" ☐ Hepatatis A ☐ MMR (measles, mumps, rubella)	☐ Polio ☐ Smallpox ☐ Other

PAST MEDICAL HISTORY	
Screening Tests: (blood, hearing, vision)	
Surgeries:	
Hospitalizations:	
Physical Trauma:	
Mental Trauma:	
Emotional Trauma:	
Date of last blood work:	

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Has your child met all of their developmental milestones? Any concerns?			
FAMILY HISTORY (including which relative)			
Allergies		Asthma	
Diabetes		Heart Disease	
Hypertension		Hypercholesterolemia	
Stroke		Cancer	
Anxiety		Depression	
Addiction/ Alcoholism		Other mental illness	
Other			

SLEEP	
Hours of sleep per night: Sleep times:	Naps (#, amount)
Quality of sleep:	# nightmares/week
Sweat (location)	Position:
Any concerns with child's sleep:	Concerns with child's energy:

DIET	
Breastfed? How long?	Food allergies/intolerances/ dietary restrictions
Formula? Type?	Did your child experience colic?
Foods introduced before 6 months?	
Foods introduced between 6-12 months?	
Describe appetite:	

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages	
DIGESTION	
How frequently do they have a bowel movement?	Do they experience constipation or diarrhea?
Do they experience gas, bloating, cramping?	Soiling during day? Night?
Are they toilet trained?	Other concerns?
Behavioural/ Social	
Describe your child	
What do they love?	
Periods of crying/tantrums?	
Temperament:	
Discipline	
Plays well with other:	
Stress level:	

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Sources of stress:	
Sensitive to heat, cold, light or dark?	
Dental:	
Exercise and play (amount/freq)	
Screen time (hrs/day)	Reading (freq)
ENVIRONMENT AND EXPOSURE	
Housing situation	
Child care (where, amount)	
Neighbourhood	
School	
School performance and behaviour	
Toxin exposure	Animal exposure
Smoke/drug/alcohol exposure	Communicable disease exposure
OTHER	
Do they experience symptoms in any of these systems?	
Skin	
Head	
Eyes	
Ears	
Nose and sinuses	

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Mouth and throat	
Neck	
Respiratory (incl asthma, cough, difficulty breathing)	
Cardiovascular (inc chest pain, palpitation)	
Breast	
Urinary (incl urine, kidney)	
Musculoskeletal (incl joint pain, muscle spasms, weakness)	
Peripheral vascular (incl circulation)	
Neurological (incl memory, numbness, tingling)	
Endocrine and hormonal	
Blood	
Other	

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

THANK YOU FOR COMPLETING THIS FORM!
IT WILL HELP YOUR DOCTOR GAIN MORE INSIGHT ON YOUR ENTIRE CASE

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<u>Child Naturopathic Consent Form</u>

1. Accuracy of Information
□ I certify that the above medical information is correct to my knowledge.

2.Privacy and Sharing of Information
□ I authorize the clinic and its associated health professionals to collect the personal and medical information of my child as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with their family doctor and/or referring doctor as deemed necessary for their beneficial treatment. I also understand that my child's personal and medical information is confidential and will only be disclosed to third parties with my permission.

3. Cancellation Policy
Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee of $25.
□ I am aware of the Cancellation Policy.

4. Patient Informed Consent
Naturopathic medicine is the treatment and prevention of disorders by natural means. The naturopathic doctor will take a thorough case history, do a screening or complaint oriented physical exam, and may analyze urine and blood samples where indicated. It is very important that you inform your Naturopathic Doctor immediately of any disease process from which you are suffering and any medications/over the counter drugs that you are currently taking or if any changes to the above take place.

Traditional Chinese Medicine (TCM) and acupuncture, nutrition, botanical (herbal) medicine, homeopathy and physical medicine, are some of the treatments used by naturopathic doctors. Some of the health risks associated with naturopathic medicine include, but not limited to, aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain or bruising from acupuncture, and fainting or puncturing of an organ with acupuncture needles.

As the parent or legal guardian, you will receive information about your child's diagnosis and/or treatment, alternative courses of action, the material effects, costs, expected benefits, risks, side effects and in each case the consequences of not having the diagnosis and/or treatment acted upon.

Your naturopathic doctor will answer any questions that you may have to the best of his/her ability. Results are not guaranteed. Your provider will exercise judgement during the course of your treatment that is in your best interest, based on the facts that are known. You must be aware that naturopathic treatment and conventional medical treatment are not mutually exclusive, and therefore, you are free to seek or continue medical care from a qualified physician.

□ I authorize Lesley D'Souza, ND to examine and administer naturopathic care and treatment to the above patient, whose relationship to me is as a parent or legal guardian. I acknowledge that the nature of the naturopathic treatment they are to receive including the benefits of the treatment, any risks associated with the treatment and any medical alternatives has been explained to the patient and myself. I may withdraw my consent to this treatment at any time. I acknowledge and declare that I am aware and agree to all of the above and I thereby authorize examination and treatment by Lesley D'Souza, ND.

Date ___________________________

Print Name ____ Signature ____

Child's Name: ____

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