DR. JENNIFER DYCK BSc, ND
106-1851 Kirschner Road, Kelowna BC, V1Y 4N7
p. 778-436-9366 f. 778-436-9367 www.DrJenniferND.com

NATUROPATHIC INTAKE FORM – CHILD Today's Date____________________

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized to do so. Please complete this intake form thoroughly and to the best of your knowledge. It is understood that you may not recall all relevant information at this time and this is not intended to be a complete record of your medical history.

Name ____ Age _____ Date of Birth ______________ Sex ___
Health Card # _________________________________ Extended Coverage ____________________________
Address______________________________ City_______________ Province________ Postal code__________
Phone____________________________ Names of Parent(s)/Guardian(s) ______________________________
Contact information for Parent/Guardian if different from Child's ______________________________________
____
Emergency contact__________________ Relation___________________ Phone__________________

OK to leave phone messages re: appointments? Y / N
Email________________________ Would you like to receive email notifications of appointments: Y / N

Do you have an outstanding WCB or ICBC claim? Y / N

I understand that I am required to give a minimum of 24 hours notice if I am unable to make my appointment. In the event that I miss an appointment without sufficient notice, I may be charged the full cost of the missed appointment. Signature (of parent/guardian if under 18): __________________________ Date: __________

What is the major health concern that has brought you to this office today? Please describe it in detail including when you first noticed this condition and describe any factors that you suspect may be playing a role.
____
____
____
____

Personal Health Habits

Height __________ Current weight ____________ Weight 1 year ago ____________

Current/Recent Heath Care Providers (Conventional and Complimentary)

Name	Dates	Care Provided

Supplements and Medications
Please include all current supplements (vitamins, minerals, herbs, homeopathic remedies, etc.) and medications (prescription and over-the-counter):

Supplement/Herb	Brand name	Potency (mg, IU etc)	Dose	Frequency

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Medication	What it's for	For how long?	Strength	Dose	Frequency

Approximately how many times have you taken antibiotics? ____________
Have you ever had an adverse reaction to any medications or supplements? Y / N

Medical History

Please indicate if you have had any of the following childhood illnesses (CIRCLE):

Asthma	Measles	Rheumatic fever
Chicken pox	Mumps	Diphtheria
Scarlet fever	Mononucleosis	Tuberculosis
Eczema	Polio	Whooping cough
Frequent ear infections/colds	Rubella (German measles)	Other: ____________

Please list any serious conditions, illnesses, injuries, accidents, and/or hospitalizations with their approximate dates. ____
____
____

Immunizations (CIRCLE all that apply)

DPT	Tetanus Booster	Chicken pox
MMR	Flu shot	Small pox
Polio	Hepatitis A	Other: _____________
Haemophilus Influenza B	Hepatitis B	

Please indicate if any post-immunization reactions were noted ________________________________

Blood Type

A B AB O
Rh- Rh+

Family History: Please indicate if any of the following pertain(ed) to blood relatives NOT including yourself:

Condition	Relative	Condition	Relative
Alcohol/substance abuse		Heart condition	
Allergies (hay fever, food)		High blood pressure	
Alzheimer's disease		Infertility	
Arthritis		Kidney problems	
Asthma		Liver disease	
Autoimmune disease		Mental illness/Depression	
Bleeding disorders		Obesity	
Cancer (indicate type)		Osteoporosis	
Diabetes (Type I or II)		Stroke	
Eating Disorder(s)		Thyroid condition	
Epilepsy		Other:	
Glaucoma			

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Pregnancy and Delivery History

Were there any difficulties encountered during the pregnancy? Y / N If yes, please describe:______________
____

Were there any difficulties in delivery? Y / N If yes, please describe ____________________________________
What was the type of delivery? (CIRCLE) Natural birth Cesarean V-bac Other ______

Feeding History

Breast Fed? Y / N If yes, to what age? _____ Please list any difficulties _______________________________

Formula Fed? Y / N If yes, at what age? _____ Type of Formula? ___________
Please list any difficulties ____

At what age were solid foods introduced (including purees)? ________

Please fill out the appropriate order of introduced foods with 1 being the first. Use the same number if more than one food group was introduced at the same time:

Grains ____
Fruits ____
Vegetables ____
Legumes ____
Meat ____
Egg ____
Dairy ____
Nuts and seeds____
Honey and other sugars ____

Please list if there are any food sensitivities, intolerances, allergies, or preferences for certain foods:
____
____

Lifestyle Factors

To the best of your knowledge, have you ever been exposed to pesticides, heavy metals, toxic chemicals, radiation, or other toxins beyond those encountered in daily life?
____
____

Are you frequently exposed to animals? Y / N

Please list all allergies (medications, foods, pollens, animals etc)____
____

Please rate the following and write in any comments:

Sleep	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	Number of hrs per night? ___
Energy Level	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	___________________________
Appetite	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	___________________________
Digestion	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	___________________________
Mood	POOR	FAIR	AVERAGE	GOOD	EXCELLENT	___________________________

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Review of Systems

Please CIRCLE if YOU are experiencing any of the following, OR write a **P** next to those symptoms that you have experienced in the past.

Allergies
Anemia
Asthma
Autoimmune disease
Brittle hair/nails
Bronchitis
Bruising/bleeding, easily
Cancer
Chest pain
Cold/flu, frequent
Colic
Cough, chronic
Dental problems
Depression
Developmental delays
Diabetes
Digestive problems (diarrhea, constipation, cramping)
Dizziness

Ear infections, frequent
Eating disorder
Environmental sensitivities
Epilepsy
Excessive thirst
Eye conditions
Fatigue, unusual
Fever
Food intolerance
Genetic disorder
Headache, frequent
Hernia
Hyperactivity
Infection, chronic
Inflammatory bowel disease (Crohn’s, ulcerative colitis)
Irritable bowel syndrome
Itchiness (skin etc)
Joint ache or pain

Kidney or bladder disease
Learning difficulties
Migraines
Mood change
Nervousness, anxiety
Nosebleeds, frequent
Parasites, worms
Poisoning, food or other
Rashes
Sinus problems
Skin problems
Sleep disturbances
Sore throat, tonsillitis
Urination, frequent or painful
Urinary tract infection
Warts
Weight change

Please list any other symptoms of concern that you are experiencing or have experienced in the past:

____

____

If you are in a clinical trial or experimental protocol, please provide details:

____

What are your Treatment Goals and Expectations?

____

____

____

Clinical Research

For the purposes of research and continuing education, it is occasionally helpful for practitioners to review case files and to discuss cases with colleagues, or to publish specific information in professional journals where there are important lessons to be learned form a case. I would like to ask your permission to potentially use selected information from this file for such purposes. At all times identifying features will be kept private and no confidential information will be divulged. This is strictly for the purposes of learning and teaching.

Please **initial** whether or not you give permission. To be completed by parent/guardian if under 18 years of age.

__ I give my permission for selected information in this file to be used for continuing learning purposes.

__ I do not give my permission for selected information in this file to be used for continuing learning purposes.

Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of a treatment protocol specific to your healthcare needs.

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Naturopathic Patient Disclosure & Informed Consent

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors (NDs) assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used in order to stimulate the body's inherent healing capacity. Your ND will take a thorough case history and conduct a screening physical examination as needed. This may include a breast, gynaecological, rectal, or prostate exam, as well as taking blood, saliva and urine samples as required. Treatment may involve such interventions as botanical medicine, traditional Chinese medicine and acupuncture, bony manipulations, massage, supplementation, naturopathic injections, hydrotherapy, nutritional and lifestyle counseling, laser or PEMT treatment for pain, psychological counseling, homeopathy, and medication prescription.

I understand that I must inform the ND immediately of any disease process that I may be suffering from or have suffered from, if I am on any medication or over the counter drugs, if I am pregnant, suspect I may be pregnant or breast feeding.

I understand that my identity will be protected at all times and, if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that the physicians at this clinic are legally obligated to supersede confidentiality if they become aware of current child abuse or neglect, threats to harm or kill another individual and serious threat of suicide involved with my case. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that fees are payable at the time of appointment; including fees for services, prescriptions, and laboratory test. I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee.

I understand that the results are not guaranteed. I do not expect the ND will be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above.

I intend this consent form to cover the entire course of treatment with this ND. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

I understand that if I am a minor (under the age of 19) a parent or legal guardian must give their consent for treatment.

______________________________ ______________________________

Patient Signature Date (mm/dd/yyyy)

______________________________ ______________________________

Signature of parent or guardian Name of Guardian if patient is a minor