



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 Health 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
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



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			



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 _____ Legumes _____ Dairy _____
Fruits _____ Meat _____ Nuts and seeds _____
Vegetables _____ Egg _____ 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	_____



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 | Ear infections, frequent | Kidney or bladder disease |
| Anemia | Eating disorder | Learning difficulties |
| Asthma | Environmental sensitivities | Migraines |
| Autoimmune disease | Epilepsy | Mood change |
| Brittle hair/nails | Excessive thirst | Nervousness, anxiety |
| Bronchitis | Eye conditions | Nosebleeds, frequent |
| Bruising/bleeding, easily | Fatigue, unusual | Parasites, worms |
| Cancer | Fever | Poisoning, food or other |
| Chest pain | Food intolerance | Rashes |
| Cold/flu, frequent | Genetic disorder | Sinus problems |
| Colic | Headache, frequent | Skin problems |
| Cough, chronic | Hernia | Sleep disturbances |
| Dental problems | Hyperactivity | Sore throat, tonsillitis |
| Depression | Infection, chronic | Urination, frequent or painful |
| Developmental delays | Inflammatory bowel disease
(Crohn's, ulcerative colitis) | Urinary tract infection |
| Diabetes | Irritable bowel syndrome | Warts |
| Digestive problems (diarrhea,
constipation, cramping) | Itchiness (skin etc) | Weight change |
| Dizziness | Joint ache or pain | |

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 from 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.



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, gynecological, 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 tests. I understand that 48 hours’ notice is required for appointment cancellation; otherwise, I will be responsible for the cancellation fee.

In the event that your appointment is Telemedicine using audio and/or video, signing this consent form provides the clinic with your permission to communicate with you via telemedicine. If you choose to communicate with Dr. Jennifer Brix using telemedicine, you should be aware that:

- it may not be secure. The clinic cannot guarantee the security of any information given over telemedicine.
- there may be technical difficulties such as low/no WIFI connection, delay in sound or video, and potentially minor delays relating to the above.

I understand that I can change my consent to telemedicine at any time. I understand that I may need to confirm my identity during telemedicine appointment(s) by stating my personal health number, or visually showing my photo identification, or I agree that Brix Wellness Centre stores an up-to-date photograph of me, and of my choice, to confirm my identity during a video telemedicine appointment.

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