haessler naturopathic*

Child Intake

Child's Name:________________________________ Date of Birth: _____________ Age: _____ Gender: M / F

Who is filling out this form? Name: ______________________________ Relationship to child: _______________

Contacts (in order of preference)

1. Name: _______________________________ Home Phone: __________________ Work: __________________

Address:____ City:___________________ Postal Code:_____________

Email:_____________________________ Relationship to Child: _______________________________________

2. Name: _______________________________ Home Phone: __________________ Work: __________________

Address (if different than above):_______________________City:___________________ Postal Code:_____________

Relationship to Child: ____

Whom does the child live with? ____

Other health care providers:

Name:_____________________________ Designation:___________________________ Phone:________________

Name:_____________________________ Designation:___________________________ Phone:________________

Name:_____________________________ Designation:___________________________ Phone:________________

How did you hear about Haessler Naturopathic?: ____

THIS IS A CONFIDENTIAL MEDICAL RECORD AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT FOLLOWING APPROPRIATE WRITTEN AUTHORIZATION. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

What are your child's health concerns, in order of importance?

1. ____
2. ____
3. ____
4. ____

Has your child seen any specialists? Yes No If yes, please indicate name of doctor and year of visit.

____

____

____

____

MEDICAL HISTORY:
Please list all **current prescription and non-prescription** (vitamins, herbs, homeopathics) medications your child is taking. Please indicate the name, dosage, duration of use, and reason for taking:

___

___

___

___

Has your child ever had an adverse reaction to a medication? Indicate the drug and the reaction experienced:

___

How many times has your child been treated with antibiotics? ___

Immunizations (please check):

Flu Shot
Diptheria/Pertussis/Tetanus
Measles/Mumps/Rubella
Haemophilus Influenza
Chicken Pox
Polio
Hepatitis A
Hepatitis B

Describe any adverse reactions: ___

List all known allergies (food, medicines, environmental, etc.): ___

___

Which of the following diseases has your child had?

Measles
Roseola
Impetigo
Mumps
Scarlet Fever
Mononucleosis
Rubella
Whooping Cough
Ear Infections
Chicken Pox
Strep throat

Please indicate any serious conditions, illnesses, injuries, and/or any hospitalizations you child has experienced, along with approximate dates: ___

___

___

FAMILY MEDICAL HISTORY:

Relation	Current Age	Health problems	Cause, if deceased
Father			
Mother			
Grandparents			
Siblings			

PRENATAL HEALTH:

What was the health of the parents at conception (please circle)?
Mother Poor Fair Good Excellent Unknown
Father Poor Fair Good Excellent Unknown

What was the mother's age at the child's birth? ________________

How was the mother's diet during pregnancy? Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Yes No Unknown

Did the mother experience any of the following during pregnancy?
Bleeding Diabetes High Blood Pressure Nausea
Vomiting Thyroid Problems Physical/ emotional trauma
Other: ____

Did the mother use any of the following during pregnancy?
Tobacco Alcohol Recreational Drugs: ______________________________
Prescription medications: ____
Over-the-counter medications: ____
Supplements: ____

BIRTH HISTORY:

Pregnancy Length: Full Premature: _______ wks Late: __________ wks

Location of birth: Hospital Home Birthing Center Other: ____________________

Type of birth: Vaginal C-section

Types of Intervention: Induced labour Use of forceps Epidural/anesthesia
Other: ____

Length of Labour: ___________________ Birth Weight: ______________________

Did the child experience any of the following at, or shortly after, birth?
Jaundice Seizures Colic Respiratory Difficulties: _________________________
Birth injuries: ___________________________ Birth defects: ______________________________
Skin Disorders: __________________________ Other: ____________________________________

FEEDING HISTORY:

How was your child fed as an infant?
Breast fed: How long? ________________ Formula: Milk / Soy / Other: ______________________
Please describe any reactions you observed: ____

When was your child first introduced to solid foods, and in what order? _________________________

____

If any adverse reactions were noticed, what were they? ____

Please describe a typical day's diet:
Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages (and total quantity): ____

What are your child's favourite foods? ____

Does your child drink caffeine (i.e. pop, tea)? YES NO Type: _____________ Frequency: ___________

HEALTH AND DEVELOPMENT:

How was your child's health in the first year? Poor Fair Good Excellent

At what age did your child first:
Sit up: _________ Crawl: __________ Walk: ____________ Talk: ___________

Is your child in: school daycare homecare other: _________________________________

What are your child's favourite activities? ____
____

How many hours of sleep does your child get per night? ___________________

Does your child have any problems associated with sleeping (e.g., trouble falling asleep, waking up, etc.)?
____

Does your child exercise regularly? Yes No How much and how often? _________________________

How much television does your child watch? _________ hrs per day

Is your child exposed to second hand smoke? YES NO Where? ______________________________

Is your child frequently exposed to animals? YES NO What type? __________________________

Do you know of any toxins or other hazards that your child is regularly exposed to (home renovations, hobbies, older home/ school) renovations?____

Please list any other relevant health/ personal information that you feel is missing: _______________________
____
____
____

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INFORMED CONSENT TO TREATMENT OF A MINOR

This is to acknowledge that I, ____________________________________, parent/ legal guardian of ___________________, whose relationship to me is as a ________________, have been informed and understand that:

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic doctors assess the whole person, taking into consideration the physical, mental, and emotional aspects of an individual. A number of different approaches are used: diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, physical medicine (Bowen therapy and Suikodo) and lifestyle counselling.

Jennifer Haessler, BScH, ND, will take a thorough case history, and perform a screening physical exam before developing an individualized treatment plan. Certain laboratory assessments may also be required on a case specific basis.

Even the gentlest therapies can sometimes cause complications. Some therapies must be used with caution in conditions such as diabetes, heart, liver or kidney disease, during pregnancy and lactation, in children, and while taking other medications.

There are some slight health risks to naturopathic medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needle

I, as parent/ legal guardian, authorize Jennifer Haessler, BScH, ND to take whatever measures she considers necessary or desirable in connection with naturopathic care and treatment. I understand that results are not guaranteed. I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during a clinic visit.

This consent form is intended to cover the entire course of treatment for the present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

With this knowledge, as parent/ legal guardian, I voluntarily consent to the examination and administration of naturopathic medical care and treatment mentioned above, except for:
____

____

Dated in Port Elgin, ON this______ day of ________________________, ____________

Guardian's Name: ____

Signature of Guardian: ____

Signature of Naturopathic Doctor: ____

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