

**PURE HEALTH
CHILD INTAKE FORM**

Dr. Julia Sung Gill, Bsc. (Hon), ND
Naturopathic Doctor

PATIENT INFORMATION

Child's Name: _____ Today's Date: ___/___/___ (D/M/Y)
Age: _____ Gender: Male Female Date of Birth: ___/___/___ (D/M/Y)
Address: _____
City: _____ Province: _____ Postal Code: _____
Parent or Guardian Name: _____
Cell Phone: _____ Home Phone: _____ Other/Fax: _____
Occupation: _____ Email: _____
How did you hear about our Clinic? _____

Emergency Contact

Name: _____ Relationship: _____ Phone Number: _____
Do you have extended health care insurance for Naturopathic Medicine? Y / N

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Please list the child's current health concerns (In the order of importance):

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

Please list all accidents, surgeries or hospitalizations and the year they occurred:

1. _____
2. _____
3. _____

Family Doctor's Name: _____ Phone Number: _____

Last physical exam: _____ Last blood test: _____

Is your child currently seeing any other alternative health care professionals? Y / N

Please list all medications and supplements that you are currently taking:

	Medication/Supplement	Dosage	Reason for use
1.			
2.			
3.			
4.			
5.			

Please list all allergies: _____

Has there been an event or sickness that your child has never fully recovered from? Please indicate: _____

Please indicate what **immunizations** your child has had:

- | | | |
|---|--|---|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Flu Vaccine | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Polio | <input type="checkbox"/> Other: Please list |

Other: _____

Please describe any adverse reaction: _____

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

SYMPTOM CHECKLIST

Please take a moment to circle the following symptoms and childhood illnesses which your child may have experienced either in the past or presently.

Childhood illnesses

- | | | |
|--------------------|--------------------------|--------------------------|
| Acute Epiglottitis | Measles | Rubella (German Measles) |
| Allergies | Mononucleosis | Scarlet Fever |
| Anemia | Mumps | Sinusitis |
| Asthma | Pneumonia | Tonsillitis |
| Chicken Pox | Recurrent Ear Infections | Whooping Cough |
| Fevers | Rheumatic Fever | Impetigo |
| Frequent Colds | | |
| Other: _____ | | |

Symptom Checklist

- Appetite Change
- Bad Breath
- Burning Urination
- Constipation
- Cough
- Cries Easily
- Diarrhea

- Easy Bruising
- Eczema
- Fatigue
- Hair Loss
- Hearing Loss
- Indigestion
- Insomnia

Symptom Checklist

- Nervousness
- Night Sweats
- Sore Throat
- Stomach Aches
- Urinary Frequency
- Visual Disturbances
- Vomiting Wheezing

LIFESTYLE PATTERNS

Does your child sleep well?	Y	N	Does your child wet the bed?	Y	N
Does your child go to daycare?	Y	N	Does your child crave junk foods?	Y	N

FAMILY HISTORY

Please indicate all family members who have any major health conditions:

TYPICAL DIET

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (and total quantity): _____

Cravings: _____

Aversions: _____

Any dietary restrictions (religious, vegetarian, etc)? _____

HEALTH HISTORY FROM BIRTH

Birth mother's illnesses during pregnancy (circle all that applies):

Anemia	Gestational Diabetes	Trauma
Bleeding	Hypertension	Other: _____
Excessive Vomiting	Pre-eclampsia	

Substances used during pregnancy by birth mother (circle all that applies):

Alcohol	Medications	Other: _____
Caffeine	Tobacco	

Complications after delivery (circle all that applies):

Birth Defects	Fever	Respiratory Distress
Bleeding	Jaundice	Seizures
Colic	Rash	Other: _____

Breast Fed: Y N How long: _____

Bottle Fed: Y N How long: _____ Formula/Milk/Soy/Other: _____

Introduction of Solid Foods: When? _____

Thank you for taking the time to complete this form!

**WHOLSOME WELLNESS NATUROPATHICS
CONSENT TO TREATMENT**

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PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Your ND will take a thorough case history, perform a physical examination that may include a breast exam and take blood and urine samples. Therefore, it is very important that you inform your ND immediately of any disease process that you are suffering from and any medications/over the counter drugs that you are currently taking. Please advise your ND immediately if you are pregnant, suspect you are pregnant or if you are breast-feeding.

(Initials)_____ I understand that although all therapies are natural and non-invasive, there may be potential health risks and complications including but not limited to: aggravation of current symptoms; Allergic reactions to the supplements or herbs; Bruising from Biopuncture, B12 Injections or Acupuncture; Fainting from needling or at a sight of blood; Accidental burning of the skin from the use of Moxa; and Muscle strains and sprains, disc injuries from spinal manipulation.

(Initials)_____ I understand that charges are to be paid in full at the time of the visit. Payment for all dispensary items is due at the time of the visit.

(Initials)_____ I understand that a \$50 fee will be charged for any missed appointments or late cancellation (less than 24 hours).

As the patient, I am responsible for the total charges incurred for each visit including costs of supplements. If I have coverage for naturopathic medicine, it is my responsibility to bill my insurance company. I understand that most insurance companies do not cover the cost of supplements. I have read and understood the above stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name (Please Print): _____

Signature of Parent or Guardian: _____ Date: _____

“The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease”

-Thomas Edison -