NOVA HEALTH
INTEGRATIVE MEDICINE

NOVA HEALTH - Located in the Core Link Wellness Centre
2238 Caroline St., Burlington ON L7R1M6
Tel: 905. 592.0095 Fax. 905.592.0106

Pediatric Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care.

Child's Name:_____ Today's Date:_____

Age:_____ Date of Birth (m/d/y):_____ Gender: _____

Do you have a health benefit plan? □Yes □No If Yes which company? _____

List Contact information in order of preference:

Primary Contact:

Name:_____

Relationship: _____ Phone: (_____)_____

Address:_____City:_____

Province:_____ Postal Code:_____

Phone:H:(_____)_____C: (_____)_____W(_____)_____

May we leave voicemails at the above phone numbers? If so, select which ones. □ Home □ Cell □ Work

Email address:_____

Secondary Contact:

Name:_____

Relationship: _____ Phone: (_____)_____

Address:_____City:_____

Province:_____ Postal Code:_____

Phone:H:(_____)_____C: (_____)_____W(_____)_____

May we leave voicemails at the above phone numbers? If so, select which ones. □ Home □ Cell □ Work

Email address:_____

Where did you learn about this clinic?

□ Google
□ OAND/CAND
□ Seminar
□ Social Media
□ Other
□Referral from: _____

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Health Priorities/ Chief Concerns:

List your main health concerns in order of importance

1)_____

_____

2)_____

_____

3)_____

_____

Medical History:

Please list your medical providers.

Name of family doctor:_____

Phone Number: (_____)_____

Address:_____

Other Medical Providers: _____

Please indicate any serious illnesses, conditions, or reasons for hospitalizations.

Medical Condition/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list all current medications/supplements

Medications/Supplements	Dose	Prescribing Physician	Length of Use

Has your child taken antibiotics within the last 5 years (circle one)? YES NO

How many times has your child taken antibiotics within the last 5 years? _____

Has your child ever been infected with a Methicillin Resistant Organism (including MRSA)? YES NO

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Please indicate any allergies and/or food sensitivities

Allergy/Food Sensitivity	Symptoms

Has your child received vaccinations (circle one)? YES NO

If YES, please list which ones:

_____

_____

Prenatal History:

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

Did the mother receive prenatal medical care? YES NO

Did the mother experience any of the following during pregnancy? (check the box beside the complication)

Nausea/vomiting		High blood pressure		Diabetes	
Bleeding		Thyroid problems		Other	

Please indicate all supplements taken during pregnancy:

_____

Birth History:

Term length (circle one): Full term Premature: _____ wks Late: _____ wks

Length of labour: _____ Weight at birth: _____

Please check the box to indicate:

Vaginal		Forceps		Epidural/drugs	
Cesarean Section		Suction		Vacuum Extract	

Were there any complications during the birth:

_____

Neonatal History:

Did the child experience any of the following at or shortly after birth? (check the box beside the condition)

Neonatal jaundice		Seizures		Birth deformities	
Rash		Birth injuries		Other:	

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Growth and Development:

Age child began to crawl: _____ Age child began to teeth: _____
Age child began to sit up: _____ Age child began to talk: _____
Age child began to walk: _____

Sleep: hours per day: _____ hours per night: _____

Feeding History:

Feeding (circle): Breast fed Bottle fed (Milk/Soy/Other): _____

Length of breast/bottle feeding: _____ Age when solid foods were introduced:_____

Feeding complications: _____

What foods were introduced before 6 months: _____

Does your child have any dietary restrictions (religious, vegetarian, vegan, etc.): _____

Describe your child's typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/Beverages: _____

Social History:

Is your child physically active? (circle one) YES NO How much, how often? _____

How many hours of screen time (TV, computer, tablet, etc.)? _____ How many hours outside? _____

Describe your child's behavior and performance at school:

_____

List the extracurricular activities your child is involved in or any favorite activities:

_____

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Family History:

Please indicate if there is any significant family medical history that may apply to your child's health, such as diabetes, asthma, cancer, or heart disease.

Condition	Family Member

Please list anything not covered above:

_____

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PATIENT CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

We understand the importance of protecting your personal information and are committed to collecting, using and disclosing your personal information responsibly. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are trained in the appropriate use and protection of your information.
Our privacy policy states that: only necessary information is collected about you; storage, retention and destruction of your personal information complies with existing legislation and the privacy protection protocols of our regulatory body, the College of Naturopaths of Ontario.

This clinic will collect, use and disclose information about you for the following purposes:

- To assess your health concerns, provide health care, and advise you of treatment options
- To establish and maintain contact with you and follow-up with you for appointments
- To invoice goods and services, process payments including necessary credit card information and complete claims for insurance purposes when indicated
- To send you newsletters and other clinic updates as per your preference
- To communicate with other treating health-care providers when necessary with your consent
- To allow potential purchasers, practice brokers or advisors to conduct an audit

INFORMED CONSENT TO NATUROPATHIC THERAPEUTIC PROCEDURES AND TREATMENT OF A MINOR

I, _____, authorize _____, doctor of naturopathic medicine, to examine and administer Naturopathic care and treatment to _____, whose relationship to me is as a _____.

I acknowledge that I will be informed of the recommended therapeutic procedure(s)/ plan and will discuss any questions or concerns that may come up with the naturopathic doctor named below. I further acknowledge and confirm that I will be informed of and understand the therapeutic procedure(s)/plan with respect to the financial costs, expected benefits, potential risks and side effects, consequences of not having/following the procedure(s)/plan, and what alternative course(s) of action are available to us. As a result I do hereby voluntarily give my informed consent on behalf of my dependent for the recommended therapeutic procedure(s)/plan and understand that I can change the status of my voluntary consent at any time.

This consent is modified as follows:
_____

PATIENT CONSENT

I have read and understand this form and consent to therapeutic care with a Naturopathic Doctor and the disclosure of my personal information as outlined above.

_____
Parent or Guardian of minor (Print Name)

_____ _____
Signature Date