

Date: _____

Baby & Child Intake

Child's name: _____ Date of birth: _____ Age: _____ Sex: M F

Referred by: _____ Who is filling out this form (name and relation)? _____

Contacts (in order of preference):

Name _____
Address _____
Phone (Home) _____
(Work) _____
(Cell) _____
Email (Optional) _____

Name _____
Address _____
Phone (Home) _____
(Work) _____
(Cell) _____
Email (Optional) _____

Relationship to child _____

Relationship to child _____

Whom does the child live with? _____

Other health care providers (please fill in their name, type of provider, address and phone/fax)

- | | | |
|---|---|---|
| 1. _____

Phone: _____
Fax: _____ | 2. _____

Phone: _____
Fax: _____ | 3. _____

Phone: _____
Fax: _____ |
|---|---|---|

Child's Health Concerns (in order of importance):

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

Medical history

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any past serious conditions, illnesses, accidents, injuries, or hospitalizations:

1. _____ (Date: _____)
2. _____ (Date: _____)
3. _____ (Date: _____)
4. _____ (Date: _____)

Which of the following has your child had?

- | | | | |
|-----------------------------------|--|---|---------------------------------------|
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Measles | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Roseola | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Impetigo | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Tonsillitis |

Does your child have any allergies (food, medications, environmental)?

Y N If yes, to what? _____

Please list all current medications (prescription, puffers, over-the-counter, vitamins, herbs, homeopathics):

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Please list past prescription medications:

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

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

Please indicate what immunizations your child has had:

- | | |
|---|--|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Tetanus Booster - When? _____ |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Other: _____ |

Please indicate if any vaccination lead to adverse reactions: _____

Has your child had any screening assessments (blood, hearing, vision, EEG, speech/language, psychological evaluation)?

Y N If yes, which ones? _____

Prenatal health

How would you describe the health of the parents at conception?

- | | | | | | |
|--------|------|------|------|-----------|---------|
| Mother | Poor | Fair | Good | Excellent | Unknown |
| Father | Poor | Fair | Good | Excellent | Unknown |

What was the health of the mother during the pregnancy?

- | | | | | |
|------|------|------|-----------|---------|
| Poor | Fair | Good | Excellent | Unknown |
|------|------|------|-----------|---------|

What was the mother's and father's age at child's conception? _____

How would you describe the mother's diet during pregnancy?

- | | | | | |
|------|------|------|-----------|---------|
| Poor | Fair | Good | Excellent | Unknown |
|------|------|------|-----------|---------|

Did the mother receive prenatal medical care? Y N Unknown

If yes, what sort of medical care? _____

Did the mother experience any of the following during the pregnancy:

- Bleeding
- High blood pressure
- Nausea
- Vomiting
- Diabetes
- Thyroid problems
- Trauma
(physical/emotional)
- Other _____

Did the mother use any of the following during the pregnancy:

- Tobacco _____
- Alcohol _____
- Recreational Drugs; which ones: _____
- Prescription Medications; which ones: _____
- Over the counter meds; which ones: _____
- Supplements; which ones: _____
- Other: _____

Birth history

Previous pregnancies/miscarriages/complications by mother: _____
 Term length: ___ Full ___ Premature: _____ wks ___ Late: _____ wks
 Length of labour: _____ Weight at birth _____
 Did you have any complications during labor? Y N In yes, what: _____
 Was the birth: ___ Vaginal ___ C-section ___ Induced ___ Forceps ___ Anesthesia used
 Did the child experience any of the following at or shortly after birth?
 Jaundice Rashes Seizures Birth injuries, what? _____
 Birth defects, what? _____ Other _____

Diet

How was your infant fed:
 Breast fed; how long? _____ Formula: Milk Soy Other _____

Did you follow a food introduction schedule? Y N

What types of foods were introduced before 6 months?

_____	_____
_____	_____
_____	_____
_____	_____

What types of foods were introduced between 6 and 12 months?

_____	_____
_____	_____
_____	_____
_____	_____

Did your child ever experience colic? Y N

Does your child have any food allergies or intolerances? Y N If yes, please list: _____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)? Y N If yes please list:

Describe your child's typical daily diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages _____

Health and Development

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

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Describe your child's sleep pattern: _____

How would you describe your child's temperament? _____

How would you describe your child's behaviour and performance at daycare/homecare/school? _____

What are your child's favorite activities? _____

Does your child exercise regularly? Y N How much, how often? _____

Does your child watch television? Y N If yes, how much? ____ hrs/day

How much time does your child spend in front of a tablet/smartphone/computer? _____ hrs/day

Does your child read (recreationally)? Y N If yes, how much? _____

How would you describe the emotional climate of the child's home? _____

Family history

Indicate if a close relative (parent, sibling) has had any of the following:

___ Allergies	___ Birth defects	___ Mental illness
___ Diabetes	___ Arthritis	
___ Asthma	___ Heart disease	
___ Kidney disease	___ Cancer	

Do either of the parents have a chronic illness? Y N If yes, please describe : _____

Environment

Does anyone in the child's household smoke? Y N

Are there animals in the home? Y N

How is the child's home heated? Gas Electric Wood Other: _____

Do you know of any toxins or other hazards your child is regularly exposed to? Y N If yes, what? _____

Is there anything else you feel I should know?



MUTUAL UNDERSTANDING AND CONSENT TO TREATMENT

The following information is provided to enable our sharing of a common understanding of our rights and roles in this professional therapeutic relationship. Please read this agreement and sign at the end indicating that you have understood and agreed to the following.

- Information revealed during counseling and discussion sessions is strictly confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor. Your record and the information within will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- Naturopathic medical treatments are in no way meant to replace conventional medical care or care from another licensed health practitioner. Please let your naturopathic doctor know if you are being treated by other health care providers. It is your responsibility to disclose changes in your condition, symptoms, contact information or treatments between visits.
- Naturopathic medicine uses non-invasive methods for the assessment of bodily dysfunction and the use of natural therapeutics for their correction. This may include: physical examination, nutrition, supplementation, homeopathy, botanical medicine, acupuncture/traditional Chinese medicine, hydrotherapy, detoxification techniques, bodywork, counseling, and lifestyle modifications. If at any time the patient wishes to discontinue a particular therapy/treatment they are free to do so.
- The treatment plan will be explained to you, as well as potential side effects of any therapies. You are encouraged to ask any questions you may have. As with any form of medicine, we cannot guarantee the outcome of any treatment offered.
- If you have a serious health problem that requires immediate attention, call your other medical doctor, call 911 or have someone take you to the emergency room. If you notice an adverse effect from one of the components of your health plan, discontinue it and call or email Dr. Joshi to inform her of what has occurred.
- I agree to pay my full account at the time of each visit for services, cost of supplements/remedies, lab tests or other fees. I am aware that said fees are not covered by MSI.
- CANCELLATION: Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hours notice is required for rescheduling or cancellation of an appointment. The full fee will be charged for missed sessions without such notification.
- The contact information, health history, and other information that I provided on my intake form are complete and accurate.

I _____ (Print Name) understand and agree to the information on this page and give my consent to treatment. My questions, if any, were answered to my satisfaction.

SIGNATURE of patient or guardian

Date



Fee Schedule and Cancellation Policy

FEE SCHEDULE

Please read the following information carefully and keep for your records.

Initial Visit	Up to 90 Minutes	\$165
Subsequent Visit	Up to 45 Minutes	\$90
Pediatric (<12 yrs old) Initial Visit	Up to 60 Minutes	\$115
Pediatric Subsequent	Up to 45 Minutes	\$90
Acupuncture Visit	Up to 30 Minutes	\$72
Emergency Visit	Up to 15 Minutes	\$40
Injection Visit	Up to 5 Minutes	\$13.50

NSF Cheques are subject to a \$25 fee.

Phone consults may be arranged (depending on circumstances and with the exception of initial visits) with the same fees outlined above.

All payments are due as services are rendered

While fees are not covered by MSI, many insurance companies offer coverage of naturopathic services. Check with your insurance provider for more information.

CANCELLATION POLICY

In naturopathic medical practice, scheduled visits are significantly longer than in other forms of medicine. As such, missed or inappropriately cancelled appointments can account for a significant amount of lost appointment time over the course of the day. We do not overbook patients in this practice to account for missed or cancelled appointments. It is therefore necessary to enforce the following cancellation policy.

You are responsible for the full fee of a missed appointment unless you provide at least 24 hours notice of cancellation.

In unforeseen circumstances, such as illness or bad weather, in the absence of adequate cancellation or attendance, you can request that your appointment be conducted over the phone. Please note, however, normal visit charges will apply.

If you need to cancel or rebook your appointment time, please call 406-0100 at your earliest convenience.

By signing below you acknowledge your understanding of the above listed fee structure and cancellation policy.

Thank you in advance for your cooperation.

Name/Signature

Date