SAGE ELEMENTS
NATUROPATHIC CLINIC

Baby & Child Intake Form

Child's name _____ **Date of birth** _____ **Age** _____

Who is filling out this form (name and relation) _____

How did you hear about me _____

Contacts (in order of preference):

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

Email (Optional) _____

Relationship to child _____

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

Email (Optional) _____

Relationship to child _____

Who 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: _____)

Has your child had any of the following:

____ Chicken Pox	____ Measles	____ Roseola	____ Tonsillitis
____ Ear Infections	____ Mononucleosis	____ Rubella	____ Whooping cough
____ Impetigo	____ Mumps	____ Strep Throat	

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

Please list all current medications & supplements:

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

Please list past prescription medications:

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

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

Please indicate what vaccinations and immunizations your child has had:

____ DPT (diptheria, pertussis, tetanus)	____ Tetanus Booster - When? _____
____ MMR (measles, mumps, rubella)	____ Flu
____ Haemophilus influenza B	____ Polio
____ Hepatitis A	____ Smallpox
____ Hepatitis B	____ Other: _____

Were there any adverse reactions: _____

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

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 pregnancy:

____ Bleeding
____ Diabetes
____ High blood pressure
____ Nausea/vomiting
____ Thyroid concerns
____ Trauma (emotional or physical)

Did the mother use any of the following during pregnancy:

____ Tobacco _____
____ Alcohol _____
____ Recreational Drugs _____
____ Prescription Medications _____
____ Over the counter meds _____
____ Supplements _____
____ Other: _____

Birth history

Previous pregnancies/miscarriages/complications: _____
Term length: ☐ Full ☐ Premature: _____ weeks ☐ Late: _____ weeks
Length of labor_____ Weight at birth _____
Did you have any complications during labor: _____
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 ☐ Birth defects
Other _____

Nutritional health

Was your child breast fed & for how long: _____

Did you follow a food introduction schedule? Y☐ N☐

What types of foods were introduced before 6 months? Please indicate if any reactions.

_____ _____
_____ _____
_____ _____
_____ _____

What types of foods were introduced between 6 and 12 months? Please indicate if any reactions.

_____ _____
_____ _____
_____ _____
_____ _____

Did your child ever experience colic? Y☐ N☐

Does your child have any food allergies or intolerances: _____
Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.): _____

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 behavior 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: ____ hours/day
How much time does your child spend in front of a tablet/smartphone/computer: _____ hours/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

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

- ☐ **Allergies**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Cancer**
- ☐ **Diabetes**
- ☐ **Eczema**
- ☐ **Heart disease**
- ☐ **Kidney disease**
- ____ **Mental illness**

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? _____
Has your child ever been bitten by a tick or spider, or scratched by a cat: _____

Is there anything else you feel I should know?

_____
_____
_____
_____

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NATUROPATHIC CLINIC

Informed Consent for Naturopathic Care

Please read carefully before your appointment. This will be discussed and signed during your appointment.

- I understand that all that has been discussed between Dr. Joshi and myself during my appointment is strictly confidential. Exceptions to this confidentiality include disclosure regarding intention to harm myself or others, and where there is reasonable suspicion of emotional, physical and/or sexual abuse of a minor. My records and the information within will not be released to others without my consent or unless required by the law.

- I understand naturopathic medical treatments do not replace conventional medical care or care from another licensed health practitioner. I understand I am at liberty to seek or continue care from other healthcare practitioners. I will let Dr Joshi know who the practitioners are and the treatments.

- I understand it is my responsibility to disclose changes in my condition(s), symptoms, diagnosis, treatments, or change in medication or supplements, between appointments. I will advise Dr Joshi if I am pregnant, suspect I am pregnant, or am breastfeeding.

- During your appointment, a review of your health history and health concerns, and a concern-oriented physical exam, and lab testing, may be done. Individualized treatment recommendations may include: dietary and nutritional guidance, lifestyle counseling, vitamin and mineral supplementation, homeopathy, herbal medicine, Traditional Chinese Medicine, hydrotherapy, and hands-on therapy (maya abdominal therapy). If at any time, I wish to decline or discontinue any treatment, I understand I may do so.

- I acknowledge that Dr Joshi has discussed my treatment plan with me, as well as any potential side effects, allergic or adverse reactions of the therapies recommended. I understand the nature, risks, and benefits of the naturopathic treatment plan. I was encouraged to ask questions about my care and treatment plan and have had my questions answered to my satisfaction. I understand that, as with any form of medicine, Dr Joshi cannot guarantee the outcome of any treatment offered.

- I understand virtual care (telephone or video consults) may be offered as a complement to in-person care when clinically appropriate.

- I understand if I have a serious health concern that requires immediate attention, I will call 911 or go to the emergency room. If I notice an adverse effect from one of the treatment modalities of my treatment plan, I will discontinue it and contact Dr. Joshi for guidance.

All contact information, health history, and other information provided in my intake form are complete and accurate. I have read the informed consent. I consent to receive present and future naturopathic care from Dr Priya Joshi ND.

Patient Name (please print): _____

Signature of Parent or Guardian: _____ **Date:** _____

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Fee Schedule and Cancellation Policy

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

Initial Appointment - Pediatric	Up to 60 Minutes	$200
Follow up Appointment - Pediatric	30 - 45 Minutes	$145
Acute Appointment	Up to 15 Minutes	$65

I agree to pay my full account at the time of every appointment for services, cost of supplements/remedies, and/or lab tests. I am aware these fees are not covered by MSI.

You may choose to purchase natural health products (that may be recommended as part of your treatment plan) at the clinic dispensary or at a place Dr Joshi may suggest.

Scheduling of an appointment reserves the time specifically for you. To respect the time of Dr Joshi and to offer availability to a patient who may require that appointment time, we kindly ask for **24 hours notice** to reschedule or cancel your appointment.

In the absence of 24 hours notice, or in the case of a missed appointment, the **full fee** of the appointment will be charged. Please note: This fee cannot be charged to insurance plans.

In unforeseen circumstances - emergency, illness, or bad weather - certain considerations will be made by Dr Joshi.

If you need to cancel or reschedule your appointment, please call 902-406-0100 or you may do so online.

I have read and agree to the above fee and cancellation policy.

_____ _____

Name & Signature of parent/guardian **Date**