

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) _____

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

Email (Optional) _____

Email (Optional) _____

Relationship to child _____

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:

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

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

Please list all current medications & supplements:

- | | |
|----------|----------|
| 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 vaccinations and 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: _____ |

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
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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
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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:

<input type="checkbox"/> Bleeding	<input type="checkbox"/> Nausea/vomiting
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid concerns
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Trauma (emotional or physical)

Did the mother use any of the following during pregnancy:

<input type="checkbox"/> Tobacco	_____
<input type="checkbox"/> Alcohol	_____
<input type="checkbox"/> Recreational Drugs	_____
<input type="checkbox"/> Prescription Medications	_____
<input type="checkbox"/> Over the counter meds	_____
<input type="checkbox"/> Supplements	_____
<input type="checkbox"/> 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?

<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rashes	<input type="checkbox"/> Seizures	<input type="checkbox"/> Birth injuries	<input type="checkbox"/> 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:

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Eczema | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | |

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?



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. During your appointment, Dr Joshi will take a thorough medical and health history. A physical examination may be done.

- Information revealed during the appointment 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 be kept confidential. They will not be released to others without your consent or unless requested by the law.
- 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 (change in medication or supplements) between visits. Please advise if you are pregnant, suspect pregnancy, or are breastfeeding.
- There are a number of different modalities used in naturopathic medicine: diet and nutritional counseling, herbal medicine, traditional Chinese medicine, homeopathy, hydrotherapy, lifestyle counseling. 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 at any time you wish to discontinue a particular therapy/treatment, you are free to do so.
- If you have a serious health problem that requires immediate attention, call your MD, or call 911 or have someone take you to the emergency room. If you notice an adverse effect from one of your treatment modalities, 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 appointment for services, cost of supplements/remedies (if I choose to purchase them), or lab tests.
- The contact information, health history, and other information that I provided on my intake form are complete and accurate.

I have read and understand the information on this page. I give my consent to treatment.

SIGNATURE of patient or guardian

Date



Fee Schedule and Cancellation Policy

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

Initial Appointment - Adult	Up to 90 Minutes	\$215
Follow up Appointment - Adult	Up to 45 Minutes	\$120
Initial Appointment - Pediatric	Up to 60 Minutes	\$165
Follow up Appointment - Pediatric	Up to 45 Minutes	\$105
Initial Appointment – Student/Senior	Up to 90 Minutes	\$200
Follow up Appointment – Student/Sr	Up to 45 Minutes	\$110
Acute Appointment	Up to 15 Minutes	\$65

Payment is due at the time of the appointment.

We will provide an official receipt that you can submit to your extended health insurance plan.

Naturopathic appointments are not covered by MSI.

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 want 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 your naturopathic doctor at their discretion.

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

Name & Signature of parent/guardian

Date