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	**___ Diabetes**	**____ Mental illness**
___ Arthritis	**___ Eczema**	
___ Asthma	**___ Heart disease**	
___ Cancer	**___ 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?

_____
_____
_____
_____

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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**

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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	$190
Follow up Appointment – Student/Sr	Up to 45 Minutes	$105
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**