



Dr. Nina Lange and Dr. Amy Rolfsen
Naturopathic Physicians
Confidential Pediatric/Adolescent Intake Form

Child's name _____ Date _____
 Address _____ City _____
 Postal Code _____
 Date of Birth ____ / ____ / ____ Age _____ Gender _____
 PHN (Care Card Number) _____
 Email address _____

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Parent Contact:

Name _____ Relationship _____
 Home # _____ Work # _____ Cell # _____
 Name _____ Relationship _____
 Home # _____ Work # _____ Cell # _____
 How did you hear about us? _____

What are your child's main health concerns, in order of importance?

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

Allergies and Emergency: please list any known allergies and emergency information

Please list your child's medications:

	Now	Past
Aspirin	_____	_____
Tylenol	_____	_____
Antibiotics	_____	_____
Other	_____	

Supplements:

	Now	Past
Vitamins	_____	_____
Minerals	_____	_____
Fluoride	_____	_____
Other	_____	

Childhood Illnesses:

___ chicken pox	___ scarlet fever	___ mononucleosis
___ red measles	___ rheumatic fever	___ ear infection(s)
___ mumps	___ strep throat	___ tonsillitis
___ rubella	___ pneumonia	

Other: _____



Immunizations: list types, when given, any reaction

Prenatal/birth/neonatal history:

Birth weight _____ premature late full term

Mother's health during pregnancy:

Age _____ bleeding extreme nausea
 illness toxemia trauma/injury
 stress x-rays high blood pressure
 diabetes medications cigarettes
 alcohol drugs Other _____
Place of birth _____

Infant Feeding:

breast fed: if yes, how long? _____
 formula fed: how long and types of formula? _____
Age solids began _____ What foods? _____
Food allergy/intolerance _____
Favourite foods _____
Least favourite foods _____

Sample daily diet: list your child's typical day including liquids

Hospitalizations/surgeries/accidents/serious injuries and illnesses: (describe each incident and give dates)

Family History: identify all family members who have or have had the following:

— _____ alcoholism _____ allergies
— _____ anemia _____ arthritis
— _____ asthma _____ diabetes
— _____ eczema _____ epilepsy
— _____ heart disease _____ hearing loss
— _____ hypoglycemia _____ mental illness
— _____ obesity _____ stroke
— _____ thyroid disorder Others: _____

Patient's Health History:

Now	Past	Never		Now	Past	Never	
_____	_____	_____	allergies	_____	_____	_____	fatigue
_____	_____	_____	anemia	_____	_____	_____	frequent headaches
_____	_____	_____	asthma	_____	_____	_____	headaches
_____	_____	_____	bedwetting	_____	_____	_____	heart murmur
_____	_____	_____	birth defects	_____	_____	_____	high fever
_____	_____	_____	colic	_____	_____	_____	hyperactivity
_____	_____	_____	cough/wheeze	_____	_____	_____	insomnia
_____	_____	_____	croup	_____	_____	_____	jaundice
_____	_____	_____	depression	_____	_____	_____	learning problems
_____	_____	_____	diarrhea	_____	_____	_____	moodiness
_____	_____	_____	dry skin	_____	_____	_____	stuffy nose
_____	_____	_____	earache	_____	_____	_____	thrush
_____	_____	_____	eczema/rash	_____	_____	_____	vomiting spells

Others: _____



Dr. Nina Lange and Dr. Amy Rolfsen, Naturopathic Physicians

Consent Form

Dear Patient

Naturopathic examination includes: physical and clinical diagnosis, traditional Chinese medical diagnosis and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, clinical nutrition, lifestyle counselling, intramuscular injection therapy, intravenous vitamin/mineral/nutrient therapy and pharmaceutical medications.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side effects. I also understand that there is no guarantee or warranty for a specific cure result.

I also understand that if I miss an appointment or cancel on short notice (less than 24 hours), I may be charged a fee for the missed appointment.

Signature x _____ Date x _____

Doctor's Signature x _____ Date x _____

PARENTAL CONSENT (if applicable)

If you are under the age of 19 parent consent is required for naturopathic treatment.

Signature of Parent/Guardian x _____ Date x _____

Welcome!

Thank you for taking the time to fill out this extensive questionnaire. Your answers will help us decipher what is going on so we can come up with the steps that will lead you to vibrant health!