MNM

Mardian Natural Medicine

347 Old Chicopee Trail, Kitchener, Ontario, N2A 4G5
Telephone: (519) 896-4800 Fax: (519) 896-4806
Email: info@MNM.ca Website: MNM.ca

Child Intake Form

Childs First Name: _____ Last Name: _____

Age: _____ Birth Date: _____ Sex: Male ☐ Female ☐

Caregiver(s) Information: E-Mail Address: _____

Name: _____ Relation: _____

Address _____ City_____ Postal Code _____

Home Phone: _____ Work : _____ Other: _____

How did you hear about this clinic? _____

Family Doctor or Pediatrician _____

What is your childs **main** health concern? (reason for visit) _____
_____

When did it start? _____
What makes it better? _____
What makes it worse? _____
What medications or treatments have you tried? _____
_____

Please list any other health concerns you have at this time: _____
_____

Please list medications (prescription and over-the-counter):
Taken in the past: _____
_____
Current Medication: _____
_____

Prenatal History

Mother's age at child's birth: _____ Father's age: _____
Number of previous pregnancies by natural mother, miscarriages, or complications: _____
_____

Please circle any of the following conditions if they were present during the pregnancy:
Bleeding ~ Nausea ~ Vomiting ~ Flu ~ Edema (swelling) ~ Hypertension ~ Diabetes ~ Drug Use
Physical trauma ~ Emotional trauma ~ Caffeine Use ~ Herpes ~ Alcohol Abuse ~ German Measles
Thyroid problems ~ Infections (yeast etc.) ~ Fainting ~ Smoking ~ Second hand smoke exposure

Medication use:_____
Vitamin/Homeopathic/Herb use:_____
Other: _____

Birth History

Length of gestation: 9 months_____ Early (# of weeks) _____ Late (# of weeks) _____
Length of labour: _____ Spontaneous? **Y/N** Induced? **Y/N** How? _____

Type of delivery: **Vaginal** ☐ **C-Section** ☐ **Emergency C-Section** ☐

Interventions used: **Anesthesia** ☐ **Epidural** ☐ **Episiotomy** ☐ **Forceps** ☐ **Other** _____
Child's Weight at birth _____ Length _____ APGAR score _____

Child's Health History Check any condition that your child has **now 'N'** or in the **past 'P'**

	N	P		N	P		N	P		N	P
Allergies			Measles			Fungal infections			Sleeping problems		
Asthma			Rashes			Bladder infections			Chronic sore throats		
Bed wetting			Easy bruising			Meningitis			Unusual fears		
Bad breath			Eczema			Mood swings			Vision problems		
Body odour			Mumps			Emotional trauma			Vomiting		
Fatigue			Bloody Urine			Nervousness			Walking problems		
Bronchitis			Fever			Night sweats			Crawling problems		
Cough			Fractures			Nose bleeds			Whooping cough		
Colds			Pneumonia			Frequent urination			Other:		
Constipation			Gas			Physical trauma					
Croup			Seizures			Eye infections					
Chicken pox			Hair loss			Growing pains					
Cradle cap			Headaches			Stomach aches					
Diarrhea			Tonsillitis			Ear infections					
Strep throat			Lice			Hearing problems					

Immunization History

Please check the vaccines your child has received, include approximate dates if possible:
Measles, Mumps, Rubella (MMR)_____ Polio_____
Pneumococcus _____ Chicken pox (Varicella) _____
Hib (*Haemophilus influenza* type b) _____ Flu Shot _____
Hepatitis A _____ Hepatitis B_____
Diphtheria, Pertussis, Tetanus (DPT) _____ Other _____

Has your child had any adverse reactions after a vaccination? (Please check)

Excessive crying ☐ **Pain** ☐ **Swelling** ☐ **Mood changes** ☐ **Limping** ☐ **Rash** ☐

Loss of appetite ☐ **Vomiting** ☐ **Insomnia** ☐ **Change in behaviour** ☐ **Fever** ☐

Nutritional History

Was the child breast fed within the first 10 hours after birth? **Y/N**
What kind of formula was used (if any)? **Dairy Soy Goat Rice Other:**_____
Briefly outline your child's typical daily diet:
Breakfast _____
Lunch _____
Supper _____
Snacks _____
Fluids/Water _____
Supplements _____

General History

Does your child sleep through the night? **Y/N** Hours of sleep: _____
Do you think your child could use more sleep? **Y/N** Does your child wake refreshed? **Y/N**
Does your child nap? **Y/N** How long? _____
Does your child have any known allergies? _____
Please list any hospitalizations and surgeries (include dates) _____
_____
How would you describe your child's temperment? _____
How do they handle stress? _____
How does your child express their emotions? _____
Has your child experienced any emotional traumas? _____
Has your child experienced any abuse (sexual/physical/mental)?_____

Is your child exposed to second hand smoke? **Y/N** Are there any smokers in your home? **Y/N**
Is there any mould in your home? **Y/N** Any pets? **Y/N**

Family History

Please circle any of the following that pertain to your immediate family (parents and siblings)

Allergies	**Arthritis**	**Asthma**	**Birth defects**	**Autoimmune disease**
Blood disorders	**Cancer**	**Depression**	**Diabetes**	**Eczema**
Heart disease	**Hepatitis**	**Herpes**	**HIV/AIDS**	**Hypertension**
Kidney disease	**Ulcers**	**Irritable bowel**	**Thyroid disease**	**Tuberculosis**

Other: _____
Briefly list any health conditions that grandparents may have or had in the past:
Maternal grandmother _____ Maternal grandfather _____
Paternal grandmother _____ Paternal grandfather _____

Is there anything else you would like to comment on? _____
_____
_____

Thank-you for taking the time to fill in this lengthy questionnaire. This information will be a valuable tool in assessing your child's health care needs.

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Consent to Treatment / Office Policy

The Legal Guardian must sign this document before any treatment will be rendered.

Each person seeking care in this clinic should understand that the practitioner is a naturopathic doctor. If a medical diagnosis is required, it must be obtained from a licensed medical doctor.

By signing this document you are acknowledging the following:

1. The methods utilized in this clinic have a proven clinical foundation yet may not be accepted by standard (allopathic) medicine.
2. Naturopathic Doctors are required by their licensing board to perform a physical examination on each new patient. This will be adhered to unless a full report is sent by the referring practitioner and that report is accepted by the attending practitioner.
3. Naturopathy uses non-invasive methods for the assessment of bodily dysfunction and natural therapeutics for its correction. The therapeutics used in this clinic include: nutrition, homeopathy, botanical medicine, hydrotherapy, detoxification techniques, acupuncture, Bowen therapy, and lifestyle modification techniques.
4. The practitioner reserves the right to determine which cases fall outside of their scope of practice, in which event an appropriate referral will be recommended.
5. As a client, you are accepting or rejecting this care of your own free will.
6. The ultimate responsibility of your health care is your own and we are here to support you in this. We reserve the right to discontinue our service where it is apparent that your expectations and what we provide are not in agreement.
7. As a client, I confirm that none of the Naturopathic Doctors, nor anyone else at this clinic has suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider.
8. I agree to pay my full account for each visit or treatment, including fees for services, cost of supplements and remedies, cost of lab tests and any other fees. I am aware that these fees are not covered by OHIP.
9. I am aware that any phone call to the naturopathic doctor greater than 2 minutes will require an appointment or a charge for a phone consultation will be applied.
10. I am aware that if I do not show up on time for my appointment that there will be no extensions and I will be charged the regular fee.

I _____ (Please print your name here), have read and understood, and acknowledge the above statements.

_____ Date: _____
(Parent's or Guardians signature)