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CHILD & ADOLESCENT INTAKE FORM

Please take a few minutes to complete this form to the best of your ability. The information provided in this form will help to provide me with a general overview of your child's health on a physical, mental, and emotional level, and assist me in preparing a treatment plan that will best meet their individual health needs and goals.

Full Name ____
Date____________________________________
Date of Birth _______________________________ (d/m/y) Age________________
Sex: M F

Who is filling out this form? (Name & Relation)
____

Name of parent(s)/guardian(s):
____

Address: ____
Phone: (h) ___________________________
(w) ___________________________
(mobile) ______________________
email: ____

How can we best reach you?
____

May we leave messages pertaining to your child's visits: Y N

Is the child yours by: o Birth o Adoption o Stepchild o Other:

Are parents: o Married o Unmarried o Remarried o Widowed
o Separated o Divorced

Who does the child live with?
____

Child's primary care Physician/Pediatrician: _______________________________

How did you hear about our office? ________________________________

How would you rate your child's current state of health:
Excellent Good Fair Poor

Please list child's health concerns in order of importance (yours and theirs):
1. ____
2. ____
3. ____
4. ____
5. ____

MEDICAL HISTORY:

Please describe any serious conditions, hospitalizations, operations, illnesses or injuries with their dates:

____
____

Please list all current medications the child is taking (ie. prescription, over-the-counter, etc.)**:**

____
____
____

Please list all vitamins, herbs, homeopathics or other supplements the child is taking:

____
____
____
____

Please list any medication your child has taken for an extended period of time:

____
____

How many times has your child been on antibiotics?
o 0 – 2 o 3 – 5 o 5 or more

Does your child have any allergies (environmental, medicines, seasonal, etc.)? Describe:

____

Please indicate if your child has recently been tested for the following?

Hearing o Yes o No **Vision** o Yes o No **Yearly physical** o Yes o No

Dental o Yes o No **Speech** o Yes o No **Blood tests** o Yes o No

Please circle if your child had any of the following conditions currently (C) or in the past (P) (you may circle both):

Allergies	C	P	**Digestive problems**	C	P	**Mumps**	C	P
Asthma	C	P	**Ear infections**	C	P	**Nail biting**	C	P
Bad breath	C	P	**Eczema**	C	P	**Pneumonia**	C	P
Bed wetting	C	P	**Fainting**	C	P	**Recurring fevers**	C	P
Bronchitis	C	P	**Headaches**	C	P	**Roseola**	C	P
Bruises easily	C	P	**Herpes (oral)**	C	P	**Rubella**	C	P
Chicken pox	C	P	**Hives/Rashes**	C	P	**Scarlet Fever**	C	P
Chronic colds	C	P	**Impetigo**	C	P	**Seizures**	C	P
Colic	C	P	**Influenza**	C	P	**Sinus troubles**	C	P
Constipation	C	P	**Itchy eyes**	C	P	**Strep Throat**	C	P
Depression/Anxiety	C	P	**Measles**	C	P	**Temper tantrum**	C	P
Diarrhea	C	P	**Mononucleosis**	C	P	**Whooping cough**	C	P

Other: ____

IMMUNIZATIONS:

Has your child received regular vaccinations according to the standard Pediatric schedule? o Yes o No, explain:

____

____

If known, please indicate which of the following vaccinations your child has had:

o DPT (diphtheria, pertussis, tetanus)
o MMR (measles, mumps, rubella)
o Polio
o Hepatitis A
o "flu shot"
o HPV
o Tetanus booster
o HiB (Haemophilus influenza B)
o "Chicken pox"
o Hepatitis B
o Meningitis
o Other:

Has your child had any adverse reaction to a vaccination? Please explain.

____

____

____

FAMILY HISTORY: (*please indicate where applicable*)
Was this child adopted? No Yes, If yes please indicate date: _______________

	Father	Mother	Brothers	Sisters	Grandmother		Grandfather	
					Maternal	Paternal	Maternal	Paternal
Age (if living)								
Health (**G**=good, **P**=poor)								
Allergies								
Anemia								
Asthma, Hayfever, Hives								
Cancer								
Cystic Fibrosis								
Diabetes								
Epilespy								
Rheumatoid Arthritis								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Mental Illness								
Alcoholism								
Stroke								
Tuberculosis								
Other								
Age (at death)								
Cause of death								

PERINATAL HISTORY:

What was the health of the parents at conception?
Mother o Poor o Fair o Good o Excellent o Unknown
Father o Poor o Fair o Good o Excellent o Unknown

What was the mother's health during pregnancy?
o Poor o Fair o Good o Excellent o Unknown

How was the mother's diet during pregnancy?
o Poor o Fair o Good o Excellent o Unknown

Describe any particular food cravings during the pregnancy:
____

Was this a planned pregnancy? o Yes o No

What was the mother's age at the child's birth? _____ father's age at birth? ___

Any genetic concerns? Describe: ____
____

Where there any fertility issues? Describe:
____
____

Did the mother receive prenatal medical care? o Yes o No o Unknown

Did the mother experience any of the following during the pregnancy?
o Emotional stress o High blood pressure o Vomiting o Nausea
o Diabetes o Placenta previa o Toxemia o Bleeding
o Thyroid problems o Ultrasounds o Physical trauma
o Exposure to cigarette smoke o Other: ___________________

Did the mother use any of the following during the pregnancy?
o Tobacco o Alcohol o Recreational drugs: ____________________________
o Prescription medications: ____
o Over-the-counter medications: _______________________________________
o Supplements: ____
o Other: ____

BIRTH HISTORY:

Term Length: o Premature: _______ wks o Early: _______ wks
o Full-term o Late: __________ wks

Birth weight: ________ Birth length: ______ APGAR score: 1min ______ 5min _____

Delivery by: o Vaginal birth o Cesarean, why?______ _______________________

Check if any of the following interventions apply to the birth?
o Forceps o Vacuum extraction o External fetal monitor
o Epidural o Pitocin o Induction of labour
o Other: ____

Where there any complications during/after delivery?
____

Did the child experience any of the following at or shortly after birth?
o Jaundice o Rashes o Seizures o Birth injuries: ________________________
o Birth defects: ____
o Other: ____

Please indicate any medical problems during baby's newborn/infancy period:
____
____
____

NUTRITION & DIET:
Was your child breastfed? o No o Yes, for how long? ________________________
If formula was introduced, when? _______________ What type? ________________
When were solid foods introduced? ________
Which foods were introduced first?
____
____
Any reactions?
____

Please list any food allergies or intolerances:
____
____
____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)? ____________________

Does your child have any food aversions? If so, to which foods?
____
____

Is your child a "picky" eater? Please explain.
____

Has your child had any unusual feeding/dietary issues or habits?
____
____

Milk intake now:
o Cow milk (o Non-fat o 1% o 2% o Whole milk) o Soy milk o Rice milk
o Other: ____________

How often does your child:
Drink soda pop? o More than once/day o Once/day o Sometimes o Never
Have caffeine? o More than once/day o Once/day o Sometimes o Never
Eat chocolate? o More than once/day o Once/day o Sometimes o Never

Please describe a typical day's diet, on separate piece of paper:
Breakfast Lunch Dinner Snacks Beverages (including amounts)

SLEEP:

Does your child sleep through the night? o Yes o No o Occasionally

Hours per night__________ Naps (number & length) __________

Any sleeping problems? ____________________

DEVELOPMENT:

Child's weight: ______________ Child's height: ______________

At what age did your child: Sit alone______ Crawl ______ Walk alone_______
Say words _____ Toilet train _________

LIFESTYLE / ENVIRONMENT:

Is the child presently in: o School o Daycare o Homecare o Other: ___________

What are your child's favorite activities/interests?

____

____

Is your child exposed to cigarette smoke? o Yes o No

Do you have pets: o No o Yes,

____

Do you know of any environmental toxins / hazards (chemicals, fumes, dust, etc.) your child is regularly exposed to?

____

____

____

How often does your child:

ACTIVITY	Never	1 – 4 hrs/wk	4 – 8 hrs/wk	More than 8 hrs/wk
Watch TV/videos	o	o	o	o
Play videogames	o	o	o	o
Work on computer	o	o	o	o
Play sports	o	o	o	o
Exercise	o	o	o	o
Read (or is read to)	o	o	o	o

Other: ____

Please describe your child's temperament / behaviour, as best as you can:

____

____

Please describe any fears / anxieties / worries your child has:

____

____

Please describe your child's behaviour and performance at school:

____

____

If over 4 years old, does your child have a "best" friend? o Yes o No

Are there any concerns about relationships with:
Teachers: o No o Yes, ____
Peers: o No o Yes, ____
Siblings: o No o Yes, ____
Other: ____

Does your child have any learning difficulties? Describe:
____
____

How would you describe the emotional climate of the child's home?
____
____

Is there any other relevant information you would like to discuss that has not been covered?
____
____
____

ADOLESCENT INTAKE FORM

At what age did you experience the onset of puberty? ____________________

How would you rate your current state of health? Excellent Good Fair Poor

Are you satisfied with your current weight? o Yes o No
Have you ever done any of the following to lose weight:
skipped meals, taken pills, vomited, taken laxatives or herbal supplements?
o Yes o No
Are you satisfied with your appearance? o Yes o No
Are you satisfied about your relationship with your family? o Yes o No
Are you satisfied about your relationship with your peers? o Yes o No

Are you (or have you been) sexually active? o Yes o No
If yes, do you practice "safe-sex"? o Yes o No
Have you ever had unprotected sex? o Yes o No

Have you ever been in a relationship in which you have felt threatened or unsafe? o Yes o No

Do you ever consume alcoholic beverages? o Yes o No
If yes, how much and how often? ______________________________

Do you smoke cigarettes? o Yes o No
If yes, how much and how often? ____

Are you using any recreational drugs? (marijuana, ecstasy, LSD, etc.)?
o No o Yes If yes, which ones and how often? ____________________

How would others describe you?
____
____

Is there anything else that you would like to discuss or get information about?
____

♀ FOR GIRLS ONLY

At what age was your first menstrual period? __________
Length of cycle? _______Length of period? __________

Do you experience any of the following regarding menstruation?

o Spotting o Heavy Bleeding o Severe pain o Cramping
o Scanty bleeding o PMS o Depression o Fluid retention
o Absent periods o Infrequent periods o Cravings o Vomiting
o Moodiness o Irregular periods o Cyclical breast pain

If you checked PMS, please describe your symptoms:
____
____

Do you do breast self-examinations? o Yes o No
Are you currently taking a Birth Control Pill? o No o Yes, which one? ________
If yes, what is the reason? ____

INFORMED CONSENT

Drs. DiCicco and Bablad utilize the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's natural ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. Assessment of each patient's physical, mental, emotional and spiritual well-being is required to facilitate this work. If you are working with a Naturopathic Doctor, a physical exam and specific blood and/or urinary laboratory reports may be used as part of the treatment work-up.

Therapies used by a Naturopathic Doctor may include: Clinical Nutrition, Botanical Medicine, Homeopathy, Traditional Asian Medicine & Acupuncture, Lifestyle Counseling & Stress Management, Hydrotherapy, and Physical Medicine including massage and soft tissue manipulation.

Statement of Acknowledgement

I, (print your name) ____ , acknowledge that as a patient of Drs. DiCicco/Bablad, I have read the information included herein, and understand that the form of medical care is based on Naturopathic Medicine and other supportive principles and practices. I also recognize that even the gentlest therapies have potential complications in certain physiological conditions such as pregnancy, lactation, very young children, very elderly patients, or those on multiple medications. I therefore confirm that I have informed (and will continue to inform) my practitioner fully of my medical history, family history, medications and / or supplements I am currently taking (prescription and over-the-counter), or was previously taking. If female, I have advised my practitioner of any chance that I am pregnant or lactating, and will continue to do so.

Despite the low incidence, there are some slight risks to some Naturopathic treatments. These include, but are not limited to:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from acupuncture
- muscle strains and sprains, disc injuries from spinal manipulations.

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and may request a copy of it by paying the appropriate fee.

I understand that the treatment and therapies rendered or recommended to me by my Naturopathic Doctor, may be different than those usually offered by a medical doctor or other licensed health care providers.

I understand that any treatment or advice provided to me by my Naturopathic Doctor is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider; which I agree to disclose to my Naturopathic Doctor.

I understand that my Naturopathic Doctor has not suggested or recommended to me to refrain from seeking or following the advice of another licensed health care provider.

I understand that my practitioner will answer any questions I have to the best of her/his ability. I understand that the results are not guaranteed. I do not expect the practitioner to anticipate and explain all risks and/or complications.

I understand that charges are to be paid at the time of the visit unless previous arrangements have been made prior to my scheduled appointment. As the patient, I am responsible for the total charges incurred for each visit, and have been informed of the fee schedule and accepted methods of payment.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment I receive under the care of Vanessa DiCicco, N.D. and Jonathan Bablad, N.D. I understand that I am free to withdraw my consent with written notice and to discontinue treatment at any time. I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, regional, state or government agency attempting to gather information without so stating.

______________________________ ______________________________

(parent/guardian's signature) (date)

______________________________ ______________________________

child/adolescent signature (if applicable) (date)