DR. MATT GREENWOOD ND

NEW PATIENT INTAKE FORM - PEDIATRIC

today's date: _____

General Information

Patient Name	first	middle	last		
Address		city	prov	postal code	
Date of Birth	dd / mm / yyyy	age	sex	height	weight
Phone (Guardian)	home	work	cell		
Email (Guardian)		❍ please send me paperless invoices to this email			
Parent(s)	father	mother			
Medical Doctor	name		phone		
	address		fax		
How did you hear about us?					
How should we contact you?					

Current Health Concerns

Please list your child's current health concerns, in order of importance. If possible, specify the date you first noticed the problem.

1 _____

2 _____

3 _____

4 _____

5 _____

Did something trigger his/her change in health?

_____

_____

Is there anything that worsens his/her symptoms?

_____

Is there anything that alleviates his/her symptoms?

_____

Allergies & Sensitivities

List all allergies to medications/ environment/ food	Reaction
_____	_____
_____	_____
_____	_____

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Medical History

List any condition that your child has been diagnosed with, date of diagnosis — ongoing / past

1 _____ date: ❍ / ❍

2 _____ date: ❍ / ❍

3 _____ date: ❍ / ❍

Please list all past hospitalizations, surgeries and injuries. Any present health issues as a result? yes / no

1 _____ date: ❍ / ❍

2 _____ date: ❍ / ❍

3 _____ date: ❍ / ❍

Current and any past medications

Name	Dose/Frequency	Start date	Reason for use

Current supplements (vitamins/ minerals/ herbal medicines/ homeopathics)

Name	Dose/Frequency	Start date	Reason for use

Symptom Review

Please check all symptoms occurring presently or in the past 6 months.

GENERAL

- ❍ recent weight change
- ❍ heat/cold intolerance
- ❍ sleep problems
- ❍ fatigue
- ❍ fever/chills
- ❍ night sweats
- ❍ motion/car sickness
- ❍ body odor
- ❍ other: _____

HEAD, EYES & EARS

- ❍ headache
- ❍ head injury
- ❍ ear pain/infection
- ❍ nosebleeds
- ❍ breath odor
- ❍ sore throat
- ❍ frequent colds
- ❍ other: _____

LUNGS

- ❍ asthma
- ❍ bronchitis
- ❍ cough
- ❍ wheezing
- ❍ other: _____

CARDIOVASCULAR

- ❍ heart murmur
- ❍ anemia
- ❍ colic/stomachaches
- ❍ loss of appetite
- ❍ excess appetite
- ❍ excess thirst
- ❍ blood/mucus in stool
- ❍ excess gas
- ❍ undigested food in stool
- ❍ canker sores
- ❍ stomach flu
- ❍ other: _____

GENITOURINARY

- ❍ frequent urination
- ❍ pain on urination
- ❍ blood in urine

SKIN

- ❍ hives
- ❍ itching
- ❍ acne
- ❍ hair loss
- ❍ dark circles under eyes
- ❍ jaundice
- ❍ suspicious moles
- ❍ slow wound healing
- ❍ other: _____

MIND/NERVOUS SYST

- ❍ unusual fears
- ❍ irritability/impatience
- ❍ anxiety/nervousness

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❍ dizziness
❍ changes in hearing
❍ itchy/watery eyes
❍ changes in vision
❍ eye pain/strain
❍ loss of smell
❍ congestion/runny nose

❍ bruising/bleeding
❍ congenital defects
❍ other: _____

GASTROINTESTINAL

❍ constipation
❍ diarrhea
❍ vomiting

❍ bedwetting
❍ other: _____

MUSCULOSKELETAL

❍ joint pain/stiffness
❍ muscle weakness
❍ joint deformity/fracture
❍ other: _____

❍ nightmares
❍ mood swings
❍ hyperactivity
❍ speech difficulty
❍ difficulty concentrating
❍ seizures
❍ other: _____

Infectious Disease History

Please check all conditions that the child currently has or has had in the past

❍ Chicken pox
❍ Impetigo
❍ Rubella (German Measles)
❍ Other: _____

❍ Mumps
❍ Rheumatic Fever
❍ Measles

❍ Whooping Cough
❍ Strep throat
❍ Mono
Patient has been immunized against: _____

❍ Croup
❍ Scarlet Fever
❍ Pneumonia

Birth History

OBSTETRIC HISTORY Please check applicable boxes and provide number.

❍ Pregnancies _____
❍ Miscarriage _____
❍ Gestational Diabetes
❍ Abnormal bleeding
❍ Nausea

❍ Caesarean _____
❍ Abortion _____
❍ Postpartum depression
❍ Illnesses _____
❍ Gestational Diabetes

❍ Hypertension
❍ Phys/Emot Trauma
❍ Induction
❍ Cigarette/Alcohol Use
Other complications:

❍ Vaginal Deliveries
❍ Living Children _____
❍ Breast Fed: For how long? ___
❍ Medications: _____

PATIENT'S BIRTH HISTORY

Maternal age: Length of Labour: ____ Term: ❍ Full ❍ Premature ❍ Late

Type of delivery: ❍ Vaginal ❍ C-section

Complications:

Family History

Please check all that apply. If deceased, please indicate with 'D'.	Mother	Father	Siblings	Children	Grandparents (maternal)	Grandparents (paternal)	Aunts	Uncles
Cancer								
Genetic disorder/Birth defects								
Heart disease/Stroke/Hypertension								
Diabetes								
Dementia								
Psychiatric/Mood disorder (ie. anxiety)								
Food/Environmental allergies								
Rheumatoid arthritis								

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Social History

Living With whom does the child live?

Occupation What is the child's guardian's occupation?

Diet

❍ Formula: type _____ Breakfast: _____ Lunch: _____

❍ Breast fed: duration _____ Dinner: _____ Snacks: _____

Stool or diapers/day_____ Drinks: _____ Water Intake: _____

Age began solids _____ What foods were introduced? _____

Known food intolerances:

Education

What school does the child go to? _____ What grade? _____

Favorite subject: _____ Favorite activity/hobby: _____

Behaviour/Performance in School/at Daycare: _____

Exercise: _____ How often? _____ TV hours/day:_____

Environment Is your child exposed to? ❍ Tobacco smoke ❍ Pet dander, specify _____

Development

Age began: sitting _____ walking _____ talking _____ crawling _____

Can you describe your child's temperament in a few words:

Sleep Hours/night _____ General quality of sleep patterns _____ Sleep position: _____

Other Please make note of anything else you feel would guide us in the treatment of your child:

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Declaration and Informed Consent for Naturopathic Care

1. I understand that the practice of naturopathic medicine requires taking a **thorough case history**, and may require a **physical exam** and, in some cases, **diagnostic testing** involving collection of blood, urine and/or saliva.

2. I confirm that the information I have provided to the doctor is **complete and inclusive of all health concerns,** as well as current medications - including over-the-counter drugs.

3. I understand that naturopathic medicine **carries a risk of complications and that resolution of symptoms is not guaranteed**. Slight health risks of some naturopathic treatments include, but are not limited to:
    - temporary aggravation of pre-existing symptoms
    - allergic reactions and other adverse effects to herbs or supplements
    - pain, fainting, bruising or injury from venipuncture or acupuncture

4. I understand that the treatment this child receives through the doctor is **not mutually exclusive from any other treatment** or advice the child may now, or in the future, be receiving, and we are at liberty to seek, or continue, medical care offered by any another qualified health care provider.

5. I confirm that I have the **ability to accept or reject the recommended treatment** for this child of my own free will and choice.

6. I understand that a record of this child's visits will be kept and that that this record will be **kept strictly confidential** and not released to any persons without my consent.

7. I have read and understood the fee schedule and I acknowledge that I am **responsible for payment of services in full at each visit.**

8. I understand that there is a **cancellation fee** for appointments missed without notice or cancelled with less than 24 hours notice. The charge will be **100% of the fee** of the appointment missed.

9. I acknowledge that I understand and **have been informed of the recommended therapeutic procedures** and have discussed these and any other related information with the patient and the practitioner to my satisfaction.

10. I am here as a guardian to a child seeking naturopathic medicine and am **not attending the clinic for any other reason** or misrepresenting myself in any way to the practitioner without making my intention known to the practitioner and/or staff.

11. I understand that the doctor reserves the right to determine which cases fall outside of his scope of practice, in which case the **appropriate referral** will be recommended.

Patient Name (please print): _____

Guardian Name (please print): _____

Guardian Signature: _____

Date: _____