The VILLAGE NATUROPATHS

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Richard Vuksinic, ND

CONFIDENTIAL PEDIATRIC INTAKE FORM

www.villagenaturopaths.com

Child's name _____ Date of birth _____ Sex M F

Date _____ Referred by _____

Who is filling out this form (name and relation)? _____

Contacts (in order of preference)

Name _____ Phone _____ h

Address _____ _____ w

_____ _____ other

_____

Relationship to child _____

Name _____ Phone _____ h

Address _____ _____ w

_____ _____ other

_____

Relationship to child _____

Name _____ Phone _____ h

Address _____ _____ w

_____ _____ other

_____

Relationship to child _____

Whom does the child live with? _____

Other health care providers

1. _____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

(_____)_____ (_____)_____ (_____)_____

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

1. _____
2. _____
3. _____
4. _____
5. _____

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Medical history

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

_____

_____

_____

_____

Which of the following has your child had? (n – never, m – mild, a – average, s – severe)

n m a s rubella (german measles)	n m a s roseola	n m a s impetigo
n m a s measles	n m a s scarlet fever	n m a s mononucleosis
n m a s chicken pox	n m a s whooping cough	n m a s ear infections
n m a s mumps	n m a s strep throat	

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

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

_____

_____

Please list past prescription medications.

_____

_____

_____

_____

How many times has your child been treated with antibiotics? _____

Please indicate what immunizations your child has had

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis B
☐ Tetanus booster; when? _____	☐ "Flu"	☐ Hepatitis A
☐ MMR (measles, mumps, rubella)	☐ Polio	

Other _____

Please indicate if any caused adverse reactions

_____

_____

What screening tests has your child had (blood, hearing, vision, etc.) _____

_____

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Prenatal health

What was 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 age at child's birth? _____

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during the pregnancy:

☐ Bleeding ☐ High blood pressure ☐ Nausea ☐ Vomiting

☐ Diabetes ☐ Thyroid problems ☐ Physical or emotional trauma

Other _____

_____

Did the mother use any of the following during the pregnancy?

☐ Tobacco ☐ Alcohol ☐ Recreational drugs: _____

☐ Prescription medications: _____

☐ Over-the-counter medications: _____

☐ Supplements: _____

☐ Other: _____

Birth history

Term length: ☐ Full ☐ Premature: _____ wks ☐ Late: _____ wks

Length of labour: _____ Weight at birth _____

Any complications? _____

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 _____

Diet

How was your infant fed?

☐ Breast fed. How long? _____ ☐ Formula. Milk/Soy/Other: _____

☐ Other: _____

What foods were introduced before 6 months? (Please list approximate month as well.)

_____
_____
_____

6–12 months?

_____
_____
_____
_____

Did your child ever experience colic? Y N How severe? mild moderate severe

Does your child have any food allergies or intolerances? Please list.

_____
_____
_____
_____

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

_____
_____

Describe a typical day's diet

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages (and total quantity) _____

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 behaviour and performance at school?

_____
_____

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Family history

Indicate if a close relative (parent, sibling) has had any of the following

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Other	
Juvenile arthritis			

☐ I don't know the family medical history

Do either of the parents have a chronic illness? Y N Please describe

_____

Environment

Is the child in school daycare home care other _____

What are your child's favorite activities? _____

_____

Does the child exercise regularly? Y N How much, how often?

_____

_____

How much television does your child watch? _____ hrs a day/week

How often does your child read (not for school), or How often does someone read to your child?

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

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? _____

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe.

_____

_____

_____

_____

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

_____

_____

Is there anything that you feel is important that has not been covered?

_____

_____

_____

_____

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INFORMED CONSENT TO TREATMENT

General Information

This form applies to patients of Richard Vuksinic, ND and/or Kristina Kastelanac, ND – Naturopathic Medicine. By consenting to treatment, your naturopathic doctor will have access to your file and personal information.

Though gentle, naturopathic therapies have complications associated with certain conditions. It is **essential** to be complete in informing your doctor of your current state of physical and mental health, if you are on prescription, over-the-counter or recreational drugs, or if you suspect you are pregnant or are currently breastfeeding.

There are some minor risks associated with naturopathic therapies which include but are not limited to: bruising, pain or injury from acupuncture, fainting, organ puncture from acupuncture, aggravation of pre-existing symptoms and conditions, allergic reactions to botanicals or supplements, muscle sprains, strains or disc injury from spinal manipulation. The utmost care will be taken to prevent such outcomes.

Patient Consent to Treatment

1. This is to acknowledge that I have been informed and understand that any advice or treatment that I receive as a patient at this clinic is not mutually exclusive from any other treatment I am currently receiving or may in the future receive from another licensed health care provider.
2. I understand that I may seek and/or continue to receive medical care from another healthcare provider qualified to practice in Ontario.
3. I understand that no one at this clinic is suggesting I refrain from seeking advice from another qualified health care provider.
4. I understand that my Naturopathic Doctor (ND) keeps a record of services provided to me, and this record is kept confidential, only to be released to others if directed by myself or if required by law. I may request to see this record at any time and have a copy of this record by paying a fee.
5. I understand that my ND reserves the right to determine if my health concerns fall out of the scope of her practice, in which case an appropriate referral may be recommended.
6. I understand that services at this clinic are not covered by OHIP, and I will be paying for fees at the time of the appointment; including fees for the visits, prescriptions, services and tests.
7. I understand that of my own free will, I would accept or reject the treatment protocol recommended by this clinic.
8. I understand that therapies recommended to me will be explained in full by my doctor, and that my questions will be answered as best as possible, in a manner which I can comprehend.
9. I understand that the results are not guaranteed. I do not expect my ND to anticipate all risks and complications, but rely on her to utilize appropriate judgment in my best interests, based on the facts and findings then known.
10. I understand that 24hrs notice is required for visit cancellation or change of appointment, or I will be charged the full cost of a visit.

11. I understand that my naturopathic doctor may prescribe to me medicines or devices ,and that I may purchase them from my naturopathic doctor, a pharmacy, a health food store, or a medical supply company of my choice.

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I voluntarily consent to treatment at: (please circle one)

a) Priority Massage and Health with KRISTINA KASTELANAC, ND or RICHARD VUKSINIC, ND

b) McLauchlin Wellness Clinic with RICHARD VUKSINIC, ND

c) Dorchester Chiropractic KRISTINA KASTELANAC, ND

using the diagnostic and therapeutic procedures mentioned above, except for (please list treatments you do NOT want to receive below):

I have read, understand and agree to the above statements.
I understand I am free to withdraw my consent to discontinue treatment at any time, informing the clinic in a written or verbal format.

Patient Name: _____ Parent/Guardian Signature

if under 18:_____

Patient Signature: _____