Open to Wellness Naturopathic Clinic - Child Wellness Intake Form

Child’s Name:       Date of Birth:       Age:       Sex:

Child’s Address:

Caregiver’s Name(s):

Phone Number: (Home)       (Work)       (Cell)

Siblings (Names & Ages):      

Family Physician/Pediatrician Name:       Phone:

What is your main reason for bringing your child in today?

When did this concern begin?

What treatments have been tried (please include both conventional and complementary)?

Please list any other concerns you have about your child’s health:

1. and length of time
2. and length of time

Have any of the above conditions been diagnosed?

If yes, by whom?

Please list any medications (including over-the-counter) that your child has taken:

Presently In the past

                 

                 

PRENATAL HISTORY

Please indicate if any of the following conditions were experienced by mom during pregnancy:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anxiety |  | Excess Stress |  | Toxemia |  |
| Depression |  | Fainting |  | Sleep disturbances |  |
| Diabetes |  | Herpes |  | Weight loss |  |
| Edema |  | Pregnancy induced hypertension |  | Other: |  |

Please indicate if you have any other information to share regarding your pregnancy/birth:

BIRTH HISTORY

Length of gestation: 9 months  Early (number of weeks)       Late (number of weeks)

Type of delivery: Vaginal  C-section  Emergency C-section

CHILD’S HEALTH HISTORY

Does your child have any known allergies?

Does your child sleep through the night?  Hours of sleep nightly:

Does your child nap during the day?  Does your child experience frequent nightmares?

Has your child ever been hospitalized (please list reason and dates)?

Reason:       Date:

Reason:       Date:

How many times has your child been on antibiotics? 3 How many times in the past 2 years? 0

Which of the following conditions apply to your child? Please indicate if Now (N) or in the Past (P)

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | N | P |  | N | P |  | N | P |  | N | P |
| Anxiety |  |  | Ear infections |  |  | Hearing problems |  |  | Seizures |  |  |
| Asthma |  |  | Eczema |  |  | Lice |  |  | Sinus problems |  |  |
| Bed wetting |  |  | Emotional trauma |  |  | Measles |  |  | Sleeping problems |  |  |
| Bladder infections |  |  | Fatigue |  |  | Meningitis |  |  | Sore throats |  |  |
| Body/breath odor |  |  | Fever |  |  | Mood changes |  |  | Stomach aches |  |  |
| Bronchitis |  |  | Fractures |  |  | Mumps |  |  | Strep throat |  |  |
| Chicken pox |  |  | Frequent urination |  |  | Nausea |  |  | Tonsillitis |  |  |
| Frequent colds |  |  | Fungal infections |  |  | Night sweats |  |  | Unusual fears |  |  |
| Cough |  |  | Gas |  |  | Nose bleeds |  |  | Vision problems |  |  |
| Croup |  |  | Growing Pains |  |  | Pneumonia |  |  | Vomiting |  |  |
| Delayed developmental milestones |  |  | Headaches |  |  | Physical trauma |  |  | Whooping cough |  |  |
| Diarrhea |  |  | Hair loss |  |  | Rash |  |  |  |  |  |

IMMUNIZATION HISTORY

Has your child been vaccinated?  Yes  No

If yes, did they experience any adverse or odd reactions to the immunizations?  Yes  No

If yes, please describe:

If no, is their immune system being supported another way?  Yes  No

If yes, please describe:

NUTRITIONAL HISTORY

Was your child breast fed?  Yes  No If Yes, how long?

If your child was not breast fed, please indicate what formula was used. If possible, include the brand.

List any reactions you noticed during your child’s initial food introduction as a babe.

Food Age of Introduction Reaction

           

How would you describe your child’s eating habits?

Does your child have any food cravings?  Yes  No

If yes, describe:

Please provide a rough outline of your child’s daily diet:

|  |  |
| --- | --- |
| Breakfast |  |
| Lunch |  |
| Dinner |  |
| Snacks |  |
| Water intake |  |
| Other fluids |  |
| Nutritional supplements |  |

SOCIAL HISTORY

How would you describe your child’s temperament?

Are you familiar with the 5 “love languages”? Yes/No If yes, do you know your child’s ‘love language’ yet? If yes, please describe what you’ve noticed.

How does your child interact with others (adults and other children)?

How does your child handle stressful situations?

How dos your child express his/her emotions?

How would you describe your child’s performance at school/daycare?

How do you think others would describe your child?

What does your child like to do in their downtime to relax?

HOME ENVIRONMENT

How many people live in your home?       Are there any smokers in your home?  Yes  No

Do you have any pets?  Yes  No

How is your home heated?

How often do you change the air filter in your furnace?

How often do you have your heating ducts cleaned?

Do you have any air purifications systems in your home?  Yes  No

Does the smoke resulting from forest fires affect your child?  Yes  No

If yes, describe:

Do you use natural or chemically based cleaners in your home?  Natural  Chemically based

If chemically based, please list brand and purpose of use:

Brand Purpose of Use

     

Is there anything else you would like to share with me about your child?

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HEALTH CARE AGREEMENT

Naturopathic medicine supports individuals in maintaining and restoring wellness. Naturopaths assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Dr. Monika focuses on getting you feeling better and giving you the information and tools to stay healthy naturally. Health stems from healthy habits. Your thoughts, your friends, your food choices, your passions, your ability to rest/relax, to express yourself creatively and to move and to play all have an influence on your health and how you feel. Mindfulness meditation techniques, yoga nidra, yoga therapy, simplifying, connecting with nature, and cultivating gratitude are some of the healthy-for-life brain health practices that Dr. Monika incorporates in her practice that build resilience for life’s challenges and keep you feeling your best.

My signature acknowledges that:

I have been informed of and understand that:

* 1. The treatments offered at this office are different from those usually offered by a medical doctor or other licensed health care provider.
  2. I am at liberty to begin/continue receiving medical care from a physician, surgeon or other licensed health care provider throughout the duration of my naturopathic care.

1. Informed consent: I declare that I have received a full and complete explanation of the treatment or services that I may receive at this office and hereby authorize and consent to treatment. I further understand and am informed that, as in all health care, in the practice of naturopathic medicine there are some very slight risks to treatment. I do not expect the doctor to be able to anticipate and explain all the risks and complications.
2. Payment options and policy: I understand and agree that health insurance policies are an arrangement between the insurance carrier and myself. Therefore, all services rendered to me are charged to me directly and that I am personally responsible for payment.
3. Missed appointments: I agree that missed appointments not canceled within 24 hours will result in a $45.00 fee billed to me immediately.
4. Phone consultations: In the event that a phone/zoom consultation is needed the fee will be based on Dr. Herwig’s hourly rate of $165.00.

I understand that results are not guaranteed. I do not expect the Naturopath to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient’s or Guardian's signature

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date