



**Shifra Centre for Wellness**

**Dr. Carrie Mitchell & Dr. Andrea Clarke, ND**  
 Naturopathic Doctors  
 403.932.3176

## NATUROPATHIC INTAKE FORM - PEDIATRICS

<b>Name</b>	Sex	DOB:	Age:
<b>Address</b>	<b>Phone Number</b>		
<b>Emergency Contact</b>	<b>Emergency contact Number</b>		

### PERSONAL HEALTH HISTORY

<b>Past medical history</b>		
<b>Parental age and health at conception</b>	Mother ____ Poor Fair Great	Father ____ Poor Fair Great
<b>Mother's health during Pregnancy</b>		Complications:
<b>Family medical history</b> (parents, siblings, overall family trends)		
<b>Current medications, supplements, vitamins and botanicals</b>		
<b>Health Concerns (in order of importance)</b>		<b>Onset</b>
1		
2		
3		
4		
<b>Allergies, Food sensitivities</b>		

### FOUNDATIONS

<b>Exercise</b>	Type	Frequency								
<b>Diet</b>	Breakfast									
	Lunch									
	Dinner									
	Snacks									
	Water									
	Current weight ____	Ideal weight ____								
<b>Childhood Disease</b>	Rubella	Measles	Chickenpox	Mumps	Scarlet fever	Whooping Cough	Impetigo	Strep throat	Mononucleosis	Ear Infections
<b>Vaccinations</b>	<input type="checkbox"/> Up to date			<input type="checkbox"/> Delayed			<input type="checkbox"/> Non-vaccinated			

<b>Birth Story</b>			
<b>Birth Weight</b>		Term Length	
<b>How was infant fed?</b>	<input type="checkbox"/> Breastfed How long? _____ <input type="checkbox"/> Formula		
First foods introduced			
Describe child's sleep pattern			
Describe child's energy levels	(    / 10 )		
Stressors in child's life			
Any toxins / smoke exposure			

<b>System Overview</b>					
<i>Please check all that apply - Add any notes needed, and circle when necessary</i>					
Ear, Eyes Nose, Throat, Immune		Head / Mood		Lung, Heart	
<input type="checkbox"/>	Hearing changes	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Ear pain /Infections	<input type="checkbox"/>	Difficulty concentrating	<input type="checkbox"/>	Difficulty breathing
<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	Lightheadedness/ Fainting / Diziness	<input type="checkbox"/>	Chronic cough, mucous, or phlegm
<input type="checkbox"/>	Nasal discharge	<input type="checkbox"/>	Memory changes	<input type="checkbox"/>	Bronchitis / Asthma
<input type="checkbox"/>	Eye pain or itching	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	Palpitation or Irregular heart beat
<input type="checkbox"/>	Vision changes	<input type="checkbox"/>	Low mood/Irritability Anxiety	<input type="checkbox"/>	Swelling in hands or feet
<input type="checkbox"/>	Frequent coughs, colds	<input type="checkbox"/>		<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	Recent antibiotic use	<input type="checkbox"/>		<input type="checkbox"/>	Chest pain

Gastro-Intestinal		Urinary		Skin, hair, nails	
<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	Pain on urination	<input type="checkbox"/>	Rashes / Itching / Eczema
<input type="checkbox"/>	Constipation /Diarrhea / Both	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	Hives
<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Inability to hold urine	<input type="checkbox"/>	Poor wound healing
<input type="checkbox"/>	Bloating / Indigestion	<input type="checkbox"/>	History of urinary tract infections	Miscellaneous	
<input type="checkbox"/>	Reflux			Any other symptoms:	
<input type="checkbox"/>	Mucous / Blood in stool				
<input type="checkbox"/>	High / Low appetite				
<input type="checkbox"/>	# Bowel movements daily _____				

## Informed Consent

PLEASE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic medicine is the treatment and prevention of diseases by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity. Dr. Carrie and/or Dr. Andrea will take a thorough case history, perform a complaint-oriented physical examination, and if required, take a urine sample and request blood work.

It is very important that you inform Dr. Carrie Mitchell and/or Dr. Andrea Clarke of any condition or disease that you currently have and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding, please advise your Naturopathic Doctor immediately.

There are some health risks to treatment by naturopathic medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture or intramuscular injections
- Fainting or puncturing of an organ with acupuncture needles, accidental burning of the skin from the use of moxa.

I understand that a record will be kept of the health services provided. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. I understand that I can request a copy of it by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I intend this consent form to cover the entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.

Patient Name: (please print clearly) \_\_\_\_\_

Signature of Patient/Guardian: \_\_\_\_\_

Date of Initial Appointment: \_\_\_\_\_

Dr. Carrie Mitchell, ND: \_\_\_\_\_

Dr. Andrea Clarke, ND: \_\_\_\_\_