intrinsi

Naturopathic Intake Form
CHILD

103, 1608 17 Ave. SW
Calgary, AB T2T 0E3
(403) 229-9214
www.intrinsi.ca

CHILD'S NAME: **PARENT/GUARDIAN'S NAME:** **Date:**	**HOME Phone:** **CELL Phone:**
Address:	
Male/ Female **AGE**: **DATE OF BIRTH** (M/D/Y):	**EMAIL**:
Emergency Contact (Name & Relationship)**:**	**Emergency Contact Phone:**
Medical Doctor's Name:	How did you find out about us? If you were referred by a person please provide their full name for our referral rewards program:
Other Health Practitioners Name/Type:	

What are your most important health concerns in order of importance?

1.

2.

3.

4.

Child Naturopathic
Health History Questionnaire

List any prescription or over-the-counter medications:

____

____

____

List any allergies, including medication, food and environmental:

Childhood illnesses:

___Chicken Pox	___Scarlet Fever	___Mononucleosis
___Measles	___Rheumatic Fever	___Ear Infections
___Mumps	___Strep Throat	___Tonsillitis
___Rubella	___Pneumonia	___Croup
___Whooping cough	___Asthma	___Other:__________

Vaccinations:
Has your child been vaccinated?
Adverse reactions?

Hospitalizations, surgeries, accidents, serious injuries:

____

____

____

Family History: *(Check any that apply)*

___Alcoholism	___Cancer	___High Blood Pressure
___Allergies	___Diabetes	___Hypoglycemia
___Anemia	___Eczema	___Mental Illness
___Arthritis	___Epilepsy	___Obesity
___Asthma	___Heart Disease	___Stroke
___Birth Defects	___Hearing Loss	___Thyroid Disorder

___Other:

Child Naturopathic
Health History Questionnaire

Patient's Health History: *(Check any that apply)*

NOW	PAST		NOW	PAST	
____	____	Acne	____	____	Epilepsy/Seizure
____	____	Allergies	____	____	Fatigue
____	____	Anemia	____	____	Frequent Headaches
____	____	Asthma	____	____	Headaches
____	____	Bed Wetting	____	____	Heart Murmur
____	____	Birth Defects	____	____	High Fever
____	____	Colic	____	____	Hyperactivity
____	____	Constipation	____	____	Insomnia
____	____	Cough/Wheeze	____	____	Jaundice
____	____	Cradle Cap	____	____	Learning Disorder
____	____	Depression	____	____	Moodiness
____	____	Diarrhea	____	____	Stuffy Nose
____	____	Dizzy Spells	____	____	Thrush
____	____	Earaches	____	____	Vomiting Spells
____	____	Eczema			

What is your infant's/child's disposition?

____

Prenatal/Birth/Feeding History:

Please answer questions regarding the **mother's** health during the pregnancy with this child.

Age __________ Trauma/injury? _____ Alcohol Consumption? ____
Bleeding? ____ Stress? ______ Drug use? _____
Nausea?______ High blood pressure? _____ Smoking? _____
Illness? _______ X-Rays? ______ Other _____________
Toxemia? _____ Medications? __________

TERM: Full ____ Premature ____ Late _____ Birth weight ____

Was Pregnancy/Birth….. Easy ____ Moderate ____ Difficult ____

Place of birth: Hospital ____ Home ____ Clinic ____ Other _______

FEEDING: Breast fed? ____ How long? ____
Formula fed? ____ What kind ___________ How long? ____________
Age solid foods introduced ______
Food intolerances? ________________________________
Favorite foods? ____________________________________

Child Naturopathic
Health History Questionnaire

Social History

Parents: Married ____ Separated ____ Divorced ____
Mother's occupation: ______________________________________
Father's occupation: ______________________________________

Daycare? ______

Siblings: *(Please list names, ages and health problems)*

Are there others living at home with the child?

Service & Payment Policy

Clients are responsible for charges incurred, both for services rendered and for cancellations with less than 24 hours notice.

We require 24 hours notice for cancellations or changes to appointments. Please note that a cancellation fee of 100% will be charged for appointments missed or cancelled without 24 hours notice. Without appropriate notice, cancellations affect three parties. First, you miss the benefits that you would have acquired from a treatment. Second, we as therapists lose revenue, and third, another client who could have taken the appointment misses out on a treatment.

We encourage clients to check with their individual insurance providers regarding services and credentials covered. It is the client's responsibility to ensure compliance with their insurance plan for reimbursement purposes. The English Osteopaths are happy to provide any information that you may require for insurance purposes but are not responsible for any rejected insurance claims.

Your signature indicates that you have read and agree to the Service & Payment policy.

Patient (or guardian) Signature: __________________________________ Date: _________________