Mountainview
WELLNESS CENTRE
Think Wellness, Be Wellness

PEDIATRIC INTAKE FORM

(ages 12 and under)

Please ensure the information provided is accurate and complete. All information collected is considered confidential and is kept in accordance with the College of Naturopathic Physicians of BC.

Child's Name_____ **M ☐ F ☐ Today's Date** (dd/mm/yy) _____ /_____ /_____

Birth Date (dd/mm/yy) _____ /_____ /_____ **BC Care Card**_____

Home Address_____ **City** _____**Prov**_____

Parent(s)/Guardian(s) Names and Relationship w/ child_____

Primary phone#_____ **Secondary phone#**_____**E-mail**_____

Medical Doctor Name/ phone number_____

How did you find us (SuperPages, BCNA, friend/family member, our sign, our website, other)?_____

HEALTH OBJECTIVES: ☐ Wellness/Prevention ☐Please contact for annual check-ups as well ☐ Complaint Oriented

CHILD'S MAIN HEALTH CONCERNS With Date of Onset (list in order of importance)

_____

_____

_____

_____

Has there been any diagnosis? If so, what?_____

Has any lab work been done or special studies (CT, MRI, Echocardiogram)?_____

What treatments have been tried and what were the outcomes_____

_____

ALLERGIES/SENSITIVITIES_____

MEDICATION/SUPPLEMENTS:_____

_____

Immunization History:

☐DPT ☐ DP ☐Polio ☐Tetanus ☐ MMR ☐Rubella ☐Hepatitis A/B ☐Influenza

Reaction to vaccinations :_____

CHILD'S MEDICAL HISTORY (Age of child, Location (if relevant), Duration, Treatment):

☐Asthma	☐Autoimmune disease	☐Bed wetting
☐Burning on urination	☐Cancer	☐Constipation
☐Deformities of head shape	☐Dental caries	☐Diabetes
☐Diaper Rash	☐Diarrhea	☐Difficulty Breathing
☐Discharge from eyes	☐Discharge from genitalia	☐Ear Pain
☐Eczema	☐Fractures	☐Frequent colds and flus
☐Frequent urination	☐growing pains	☐Heart Disease
☐Hepatitis	☐High/Low Blood Pressure	☐Mental illness
☐ Mouth Sores	☐Nasal Discharge	☐ Nausea/vomiting
☐Neck lumps	☐Rheumatic Fever	☐Seizures
☐Squint	☐Tuberculosis	☐Kidney or bladder disease
☐Venereal Disease	☐Thyroid Disease	

☐Other conditions: _____

☐Exposure to harmful chemicals, radioactivity, fumes or other health hazards? Describe:_____

Any Hospitalizations, Surgeries, Implants etc. including date_____

Describe any significant stress in the child's life, e.g. schooling, family, bullying, etc. _____

_____

SLEEPING HABITS:

During the first year of life _____

At the present time_____ Naps_____

Trouble falling asleep or waking in the night?_____

Bedwetting? _____

BEHAVIOR AND EMOTIONAL HISTORY:

Behavior among other children; behavior at home; relationship with other family members, siblings and friends

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:_____ _____

CHILDHOOD ILLNESSES:

Chicken pox_____ _____
Measles _____ _____
Mumps _____ _____
Ear Infections _____ _____
Frequent Colds_____ _____

DIET

Amount of Water per day_____ # of pop/week_____
☐Mixed food diet ☐Vegetarian ☐Salt restriction ☐Vegan
Restrictions: ☐Dairy ☐Wheat ☐Eggs ☐Soy ☐All gluten

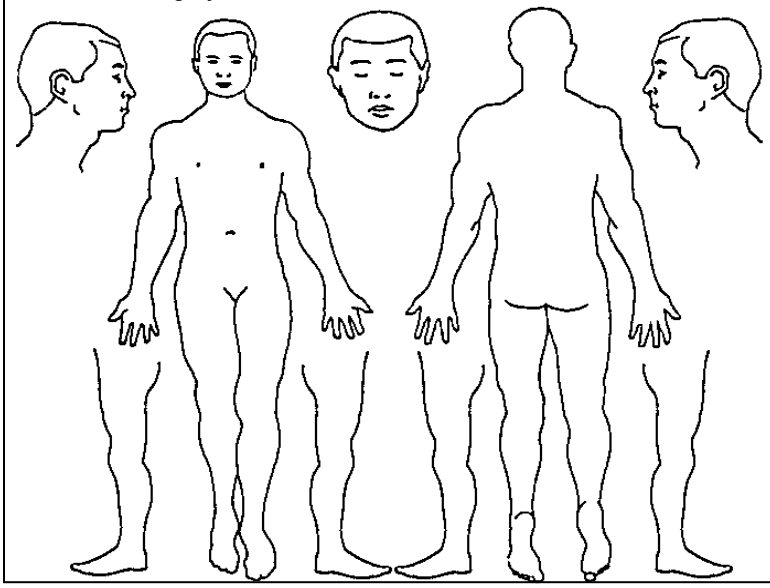
EATING HABITS: ☐Constant Snacking ☐Low Fiber
☐Small frequent meals ☐Cravings for:_____

FAMILY MEDICAL HISTORY (Parents and Siblings)

☐Allergies ☐Alcoholism ☐Asthma ☐Cancer
☐Depression ☐Diabetes ☐Drug Addiction
☐Genetic disorder ☐Heart Disease
☐High Blood Pressure ☐Infertility
☐Mental illness ☐Migraine ☐Obesity ☐ Stroke

INDICATE PAINFUL OR DISTRESSED AREAS

X – sharp/intense pain
/- radiating pain
S- Area of surgery
O- dull/ aching
N- numbness/ tingling
W-Weakness



Please indicate any other problems you would like to discuss _____

I am also interested in:

☐Modifiable Genetic Risk factors for diseases such as cancer, cardiovascular disease and osteoporosis
☐Heavy metal testing for mercury, cadmium, lead, arsenic, and other common toxic metals
☐Determining underlying factors that cause difficult weight loss such as cortisol, thyroid function, serotonin, estrogen and testosterone
☐Salivary hormone assessments for, estrogen, progesterone, DHEA, DHT, etc.
☐Metabolic assessment for nutritional status i.e. need for certain vitamins, minerals, essential fats
☐Food and/or environmental sensitivity and allergy testing

PAYMENT POLICY

Payment is due in full at the end of your visit for any applicable visit fees, lab work, treatments, or medications. All services, lab tests, and medications are GST applicable. A **Menu of Services and Tests** is provided for your convenience.

RETURN POLICY

Unopened and undamaged items purchased from the Mountainview Wellness Centre may be returned for a full refund or credit, with receipt, within 30 days of purchase. Refunds on prepaid treatment packages will void any discounts on completed treatments. Exceptions: 1.) **Special Orders** are subject to a restocking fee. 2.) **Refrigerated and Compounded Items** are considered final sale.

STATEMENT OF ACKNOWLEDGEMENT

Even the gentlest therapies have potential complications and hence the medical information I have provided is complete. The risks of some Naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reaction to supplements; pain, fainting, bruising or injury from blood draw; and disc injuries from spinal manipulations.

I have read, understood and accept the above.

_____ _____
(Signature of Patient, Parent or Legal Guardian) (Date)