208A 33123 1st Ave, Mission, BC, V2V 1G5

Full Name:_____ Date:_____

Preferred First Name:_____

Name of parent or guardian:_____

Date of Birth:_____ Sex: M___ F___

Full Address:_____

_____

Phone: home:_____

mobile:_____

work:_____

Preferred contact number for reminder/follow up calls: home__ mobile__ work__

Emergency contact name:_____

Phone:_____ Relationship:_____

Name of Medical Doctor:_____

Address:_____

Phone:_____ Date of last visit:_____

How did you hear about us?_____

Were you referred by someone? If yes, whom?_____

evoke
WELLNESS CENTRE
208A 33123 1st Ave, Mission, BC, V2V 1G5

Name:_____

Age:_____ Height:_____ Weight:_____

Please list your child's health concerns in order of importance

1.

2.

3.

Please list all prescription medications currently taken *including dose, frequency, and duration of use*

1.

2.

3.

Please list all over the counter medications your child is taking (ie. aspirin, tylenol, etc)

_____

_____

Please list all supplements and herbal remedies your child is currently taking i*ncluding dose and frequency*

_____

_____

_____

MEDICAL HISTORY:

Does your child have any allergies? (medications, foods, environmental)

_____

_____

Approximately how many times has your child been treated with antibiotics?

_____

_____

Please list any serious illnesses, hospitalizations or surgeries (including circumcision), along with approximate dates

_____

_____

Which of the following has your child had?

_ Rubella	_ Roseola	_ Impetigo
_ Measles	_ Scarlet Fever	_ Mononucleosis
_ Chicken Pox	_Whooping Cough	_ Ear infections
_ Mumps	_ Strep throat	

Please indicate any immunizations your child has had and the date of immunization (if you prefer, you may submit a copy of the immunization record):

_____DPT (diptheria, pertussis, tetanus)	_____Haemophilus influenza B
_____Tetanus booster	_____Polio
_____MMR (measles mumps, rubella)	_____Flu
_____Hepatitis B	_____Chicken Pox
_____Hepatitis C	_____Other (please specify)

Please indicate if any of the above immunizations caused adverse reactions (this may include fever, rash, change in development, etc):

_____

Please list significant health concerns of family members (including siblings, parents, aunts, uncles, and grandparents)

_____

_____

Is there anyone with a significant or chronic disease not mentioned above who is related or is non-related that lives in the home? _ YES _ NO

Was your child adopted? _ YES _ NO

If your child was adopted please complete as much information as you can concerning prenatal and birth information.

PRENATAL INFORMATION:

Age of mother at conception: _____ Occupation at time of conception: _____

Age of father at conception: _____ Occupation at time of conception: _____

Was the pregnancy planned? _ YES _ NO

Were any fertility treatments undertaken? _ YES _ NO

Was this the first pregnancy for the mother? _ YES _ NO

How many pregnancies did the mother experience prior? _____

How many times did the mother give birth prior? _____

Did the mother smoke during the pregnancy? _ YES _ NO

During which trimesters and how often? _____

Did the mother consume alcohol during the pregnancy? _ YES _ NO

During which trimesters and how often? _____

Did the mother participate in any drug use during the pregnancy? _ YES _ NO

Please specify _____

During which trimesters and how often? _____

BIRTH INFORMATION:

Were any interventions performed during the birth? _ YES _ NO

If yes, please check all that apply:

_ Episiotomy _ Vacuum extraction

_ Forceps _Caesarean section

_ Other (please specify) _____

Were there any concerns or complications during the birth? _ YES _ NO

If yes, please check all that apply:

_ Prolapse of umbilical cord _ Uterine rupture

_ Breech presentation _ Shoulder dystocia

_ Other malpresentation (please specify)

FEEDING HISTORY:

Was your child breastfed? _ YES _ NO

Was your child nursed directly from the breast and/or from a bottle? _____

_____

For how long? _____

Where there any difficulties breastfeeding? _____

_____

Was your child formula fed? _ YES _ NO

For how long? _____

What formula was used? _____

Where there any difficulties with formula feeding? _____

_____

When was food first introduced? _____

Were there any reactions? (constipation, diarrhea, skin rashes, etc)_____

_____

Please list any foods your child craves: _____

Please list any foods your child refuses to eat: _____

Does your child have any dietary restrictions we should know about? (ie. vegetarian, vegan, religious, lactose intolerance, celiac disease, etc.)

_____

_____

Please describe your child's typical daily diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

FAMILY LIFE:

Who does the child live with?_____

On a scale of 1-10, what is the stress level within the home?_____

_____

Please describe a typical family day:_____
_____
_____

Does your child exercise? If so, please indicate type and frequency.

_____
_____

SOCIAL HISTORY:

What grade is your child in (answer only if applicable): _____

How is your child educated?

_ Home School _ School _ Boarding school

_ Child is not yet old enough to attend school

Does your child attend daycare? _ YES _ NO

SLEEP HISTORY:

Where in the home does your child sleep?

_ shares bed with sibling _ shares bedroom with sibling

_ shares bed with parents _ in own crib/bed in parents room

_ in own bedroom

What time does your child go to bed? _____

What time does your child wake up? _____

Does your child have any difficulty falling asleep? _ YES _ NO

If yes please describe _____

How many times does your child wake in the night? _____

ENVIRONMENT:

When is the last time the family moved? _____

Has your home undergone any renovations while you have lived there? When? _____

Does anyone smoke cigarettes or marijuana in the home? _ YES _ NO

Are there pets in the home? Please specify. _____

What percentage of your home is carpeted? _____

What type of water is drank in the home:

_ Tap _ Bottled _ Filtered _ Reverse Osmosis _ Other (please specify) _____

What type of cleaning products are used in the home (please check all that apply, indicating the % used):

____ Conventional cleaning products (Lysol, Fantastic, Mr. Clean, etc.)

____ Home made cleaning products (vinegar, baking soda, lemon juice, etc.)

____ Environmentally friendly cleaning products

What type of laundry detergent is used? _____

Does the home have an air filter? _ YES _ NO

REVIEW OF SYSTEMS:

Has your child lost any weight? (please specify amount)_____

Frequency of colds_____

Frequency of headaches_____

Frequency of dizziness_____

Does your child wear corrective lenses or contacts? Y N

Frequency of nosebleeds_____

Number of dental cavities_____

Urinary frequency_____

Dry skin?_____

Any aches or pains?_____

Changes in appetite or thirst?_____

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Thank you for completing our intake form. This is a confidential medical record and will be kept in the office. We will not release this information to any third party unless you have authorized us to do so.

Informed Consent

Printed name _____

As a patient of this clinic I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including the possibility of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising, or injury from venipuncture or acupuncture, and muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

_____ _____

Signature of parent or guardian if under age 18 Date

_____

Name of guardian if under age 18

_____

Witness