

Dr. Karina Wickland, B Sc, ND

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Pediatric Intake Form

General Information

Child's name: _____ Child's Age: _____
Date of first visit: _____ MSP #: _____
Date of birth: : _____ Child's grade level: _____ Sex: M F
Who is filling out this form? (name and relationship): _____
How did you learn about Dr. Wickland?: _____
Who does the child live with? _____

Guardian Contact Information :

Name and relation to child: _____
Address: _____
Phone number: (home) _____ (alternate) _____

Please list child's **current health care providers** with their **designation** (pediatrician, family physician etc.) and **contact information**:

Does your child have any known contagious diseases at this time?

No Yes: _____

Do your child have any known life-threatening allergies?

No Yes: _____

Pediatric Health Overview - *Comprehensive health care requires a complete picture of health. Please take the time to complete this questionnaire carefully. If you are unsure about a question, mark it and we can discuss it during the visit.*

PRIMARY HEALTH CONCERNS

In your opinion, what are your child's most important health concerns?

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Can you identify any events (life trauma, surgery, drug reactions) as having caused or aggravated your child's health concerns?

MEDICAL HISTORY

How would you describe your child's general state of health (excellent, good, fair or poor)?

Please indicate any surgeries, hospitalizations, injuries or serious conditions your child has experienced with approximate dates.

Current medications or supplements:

Past medications or supplements:

How many times has your child had antibiotics? _____

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

Has your child been to see the dentist? [] yes [] no

Describe any dental work done: _____

Describe your child's daily oral hygiene practice: _____

Has your child had their vision checked? [] yes [] no

Describe any vision problems: _____

Frequency of bowel movements: _____ times per day or _____ times per week

Does your child experience any pain when passing stool? _____

Do any of your child's bowel habits concern you? _____

Are there any urinary symptoms you are concerned about? _____

Has your child ever experienced any of the following conditions? If you are unsure of any of the terminology please put a question mark beside the word.

Allergies- seasonal	<input type="checkbox"/> yes <input type="checkbox"/> no	Measles	<input type="checkbox"/> yes <input type="checkbox"/> no
Diarrhea	<input type="checkbox"/> yes <input type="checkbox"/> no	Cold sores	<input type="checkbox"/> yes <input type="checkbox"/> no
Allergies-environmental	<input type="checkbox"/> yes <input type="checkbox"/> no	Meningitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Difficulty concentrating	<input type="checkbox"/> yes <input type="checkbox"/> no	Colic	<input type="checkbox"/> yes <input type="checkbox"/> no
Appendicitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Mumps	<input type="checkbox"/> yes <input type="checkbox"/> no
Difficulty sleeping	<input type="checkbox"/> yes <input type="checkbox"/> no	Conjunctivitis(pink eye)	<input type="checkbox"/> yes <input type="checkbox"/> no
Atopic Dermatitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no
Ear infection	<input type="checkbox"/> yes <input type="checkbox"/> no	Constipation	<input type="checkbox"/> yes <input type="checkbox"/> no
Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	Sinusitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Eczema	<input type="checkbox"/> yes <input type="checkbox"/> no	Convulsions	<input type="checkbox"/> yes <input type="checkbox"/> no
Bronchitis	<input type="checkbox"/> yes <input type="checkbox"/> no	Skin rash	<input type="checkbox"/> yes <input type="checkbox"/> no
Frequent colds	<input type="checkbox"/> yes <input type="checkbox"/> no	Cradle Cap	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	Strep throat	<input type="checkbox"/> yes <input type="checkbox"/> no
Hay fever	<input type="checkbox"/> yes <input type="checkbox"/> no	Croup	<input type="checkbox"/> yes <input type="checkbox"/> no
Chicken pox	<input type="checkbox"/> yes <input type="checkbox"/> no	Thrush	<input type="checkbox"/> yes <input type="checkbox"/> no
Head lice	<input type="checkbox"/> yes <input type="checkbox"/> no	Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no
Chronic Bedwetting	<input type="checkbox"/> yes <input type="checkbox"/> no	Tonsilitis	<input type="checkbox"/> yes <input type="checkbox"/> no
Hyperactivity	<input type="checkbox"/> yes <input type="checkbox"/> no	Diaper rash	<input type="checkbox"/> yes <input type="checkbox"/> no
Chronic nose bleeds	<input type="checkbox"/> yes <input type="checkbox"/> no	Urinary tract infection	<input type="checkbox"/> yes <input type="checkbox"/> no
Impetigo	<input type="checkbox"/> yes <input type="checkbox"/> no	Seizures	<input type="checkbox"/> yes <input type="checkbox"/> no
Chronic Bruising	<input type="checkbox"/> yes <input type="checkbox"/> no	Headaches	<input type="checkbox"/> yes <input type="checkbox"/> no

VACCINATION HISTORY

Check all that apply

- All routine childhood vaccinations
- No vaccinations
- Selective or delayed schedule (please describe):

- Other vaccines for travel or by choice:

Has your child experienced any adverse reactions from a vaccination:

No Yes: _____

FAMILY HISTORY

Have any close relatives had any of the following conditions:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Kidney	<input type="checkbox"/> Depression	<input type="checkbox"/> High blood
<input type="checkbox"/> Seizures	disease	<input type="checkbox"/> Cancer	pressure
<input type="checkbox"/> Anemia	<input type="checkbox"/> Birth defects	<input type="checkbox"/> Eczema	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Stroke	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Mental	<input type="checkbox"/> Juvenile
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	illness	Arthritis
	<input type="checkbox"/> Bleeding		<input type="checkbox"/> Hay fever
	disorder		

Do either of the parents have any history of chronic illness?

LIFESTYLE

What time does your child go to bed? _____ Wake up? _____

Does your child take naps? _____ When? _____

Do they have any trouble falling asleep? _____

Do they sleep straight through the night? _____

Do they wake up looking/acting refreshed? _____

Do they have any recurring dreams or nightmares? _____

PRE-NATAL HEALTH AND BIRTH HISTORY

How old was the mother at the time of the child's birth? _____

Number of previous pregnancies the mother carried to term? _____

Number of previous pregnancies not carried to term? _____

	Excellent	Fair	Good	Poor	Unknown
How was the health of the mother at time of conception?					
How was the health of the father at time of conception?					
How was the health of the mother during the pregnancy?					
How was the emotional state of the mother during pregnancy?					
How was the mother's diet during pregnancy?					

Did the mother receive medical care during pregnancy? _____

Did the mother use any of the following during her pregnancy?

- alcohol, cigarettes or recreational drugs _____
- prescription drugs or over the counter medications (eg. Tylenol) _____
- _____
- supplements or remedies? _____

Were there any interventions used during the pregnancy? (eg. ultrasound or amniocentesis) _____

Were there any interventions used or complications during the delivery? (eg. Epidural, forceps, c-section, induction) _____

Weight of infant at birth: _____

Term length of pregnancy:

[] pre-term (37 weeks or less): _____ weeks

[] full-term (38-42 weeks): _____ weeks

[] post-term (42 weeks or more): _____ weeks

DIET HISTORY

Breast fed? _____ How long? _____

Approximate feeding schedule? _____

Formula? _____ How long? _____ Combined with breast milk? _____

What type of formula was used? (milk, soy, other) _____

At what age was solid food first introduced? _____

What types of food were introduced and in what order? _____

Did your child have any reaction to the food being introduced? _____

Does your child have any known food allergies? _____

Does your child have any dietary restrictions? (eg. Religious, vegetarian, vegan) _____

What is a typical day's diet for your child?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

List any foods that your child seems to crave, regardless of their nutritional value:

What is the approximate weight of your child? _____

Has there been any recent weight gain or weight loss? _____

Are you satisfied with your child's diet the way that it is now? Why or why not?

Is there anything else you would like to comment on?

Thank you for taking the time to fill in this information.

Declaration and Consent for Naturopathic Care

I would like to take this opportunity to welcome you to our clinic. As a naturopathic doctor (ND) I will conduct a thorough case history, a physical exam and **may** utilize specific blood, urinary or other laboratory reports as part of the treatment work-up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, physical medicine and lifestyle counseling to assist the body's ability to heal and to improve the quality of life and health.

Statement of Acknowledgement

Printed name of patient: _____

As a patient of Dr. Karina Wickland, 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. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. **Slight** health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing or old symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from venipuncture or injections

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient of Dr. Wickland is **not mutually exclusive** from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. I understand results are not guaranteed.
- I understand that a record will be kept of my visits. This record will be kept confidential and **will not be released** without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for **payment at the time services are rendered**. Dispensary items must be paid for in full before leaving the office.
- I am aware that **24 hours notice** must be given for all cancelled appointments or a **cancellation fee** will be applied.
- I understand that Dr. Wickland reserves the right to determine which cases fall outside of her scope of practice, in which case the **appropriate referral will be recommended**.

I consent to receive naturopathic treatment from Dr. Karina Wickland. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: _____

Date: _____