fernskinclinic

Date

Name	Contact Number	
Street	Age	Weight
City/Post Code	Birth date	Sex
Occupation	Physician	Referred By
Other Concurrent Therapies		
Email Address		

Medical Information

What is your main health concern regarding your child? Onset/Duration

Does your child have any medical conditions? Please list as well as all current medications, your daily dosage, and how long you have taken them:

Please list all allergies:

Please list all current supplements, your child's daily dosage, and how long they have taken them:

Is there anything that aggravates the present condition?

Is there anything that alleviates the present condition?

How many hours of sleep does your child get on average? Do they wake feeling rested?

Birth History

Please check the box to indicate:
Vaginal Forceps Epidural / Drugs Cesarean Section Suction Vacuum Extract
Length of labor: __________________ (circle to indicate) pre term post term How many weeks late ________
Weight at birth: __________________
Where did the birth occur? (circle one) home hospital birthing center
Did you use a midwife, doula or both? (circle one) midwife doula both midwife and doula
Was the birth traumatic on you, the baby or both? (circle one) mother baby both mother and baby
List complications during birth if present:

____

____

Dietary/Feeding History

Feeding (circle): breast fed bottle fed Picky eaters (circle): yes no
Most Common Eating Style (circle):
home made (from scratch) home made (packaged food) eating out at restaurant

Length of breast / bottle feeding: __________________

Age when solid foods were introduced: __________________

Feeding complications: ____

What foods were introduced before 6 months: ____

List the solid foods introduced: ____

Does your child have any dietary restrictions (religious, vegetarian / vegan etc.): _______________________

Please list any food cravings your child has ____

Please list any food aversions your child has ____

Describe a typical day's diet:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks/ Beverages: ____

Social History

Please describe the disposition of your child when interacting with other children, parents, and other caregivers:

____

Describe your child's behavior and performance at school:

____

Is your child physically active? yes no How much, how often? ________________________________

How many hours of T.V per day? ____ How many hours on computer? _____ How many hours outside? ____
How many hours are spent reading with your child outside of school? _____
Schooling (circle): daycare preschool school
List the extracurricular activities your child is involved in or favorite activities:

____

____

Do you have any behavioral concerns regarding your child?

____

____

Has your child ever been diagnosed with ADD/ADHD or any other behavioral issues? If yes please list when and if on medications.

____

____

____

____

____

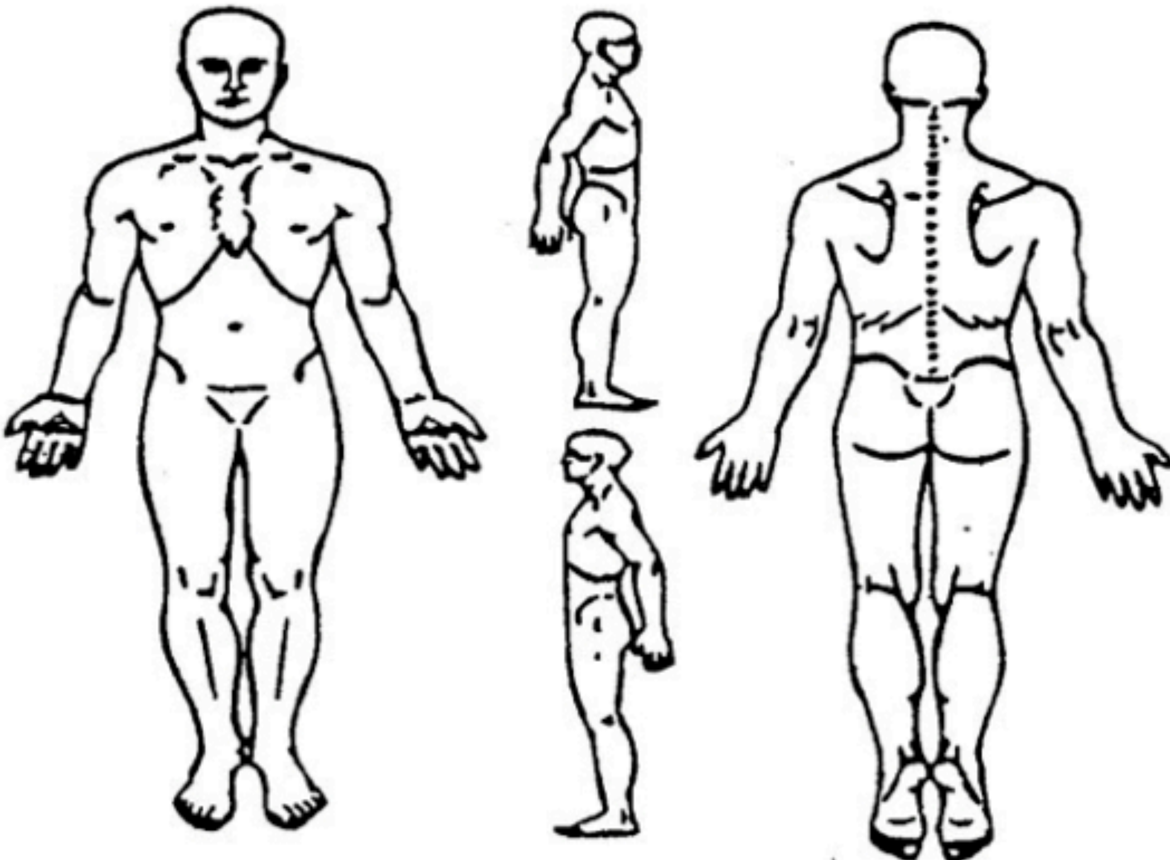
____

Health Details

General Symptoms	Cardiovascular	Respiratory
history of headaches/migraines fever chills night sweats excessive sweating dizziness fainting weight gain allergy numbness/tingling in hands or feet mental/emotional issues chronic fatigue lethargy anemia	low blood pressure high blood pressure cardiovascular disease heart attack phlebitis varicose veins atherosclerosis swelling of hands/feet poor circulation irregular heartbeat shortness of breath chest pain heart palpitations	asthma emphysema chronic cough frequent lung infection bronchitis excessive phlegm difficulty breathing other:
Eyes, Ears, Nose, & Throat	**Gastrointestinal**	**Kidneys & Reproductive Health**
mercury fillings gum infections frequent colds tonsillitis frequent sore throat swollen glands glaucoma eye pain itchy eyes glue ear frequent ear infections nasal congestion sinusitis hay fever frequent nose bleeds mouth ulcers cold sores	excessive thirst excessive hunger food cravings belching gas/flatulence vomiting abdominal cramps constipation diarrhea intestinal bloating colon trouble hemorrhoids liver problems frequent nausea gallbladder problems jaundice colitis diverticulitis ulcers chron's disease ulcerative coltis parasites/worms	frequent urination cystitis interstitial cystitis painful urination blood in urine inability to urinate urinary incontinence kidney infection kidney stones STD - if yes, please list ______________________________ ______________________________ treatment:

Skin & Hair	Men	Women
hives or allergy acne eczema psoriasis dryness sensitive skin pigmentation warts athletes foot fungal infection boils skin cancer rashes ulcerations vitiligo alopecia loss of hair male pattern baldness	prostate problems incomplete urination testicular pain cysts hernia discharge sores how many times do you wake during the night to urinate? _______	PMS frequent yeast infections/candida date of last menses: regular periods? Y/N cycle length: amennorhoea dysmenorrhoea endometriosis PCOS fibroids fertility concerns miscarriage are you/could you be pregnant? Y/N pelvic inflammatory disease menopause

Pain & Injury	Musculoskeletal & Joints	
please indicate on diagram: injury/breaks neck pain back pain shoulder pain chronic pain other:	muscle weakness foot trouble jaw pain swollen joints arthritis * if yes, please indicate affected joints:	hernia spasms/cramps osteoporosis tendonitis bursitis spinal curvature fibromyalgia



Psychological/Emotional Health:

Anxiety
Depression
Insomnia
Nervousness
Panic Attacks
Bi-Polar
Suicidal thoughts
Constant worry/paranoia
Have you ever been medicated for a psychological issues? Y/N If so, please provide details:

____

____

If there is any other relevant information pertaining to you/your child's health that was not covered in this intake please state it below or on the back of the form:

____

____

Informed Consent

Your ND will take a thorough case history and perform a relevant physical examination. It is very important that you inform your naturopath of any medical concerns or medication and supplements you may be taking. Please advise your ND if you are pregnant, suspect you are pregnant or if you are breast-feeding. As a patient you will receive information about your treatment, which may include diet and nutritional counselling, botanical medicine, acupuncture/skin needling, lifestyle counselling, and traditional chinese medicine. As with any form of medical intervention there can be health risks associated with treatment by naturopathic medicine including acupuncture. By initialing next to each statement, you acknowledge your understanding of the associated risk and grant permission to proceed.

Possible side effects of naturopathic medical care include:

- Aggravation of pre-existing symptoms ____
- Allergic reactions to supplements or herbs ____
- Pain, bruising or injury from acupuncture/cupping ____
- Fainting from acupuncture needles/skin needling ____
- I have disclosed all medical conditions, allergies, and medications to my practitioner. Failure to do so could result in unforeseen side effects _____

With this knowledge, I voluntarily consent to Naturopathic care I intend this consent form to cover the entire course of treatment.

Patient/guardian:

Name (print): ______________________________

Signature: ______________________________

Practitioner:

Name (print): ______________________________

Signature: ______________________________

Date:

Thank you for your cooperation
All information provided on this form or during consultation will be kept strictly confidential