Pediatric Intake Form (Under 12)

Wild Heart Medicine Therapies and Farmacy

Family Focused Naturopathic Care

Dr. Karley Denoon, ND

571b (upstairs) 2nd Ave. Fernie, BC

Phone: (250) 531-0154

Fax: 1-800-858-8623

drdenoon.ca

Dr. Karley Denoon ND

Thank you for taking the time to complete the following new patient forms to the best of your ability. Often, if your child can, it is fun and informative to complete them together. They are an important step towards defining your health care needs and achieving your health goals. Please email this form in advance for review, drop in off in advance, or bring this form to your first appointment. Please also include any relevant blood work or health reports.

All the answers on this form will be held ***absolutely confidential.***

Name:		Birthdate:
Address with P.O. Box:		
City:	Prov:	Postal Code:
Family Doctor:		Phone #:
Referring Professional:		Phone #:
Care Card #:		
Guardian Information:		
Name:		Relationship:
Phone (Home):	Phone (Cell):	Phone (Work):
Email:		Occupation:
Preferred Method of Communication:		
Spouse's Name:		
Other Children's Names and Ages:		
Emergency Contact (Name, Relationship):		
Phone:		
Why did you choose to come to this clinic?:		
Have you seen a Naturopathic Doctor before? (Y/N)		Dr:

PRESENT HEALTH CONCERNS:

	Please list most important health concerns in their order of significance.	Please list any prior diagnosis including when and by whom.
1		
2		
3		
4		
5		

ALLERGIES:

(Please list your allergy, your reaction and severity on a scale of 1-10)

Medications:

Food:

Environmental:

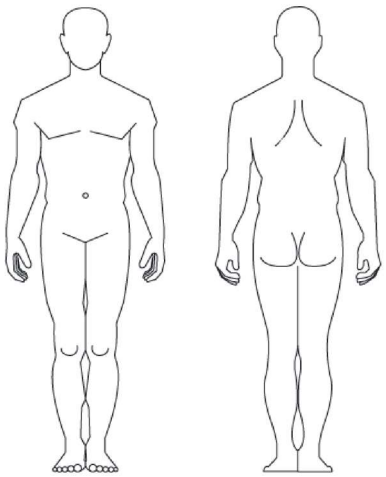
PAST MEDICAL HISTORY:

Have you ever been hospitalized? Y/N Why and which dates?

Have you ever had any major accidents, traumas or surgeries? Y/N Explain and which dates?

PHYSICAL CONDITION:

(Please indicate on the diagram the nature of your symptoms using the provided symbols.)



Aching	O
Stabbing	X
Shooting	=
Burning	~
Numbness or Tingling	^

If you have indicated pain above, please use the next 2 lines to explain the onset, duration and frequency with which you experience this pain:

571b 2nd Ave, Box 1295, Fernie BC V0B 1M0
Ph: (250) 531-0154 Fax: (800) 858-8623 Email: info@drdenoon.ca

Please describe your current physical condition (Truth please):
Exercise: Daily 5x Week 3x Week Weekly Monthly or Never

Type (length, aerobic, strength, intensity): _____

_____

FAMILY MEDICAL HISTORY:

MEDICAL CONDITION	RELATION
Alcoholism	
Allergies	
Anemia	
Arthritis	
Asthma	
Diabetes	
Eczema	
Epilepsy	

MEDICAL CONDITION	RELATION
Heart Disease	
Hearing Loss	
Hypoglycemia	
Mental Illness	
Obesity	
Stroke	
Thyroid Disorder	
Other(s)	

HAS HAD:

	CONDITION
	Chicken Pox
	Red Measles
	Mumps
	Rubella

	CONDITION
	Scarlet Fever
	Rheumatic Fever
	Strep Throat
	Pneumonia

	CONDITION
	Mononucleosis
	Ear Infection(s)
	Tonsillitis
	Other

AGE	IMMUNIZATION	DOSE	DATE/REACTIONS?
2 Months	DTaP	1 of 3	
	Hib (Haemophilus influenza type b)		
	Polio (IPV)		
	Hepatitis B		
	Pneumococcal (PCV)	1 of 3	
	Meningococcal (Men-C)	1 of 3	
4 Months	DTap / Hib / Polio (IPV)	2 of 3	
	Hepatitis B		
	Pneumococcal (PCV)	2 of 3	
6 Months	DTap / Hib / Polio (IPV)	3 of 3	
	Hepatitis B		
	Flu (Influenza)	yearly	
12 Months	Chicken pox (varicella)	1 dose	
	MMR	1 of 2	
	Meningococcal (Men-C)	2 of 3	
	Pneumoococcal (PCV)	3 of 3	

571b 2nd Ave, Box 1295, Fernie BC V0B 1M0
Ph: (250) 531-0154 Fax: (800) 858-8623 Email: info@drdenoon.ca

18 Months	DTap / Hib / Polio (IPV) booster	1 of 1	
	MMR	2 of 2	
4-6 Years	DTap / Polio (IPV)	1 of 1	
	Chicken Pox (varicella) (Catch up dose if not previously given & no exposure)	1 dose	
Grade 6	Hepatitis B (if not previously given)	2-3 doses	
	Human Papillomavirus (HPV)	3 doses	
	Meningococcal (Men-C)	3 of 3	
	Chicken Pox (varicella) (Catch up dose if not previously given & no exposure)	1 dose	
Grade 9	Human Papillomavirus (HPV) (if not previously given)	3 doses	
	TdaP (adult formulation; for age 7 & older)	1 dose	

OTHER SHOTS	AGE OR DATE GIVEN
H1N1	
Hepatitis A	
Pneumococcal (PPV)	
Seasonal Flu	

	Age		Drugs		Stress
	Alcohol		Extreme Nausea		Toxemia
	Bleeding		High Blood Pressure		Trauma/Injury
	Cigarettes		Illness		X-Rays
	Diabetes		Medications		Other

Details:

FOOD:

Breast Fed – How long?

Formula Fed – How long & type:

Age solids began:

Which foods:

Food Allergies/Intolerances:

Favourite Foods:

(Please describe a typical day's diet:)

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

571b 2nd Ave, Box 1295, Fernie BC V0B 1M0
Ph: (250) 531-0154 Fax: (800) 858-8623 Email: info@drdenoon.ca

How many hours do you spend per day:

Watching TV:	On the Computer:	Texting:
Talking on the Phone:		

Have you tried any previous treatment?

**Please report all medications on the medication history page, including vitamins/supplements.*

On a Scale of 1 (low) to 10 (high) how would you rate:

Sleep quality:	Eating Habits:	Stress Level:	Exercise Habits:
# of Hours of Uninterrupted Sleep:		Use of Sleep Aids (which ones?)	

SETTING THE STAGE:

(Please ask these questions to your child, if appropriate, and allow for as candid of a response as possible:)

What is your main expectation from this visit?

What would you like to see the future of your health look like?

What would your ideal doctor be like?

If things in your life needed to change, like what you eat, or exercise or listening, how likely would you be able to make these changes: [1 (low) – 10 (high)]:

What do you do that is healthy?

What do you do that you don't think is healthy?

What do you think would be the hardest part to making changes in your life?

Who do you know that will sincerely support you and help you out?

What do you LOVE to do:

571b 2nd Ave, Box 1295, Fernie BC V0B 1M0
Ph: (250) 531-0154 Fax: (800) 858-8623 Email: info@drdenoon.ca

Best Possible Medication History

(Include all current and relevant past prescription medications, OTCs, and complementary medicines)

MEDICATIONS

Name: _____

Start Date	Name of Medication	Strength	How to take this medication				Purpose	Comment	Prescribed By
dd/mm/yyyy	Brand and Generic name (If available)		Quantity?	Route?	Frequency?	Food?			

Pharmacy:

Informed Consent For Treatment

Welcome to Naturopathic Medicine! As a doctor of Naturopathic medicine it is my honor to take your care and health seriously. The following document is an agreement between you and I that states that you are entitled to understand any detail you wish about your health condition, treatment and diagnosis. It states that you are aware of the costs of naturopathic medicine (including late cancellation policies), the benefits and potential risks and side effects. Your health is ultimately up to you, therefore you also have the right to refuse any suggested treatment. We are in this together, so be sure to ask any questions you have, no matter what they are, at anytime and I will do my best to fulfill the meaning of doctor (docere) "To Teach".

STATEMENT OF ACKNOWLEDGEMENT

I, _____ as a patient of _____ understand that I am being treated under the practice philosophy and scope of naturopathic principles and practices. I will disclose all health concerns, conditions, medications and medical interventions, including supplements and over the counter drugs to my naturopathic doctor because I understand that safe care requires that I truthfully and completely disclose this information. I also will inform my naturopathic doctor if I am pregnant or breastfeeding so that she can take proper precautions for treatment.

I am aware and understand that I am entitled to know about my diagnosis and treatment, including the costs, benefits, risks and potential side effects. I am entitled to know the consequences of not accepting treatment and of alternative treatments that may be applicable. I am encouraged to take an active role in my care and ask any questions needed. I acknowledge that I have had the opportunity to discuss my proposed treatment with my practitioner and that she has answered all of my questions to the best of her ability.

I understand that though naturopathic treatments re generally safe and gentle, there may be health risks associated with some treatments. This may include, but not limited to: aggravation of pre existing symptoms, allergic reactions to supplements, herbs or pharmaceuticals and bruising or injury from acupuncture or intravenous therapies.

I understand that my naturopathic doctor is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at anytime. I accept full responsibility for any fees incurred during care and treatment, including a 50% late cancellation fee if providing less than 24 hours notice for cancellation of any appointments. I am aware that I am always at liberty to seek or continue care form another healthcare provider.

Signature (of patient, or legal guardian):

_____

Date: _____

Witness: _____

Printed: _____

571b 2nd Ave, Box 1295, Fernie BC V0B 1M0
Ph: (250) 531-0154 Fax: (800) 858-8623 Email: info@drdenoon.ca