Dr. Shannon Ferguson, ND
Country Hills Massage Therapy, 5149 Country Hills Blvd NW, Unit 336
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Child Intake

Child's Name: _____
Date: _____ Age: _____ Sex: _____
Date of Birth:_____

Address:
_____
_____
Tel, Home: _____
Other: _____

Email contact:
_____

Who is filling out this form? (name and relation)_____
Who does the child live with? _____

May we leave messages relating to your visits? (please circle) Yes No

EMERGENCY CONTACT:
Name: _____
Relation: _____
Address:_____
_____
Tel: _____
Email: _____

Family Physician: _____ Phone:( )_____

Other Health Care Provider(s):
Name: _____ Phone: ( )_____
Name: _____ Phone: ( )_____

Chief Health Concerns

List the reasons for your child's visit, in order of importance to you and when they began:
1. _____
2. _____
3. _____
4. _____
5. _____
Is your child currently receiving treatment for these concerns? Have they been effective?_____

Is your child currently on any medications/supplements/vitamins/homeopathics?_____
_____
_____

Has your child ever been treated with antibiotics? If yes, when and for what?_____
_____

Has your child ever been hospitalized? If yes, when and for what?_____
_____

Does your child have any known allergies or intolerances? Y N
Please list:_____
_____

Prenatal History

Please check off which would apply:

	Poor	Fair	Good	Excellent
Health of father at conception				
Health of mother at conception				
Physical health of mother during pregnancy				
Emotional health of mother during pregnancy				
Emotional health of mother after pregnancy				
Relationship of mother and father				
Mother's diet during pregnancy				

What was the mother's age at birth of child?_____
What was the father's age at birth of child?_____
Total number of siblings?_____
Number of pregnancies?_____
Number of miscarriages?_____
During the pregnancy did the mother experience any complications? Please describe. (including but not limited to high blood pressure, trauma, diabetes, thyroid problems, bleeding)_____
_____
_____

Labour and Delivery

Location of birth:_____ Duration of labour:_____
Birth weight, length:_____ Head circumference:_____

Birth description: Check off which applies to your child's birth

☐ Induced

☐ Forceps

☐ C-section

☐ Late

☐ Premature

☐ Spontaneous

☐ Epidural

☐ Medications

☐ Other_____

Did your child experience any of the following after birth:

☐ Jaundice

☐ Rashes

☐ Seizures

☐ Birth Injuries _____

☐ Birth defects _____

☐ Other_____

Immunizations

☐ MMR (measles, mumps, rubella)

☐ DPT (diphtheria, pertussis, tetanus)

☐ Haemophilus influenza B

☐ Hep A

☐ Hep B

☐ Chicken pox

☐ Polio

☐ Flu shot

☐ Tetanus - when?_____

Did your child experience any abnormal reactions to the vaccinations?_____

Childhood illnesses

☐ Chicken pox

☐ Tonsiliitis

☐ Ear infections

☐ Frequent colds

☐ Strep throat

☐ Mono

☐ Impetigo

☐ Whooping cough

☐ Pneumonia

☐ Rubella

☐ Mumps

☐ Rheumatic fever

☐ Scarlet fever

☐ Polio

☐ Measles

Nutrition

As an infant was your child (circle all that apply): Breast fed - how long _____
Forumla - describe _____ Cow Milk Goat Milk Soy Milk Nut Milk
Other_____
Age of introduction of solid foods:_____ What foods were introduced first?_____
Did your child experience any digestive issues as an infant?_____
Typical food intake in a day
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Beverages_____

Does your child have any dietary restrictions including vegetarian, vegan, religious?_____
Food allergies and intolerances_____
Favourite foods_____

Growth and Development

Current weight_____ Current height_____
Age your child began:
Sitting_____ Crawling_____ Teething_____
Walking_____ First words_____ Toilet training_____
Any concerns of parents, teachers or health care providers regarding physical or mental development?_____

Sleep

Where does your child sleep? (alone, with parents/siblings in the room, in a crib, in a bed)_____
What time does your child go to bed?_____
How many hours of sleep a night does your child get on average?_____
How long does it take your child to fall asleep?_____
How would you describe their sleep quality?_____
Does your child experience nightmares?_____
Does your child appear rested upon awakening?_____
Has bedwetting been a problem in the past or is currently an issue?_____

Lifestyle and Environment

Is your child exposed to any chemicals at home or at school? _____
_____
What is your child's hobbies?_____

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On a scale of 1-10 what is your child's energy level, 1 being the least possible and 10 being the most:_____
Emotional climate at home (circle one): very stable stable stressful very stressful
How is the home your child lives in heated?_____
Type of flooring:_____
Any pets?_____
How many hours a day is your child in front of a screen?_____
Any second hand smoke exposure? Y N

Education
Does your child go to daycare?_____
If your child is in school, what grade is he/she/they in?_____
Does your child struggle with school?_____
Does your child struggle with friendships?_____
Does your child have issues with paying attention?_____

Family History
Circle any condition any family member has been diagnosed with?

Allergies	Anemia	Headaches	Asthma
Diabetes	Hypertension	Epilepsy	Arthritis
Heart disease	Mental illness	Kidney disease	Stroke
Alcoholism	Tuberculosis	Birth defects	Drug addiction
Cancer	Autoimmune disease	Celiac disease	Other (please list below)

_____
_____

Review of Relevant Symptoms
Please check any symptoms off that your child currently has or has experienced in the past and describe if necessary:

General	**Current**	**Past**
Poor appetite		
Sleep difficulties		
Fatigue/weakness		
Intolerance to heat/cold		
Fever/chills		
Weight changes		
Change in thirst		
Skin	**Current**	**Past**

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General	Current	Past
Rashes/hives		
Easy bruising		
Lumps		
Itching		
Nail changes		
Hair changes		
Eczema		
Jaundice		
Birthmarks		
Head	**Current**	**Past**
Abnormal head shape		
Headaches		
Hearing problems		
Cradle cap		
Frequent nasal discharge		
Dizziness		
Vision problems		
Ear infections		
Nosebleeds		
Injuries		
Abnormal head size		
Crossed eyes		
Ringing or buzzing in ears		
EENT	**Current**	**Past**
Frequent sore throats		
Dental cavities		
Swollen glands		

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General	Current	Past
Sore tongue/mouth		
Speech difficulties		
Sore gums		
Chronic bad breath		
Cold sores		
Canker sores		
Respiratory System	**Current**	**Past**
Chronic cough		
Breathing noises		
Sputum or phlegm		
Difficulty breathing		
Chest pain		
Abdomen and GI	**Current**	**Past**
Change in appetite		
Blood in stool		
Diarrhea		
Food allergies		
Change in stool colour		
Change in thirst		
Belching or flatus		
Constipation		
Abdominal pain		
Nausea/vomiting		
Colic or indigestion		
Hernias		
Hepatitis		
Change in bowel habit		

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Cardiovascular	Current	Past
Murmurs		
Cold extremities		
Urinary	**Current**	**Past**
Increased frequency		
Pain with urination		
Difficulty passing urine		
Bed wetting		
Dribbling		
Blood in urine		
Increased urgency		
Difficulty starting urination		
Urinary tract infection		
Musculoskeletal	**Current**	**Past**
Broken bones		
Bone pain		
Muscle cramps		
Back pain		
Weakness		
Nervous system	**Current**	**Past**
Fainting		
Loss of balance		
Seizures/convulsions		
Numbness or tingling		
Paralysis		
Tremors		

Thank you for taking the time to fill out this form!

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Consent

Naturopathic Medicine is the treatment and prevention of diseases using natural therapies and treating the person as a whole, and as an individual. Naturopathic doctors use many modalities and therapies that are used to stimulate the body's inherent healing capacity. Your Naturopathic Doctor will take a thorough case history, and may do a screening physical examination, including a breast exam and may suggest labs or copies of lab work completed by your medical doctor.

It is very important therefore that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, if you are on any medication, supplements or over the counter drugs. Inform your Naturopathic doctor of any changes to these. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

As a patient it is your right to receive information about your diagnosis as well as treatment, including treatment alternatives, costs, benefits, risks, adverse effects, and consequences of not treating. As with any form of medical treatment, there are some risks to treatment by Naturopathic Medicine. These include but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising, fainting or injury from injections or acupuncture

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself unless law requires it. If required, I understand that my Naturopathic Doctor may discuss my case with other healthcare providers. I understand that I may look at my medical record at anytime and can request a copy of it by paying the appropriate fee of $0.10 per page. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that the results are not guaranteed. I do not expect the Doctors to be able to anticipate and explain all possible risks and complications. With this knowledge, I voluntarily consent to Naturopathic care I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent at any time.

Patient Name: (Please Print) _____

Signature of Patient or Parent/Guardian: _____ Date: _____

Naturopathic Doctor: _____

Please ensure to give at least 2 hours cancellation notice. This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on within two hours or missed appointments, 100% of the cost of the appointment will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the Naturopathic doctor. Please be aware that phone calls and emails outside of appointments are for clarification purposes only, beyond this is subject to additional consultation fees.

I, _____ (Name), understand and accept the above policies and associated fees.

Signature: _____ Date:_____