Dr. Karen Wallace
| Your Local Naturopathic Doctor |

# Child Naturopathic Intake Form

Child's Name: ____________________________________________ Date: ______________________

Date of Birth (MM/DD/YY): ________________________ Age: _______ Gender: M / F (please circle)

**Parent/Guardian Contact Information (assumed to be the emergency contact):**

Name: _______________________________________________ Relationship: ____________________

Address: _________________________ City: ______________ Province: ____ Postal code: __________

Preferred Phone: ________________________________ Home / Cell / Work (Please circle)

Email: ______________________________________ Can the clinic contact you via email? Y / N

How did you hear about Dr. Karen? _________________________________________________________

Name of Medical Doctor: ____________________________ Date of last checkup: _________________

**HEALTH HISTORY: (This is a confidential record. Information contained here will not be released to any person except when you have authorized us to do so. Please complete as thoroughly as possible.)**

Main health concerns of child, in order of importance (include severity on a scale of 1-10, 10 being very severe):

1. _____________________________________________________ Severity: ___________
2. _____________________________________________________ Severity: ___________
3. _____________________________________________________ Severity: ___________

Other: ___________________________________________________________________________

How much do these concerns interfere with the child's activities of daily living? (Please circle number)

(least) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Has your child received Naturopathic treatment in the past? Y / N (Please circle)

What expectations do you have for me as your child's ND and in the treatments provided?

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How committed are you to addressing your child's health concerns and making changes in their lifestyle/diet if necessary?

(not at all) 0 1 2 3 4 5 6 7 8 9 10 (very)

List of all **medications** your child is currently taking:

| Name | Dosage | Date started | Reason |
|---|---|---|---|
| | | | |
| | | | |

Other: ______________________________________________________________________________

How many times has your child been treated with antibiotics? _____ Date of last dose: __________

List all **supplements** your child is currently taking, including the brand and dosage:

______________________________________________________________________________

______________________________________________________________________________

**Medical History**
Please list any allergies the child may have (environmental, food, drugs, supplements):

Please indicate any serious medical conditions, illnesses, injuries, surgeries, &/or hospitalizations that your child has had in the past:

Any major mental/emotional traumas (divorce of parents, bullying, major disease, etc):

**Child's Health History** (Please circle either **c** for current, or **p** for past, if applicable, or both)

| | | | | | |
|---|---|---|---|---|---|
| Cradle cap | c | p | Eczema | c | p |
| Diarrhea | c | p | Constipation | c | p |
| Asthma | c | p | Diaper rash | c | p |
| Chronic colds/sniffles | c | p | Allergies | c | p |
| Nightmares | c | p | Bedwetting | c | p |
| Fears/phobias | c | p | Colic | c | p |
| Lice | c | p | High fever | c | p |
| Conjunctivitis (pink eye) | c | p | Ear infections | c | p |
| Strep throat | c | p | Stomach aches | c | p |
| Warts | c | p | Thrush | c | p |
| Erythema multiforme | c | p | Impetigo | c | p |
| Hyperactivity | c | p | Extreme shyness | c | p |
| Tantrums | c | p | Picky eater/poor appetite | c | p |
| Hearing/vision problems | c | p | Early puberty (before age 11) | c | p |

## INSURANCE INFORMATION

Dr. Karen can direct bill several insurance companies for naturopathic services, however every plan is unique. Please circle your primary insurance company.

Blue Cross Great West-Life Sun-Life Green Shield Manulife

Standard Life Industrial Alliance Johnson Other: _____________

**Name of insured:** _______________________________________________________________

**Policy number:** ___________________________ **ID number:** ____________________________

## NATUROPATHIC TREATMENT INFORMED CONSENT

As the parent/guardian of this child, I have the right to be informed about their health condition(s) and recommended treatments. Dr. Karen Wallace will discuss the potential benefits, risks and hazards involved.

I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions, in very young children, in pregnancy or in those on multiple medications. I acknowledge that the information I have provided about my child is complete and inclusive of all health concerns, and all medications, including over the counter drugs, supplements and herbs.

I understand that medical records will be kept confidential and secure and will not be released without my personal consent or that of my representative, unless it is required by law. However, I understand that if being treated by multiple therapists in the clinic, I agree that my child's medical information and treatment plan can be discussed between therapists to ensure the best possible treatment.

To respect the time of Dr. Karen Wallace and all her patients, I acknowledge that a minimum of **24 hours notice** is required to **cancel or change an appointment**. I understand that failure to provide adequate notice will result in a **missed appointment fee of half the cost of the visit**.

After signing this consent form, I understand I am free to withdraw consent at any time.

With this knowledge I give my written consent for my child for naturopathic evaluation and treatment. I intend this as a consent form for the entire course of treatment including any future conditions for which I seek treatment for my child.

PARENT/GUARDIAN PRINTED NAME: ___________________________________ DATE: ____________

PARENT/GUARDIAN SIGNATURE: _______________________________________

**Please email this form to info@drkarenfrackowiak.com or fax to the clinic at least one day before your appointment.**
**Symmetry Wellness Centre – 902-444-6554**