PEDIATRIC INTAKE FORM

Dr. Michael Tassone, 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 can be fun to do it together. This form is an important step towards defining your health care needs and achieving your health goals.

Please bring this completed form to your first appointment or drop it off in advance for review. Please also bring any relevant blood work or health reports. All the answers on this form will be held **absolutely confidential**.

Name: _____ Birthdate: _____

Address: _____ City: _____ Prov: _____ PC: _____

Family Doctor: _____ Phone #: _____

Referring Professional: _____ Phone #: _____

Care Card #: _____

GUARDIAN INFORMATION:

Name: _____ Relationship: _____

Phone (Home): _____ Cell: _____ 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 ☐ When: _____ Dr: _____

Are you aware of the fees for the initial consultation and follow up visits? Y / N _____

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

Medications: _____

Food: _____

Environmental: _____

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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		

Have you ever been hospitalized Y / N . If yes, why and dates?

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

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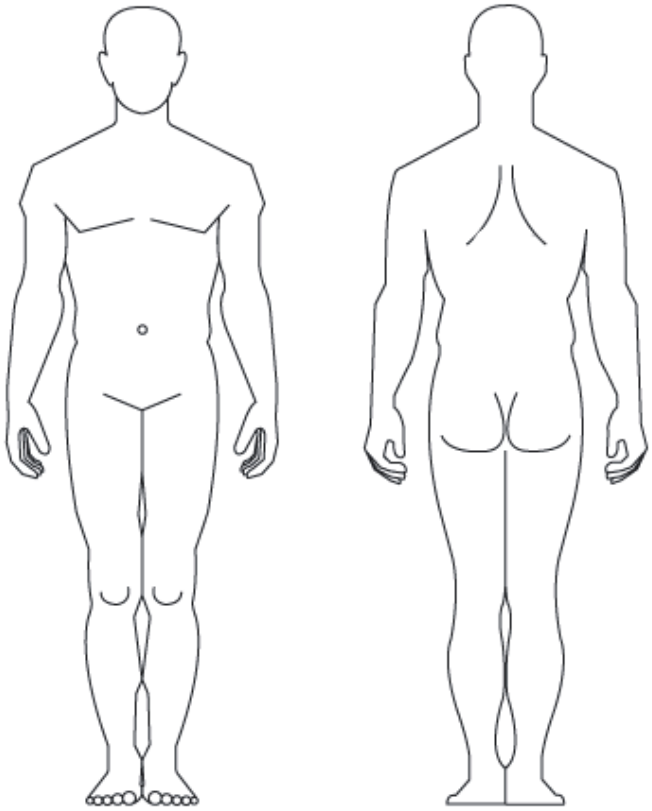
PHYSICAL CONDITION:

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



ACHING ○

STABBING ×

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:

Please describe your current physical condition:

Exercise: ☐ Daily ☐ 5x Week ☐ 3x Week ☐ Weekly ☐ Monthly ☐ Never

Type (length, aerobic, strength, intensity):

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FAMILY HEALTH HISTORY:

RELATION	MEDICAL CONDITION	AGE AT DEATH	CAUSE OF DEATH
Father			
Mother			
Brother(s)			
Sister(s)			
Son(s)			
Daughter(s)			
Paternal GF			
Paternal GM			
Maternal GF			
Maternal GM			

PRENATAL / BIRTH / NEONATAL HISTORY

Birth weight _____ ☐ Premature ☐ Late ☐ Full term

CHILDHOOD ILLNESSES

☐ Chicken pox
☐ Red measles
☐ Mumps
☐ Rubella
☐ Scarlet fever
☐ Rheumatic fever
☐ Strep throat
☐ Pneumonia
☐ Mononucleosis
☐ Ear infection(s)
☐ Tonsillitis
☐ other

INFANT DIET

☐ Breast fed - how long? _____ ☐ Formula fed - how long & type? _____

Age solids began? _____ What foods? _____

Food Allergies / Intolerances? _____

Favourite foods? _____

Sample daily diet (choose a typical day, include liquids) _____

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IMMUNIZATION HISTORY

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	
	Pneumococcal (PCV)	3 of 3	
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	

MOTHER'S HEALTH DURING PREGNANCY

- ☐ Age
- ☐ Alcohol
- ☐ Bleeding
- ☐ Cigarettes
- ☐ Diabetes
- ☐ Drugs
- ☐ Extreme nausea
- ☐ High blood pressure
- ☐ Illness
- ☐ Medications
- ☐ Stress
- ☐ Toxemia
- ☐ Trauma / injury
- ☐ x-rays
- ☐ other

Details: _____

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Have you tried any previous treatment? : _____

_____

_____

On a scale of 1 (low) -10 (high) how would you rate:

Sleep quality:_____ Eating habits:_____ Stress level:_____ Exercise habits:_____

How many hours of sleep a night do you get? : _____

DIET:

Please describe a typical days diet: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____ Beverages: _____

How many hours do you spend watching TV a day: _____ On the computer: _____

Texting: _____ Talking on the phone: _____

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BEST POSSIBLE MEDICATION HISTORY:

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

START DATE DD/MM/YY	NAME OF MEDICATION Brand and Generic name (if available)	STRENGTH	HOW TO TAKE THIS MEDICATION				PURPOSE	COMMENT	PRESCRIBED BY
			Quantity	Route	Frequency	With Food (Y/N)			

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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 Dr. Michael Tassone, ND 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 he 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 he has answered all of my questions to the best of his ability.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some treatments. This may include, but no 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 from another healthcare provider.

Signature (of patient, or legal guardian): _____

Date: _____

Witness: _____ Printed: _____

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