Rebecca Sagan B.Sc., N.D.
NATURALLY GOOD HEALTH CLINIC
1904 – B, 20 Avenue NW
Telephone 403.289.0989 Fax 403.289.0997
www.naturallygoodhealth.com

Pediatric Intake Form

Who are you?
Name:_______________________________________
Gender: M F
Age:_____________
Date of Birth:_________________________________

Parent's Names:____
Address:____
Who does the child live with:____
Phone Number:(___)_____________________
Emergency Contact:_______________________ Phone Number:________________

Does the child have a medic alert?____
Or life threatening allergies?____

What's going on?
What is the main health concern?____
When did this begin?____
How long has this gone on for?____
What other treatments have been attempted?______________________________
____
What was the result with these treatments?_______________________________
____
What factors may be contributing to this problem?_________________________
____

What have you had? Check all applicable

Chicken pox		Measles	
Mumps		Rubella	
Surgery		Allergies	

Vaccinations: Check all applicable

D-PTP (Diphtheria, Pertussis, Tetanus, Polio)		Hib (H. influenza, often given with D-PTP)	
MMR (Measles, Mumps, Rubella)		Td + P (Tetanus, Diphtheria, Polio)	
OPV (oral polio vaccine)		Hepatitis B	
Flu shot			

Have you ever been to the emergency room?_______________________________
What was it for?____

What are you taking?

Please list any medications you have taken in the past and the ones you are taking presently.____
____

Please list any supplements; vitamins, minerals, herbal medication, homeopathics, that you are currently taking.

____
____

How was your birth?

During the pregnancy were you exposed to any of the following:

Alcohol		Cigarette smoke	
Recreational drugs		Prescription medications	
Over the Counter drugs		Herbal preparations	
Ultrasound		Amniocentesis	
Illness		Large amount of stress	

Were there any complications during the pregnancy?

Nausea		Hypertension	
Vomiting		Preeclampsia / eclampsia	
Bleeding		Placenta previa	
Gestational diabetes		Maternal rubella	
Maternal chicken pox		Maternal cytomegalovirus	
Maternal toxoplasmosis		Other	

At Birth:

Weight:_________
Length:_________
Were you term?________ pre-term? _______ post-term?_______ premature?______
Where did the birth take place? Home Hospital
What type of delivery occurred? Vaginal Cesarean Section

Were there any complications with the birth?

Difficult delivery		Breech delivery	
Long 2nd stage of labour		Shoulder dystocia	
Forceps or suction used		Other	

What were the APGAR scores?____
Were any interventions administered at birth? Vitamin K Eye drops
What were your mother's feelings about the birth?____________________________

As a Newborn:

Did you have any of the following conditions?

Jaundice		Colic	
Hip displacement		Meningitis	
Scoliosis			

What do you like to eat?

As a baby were you breastfed? Yes No For how long?________________
Were you fed formula? Yes No
What kind of formula was used?______________________________________
Were there any reactions to the formulas?______________________________
How old were you when were you introduced to food?______________________
What did you eat first?____
Were their any reactions to any foods?__________________________________

What do you eat now?____
What are your favourite foods?_______________________________________
What foods do you like the least?_____________________________________
Do you exclude any foods for religious or ethnic reasons?___________________
____

Where do you live?

What kind of a building do you live in (house, apartment, etc.)?______________
How old is the building?____
Has it been renovated recently?______________________________________
Does your home have carpet?____
Has there ever been a problem with mildew in the home? __________________

What is your family like?

Has anyone in your family had any of the following diseases? If yes, please indicate who.

Cancer		Diabetes		Heart Disease	
Stroke		Hypothyroidism		Arrhythmia	
Rheumatoid Arthritis		Hyperthyroidism		High blood pressure	
Lupus		Sickle-cell anemia		Crohn's Disease	
An Autoimmune disease		Irritable Bowel Syndrome		Ulcerative Colitis	

What do you like to do?

Do you go to school? Which one?_____________________________________
Do you go to daycare?____
Do you have a nanny?____
How do you like playing with other kids?_______________________________
Do you have a pet?____
Do you watch TV? Yes No How often?__________________
Do you play video games? Yes No How often?__________________
Do you play on the internet? Yes No How often?__________________
Do you have family time? Yes No How often?__________________
Do you get exercise? Yes No
What do you like to do for exercise?___________________________________
What else do you like to do?____

How is your sleep?

What position do you like to sleep in?______________________________________
How long do you sleep at night?____
How long does it take you to fall asleep?____________________________________
Do you wake up during the night?____
Do you have nightmares?____
How do you feel when you wake up?_______________________________________
Are you rested?____
Do you take naps?____
How long are your naps?____
What is your energy like during the day?____________________________________

From Head to Toe: Please check all that apply.

Cradle cap (seborrheic dermatitis)		ADHD/ ADD	
Eczema		Urinary incontinence	
Diaper rash		Bedwetting	
Yeast infection		Fecal incontinence	
Impetigo		Seizures	
Conjunctivitis		Paralysis	
Scabies		Cerebral Palsy	
Sinusitis		Spina bifida	
Ear infections		Cystic Fibrosis	
Chronic Colds		Chronic Diarrhea	
Croup		Appendicitis	
Bronchitis		Constipation	
Asthma		Chronic Abdominal pain	
Pneumonia		Short stature	
Cardiovascular problems		Other	

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Welcome to Naturopathic Care

I want you to enjoy and benefit from your visits.

Your first visit will consist of a **consultation, detailed history, a general physical exam and more specific naturopathic assessments**. Based on this information, initial recommendations for your treatment protocol will be made on your first visit. If it is necessary for a more complete analysis of your health status, you may be asked to have further laboratory tests done, these may include; blood testing, salivary hormone testing, urine, hair and stool analysis. Through this healthcare assessment, a baseline measure of health is established which will be used to monitor your progress.

Naturopathic treatment programs often include **dietary changes, botanical/herbal medicine, nutritional supplementation, homeopathy, acupuncture and Bowen therapy**. Any side effects or risks associated with your treatment will be explained to you. Part of the program will also involve lifestyle recommendations that are logical and sensible; I encourage you to have a support team as you make these changes, often having someone else, be it a partner, family member or friend, undergoing naturopathic care at the same time, will help ease you both toward better health. Your second visit is a good time to ask any questions that you may have had after your initial visit. If you need immediate clarification on remedies, dietary recommendations or have a concern over any unfamiliar symptoms that may arise, please call the office.

On your following visits your progress will be monitored and treatments will be modified accordingly. The second visit is usually one to four weeks after your initial visit. If you are receiving acupuncture treatments, visits will be more frequent, either once or twice weekly for 6-10 sessions, Bowen therapy sessions are usually 5-10 days apart. As you start to experience a new level of wellness, an office visit every three to four months is recommended for general disease prevention and health maintenance. If an acute, non-emergency condition occurs, please give us a call as we may be able to help with a naturopathic treatment.

Many patients have allergies and are environmentally sensitive. On the day of your visit to the office please do not wear any scented products (perfumes, shaving lotions, etc.).

If you are unable to keep a scheduled appointment, please give the office 48 hours notice. We are then able to give the appointment time to someone else. If we do not receive sufficient notice you will be charged for the missed visit.

Payment for visits shall be made at the time of the appointment

Please be advised of the fees payable by **Visa, MasterCard, Debit or cash**

Dr. Rebecca Sagan ND

Initial visit 1.5 hr $210
Regular visit 30 min $95
Child Initial visit 60 min $175
Child Regular visit 30 min $89
Acupuncture follow-up 30 min $95
Bowen Therapy Initial 60 min $175
Bowen Follow-up 30 min $95

A dispensary of professional quality supplements, botanicals and homeopathics is maintained for the treatment of our patients. Items are individually priced.

If you have any concerns please contact the office and we be happy to assist you.

Naturally Good Health Clinic

INFORMED CONSENT

I would like to take this opportunity to welcome you to the Naturally Good Health Clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history. Your Naturopathic Doctor will complete a physical exam, as well as, specific blood, salivary and/or urinary laboratory reports as part of the treatment work-up if determined to be appropriate.

Statement of Acknowledgement

Printed name ____

As a patient of this clinic I understand that the form of medical care is based on Naturopathic and other supportive principles and practices. All information that is disclosed will remain confidential and will only be released with my permission. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

___________________________	_____________	___________________________
SIGNATURE/ Guardian Signature	DATE	WITNESS