Dr. Jeannie Doig, HBSc, ND
Naturopathic Physician

www.drjeanniedoig.com
Port Alberni (250) 723-9888
Tofino & Ucluelet (250) 522-0033

Child Intake Form

Child's name _____ Age _____ Date of Birth _____
Date _____ Sex M F

Who is filling out this form (name and relation)? _____

Contacts (in order of preference):

Name _____ Phone _____ h
Address _____ _____ w
_____ _____ other
_____
Relationship to Child _____

Name _____ Phone _____ h
Address _____ _____ w
_____ _____ other
_____
Relationship to Child _____

Whom does the child live with? _____

Other health care providers:

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
(___)_____	(___)_____	(___)_____

What are your child's health concerns in order of importance:
1. _____
2. _____
3. _____
4. _____
5. _____

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Medical History

How would you describe your child's general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

_____
_____
_____
_____

Which of the following has your child had? (n=never, m=mild, a=average, s=severe)

n m a s rubella (german measles)	*n m a s* roseola	*n m a s* impetigo
n m a s measles	*n m a s* scarlet fever	*n m a s* mononucleosis
n m a s chicken pox	*n m a s* whooping cough	*n m a s* ear infections
n m a s mumps	*n m a s* strep throat	

Does your child have allergies (medicines, environmental, etc.)?

_____
_____

Please list all current medications (prescription, over-the counter, vitamins, herbs, homeopathics, etc)

_____
_____
_____
_____

Please list past prescription medications.

_____
_____
_____
_____

How many times has your child been treated with antibiotics? _____

Please indicate what immunizations your child has had.

- DPT (diphtheria, pertussis, tetanus)
- Tetanus booster; when? _____
- MMR (measles, mumps, rubella)
- Haemophilus influenza B

- "Flu"
- Polio
- Hepatitis B
- Other _____

Please indicate if any caused adverse reactions.

_____
_____

What screening tests has your child had (blood, hearing, vision, etc)?

_____
_____

Prenatal health

What was the health of the parents at conception?

Mother Poor Fair Good Excellent Unknown
Father Poor Fair Good Excellent Unknown

What was the health of the mother during the pregnancy?

Poor Fair Good Excellent Unknown

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother receive prenatal medical care? Y N Unknown

Did the mother experience any of the following during pregnancy?

____ Bleeding ____High blood pressure ____Nausea ____Vomiting
____Diabetes ____ Thyroid problems ____ Physical or emotional trauma
Other? _____
_____

Did the mother use any of the following during the pregnancy?

___Tobacco ___Alcohol ___Recreational drugs: _____
___Prescription medications: _____
___Over-the-counter medications: _____
___Supplements: _____
___Other: _____

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Birth History

Term length: ___Full ___Premature: ____wks ___Late: _____wks
Length of labour: _____ Weight at birth: _____
Any complications? _____
Was the birth: Vaginal / C-section Induced Forceps Anesthesia used
Did the child experience any of the following at or shortly after birth?
___Jaundice ___Rashes ___Seizures ___Birth injuries_____
___Birth defects _____
___Other_____

Diet

How was your infant fed?
___Breast Fed. How long? _____
___Formula Fed. Milk/Soy/Other:_____
___Other: _____

What foods were introduced before 6 months? (Please list approximate month as well)
_____
_____
_____

6-12 months?
_____
_____
_____
_____

Did your child ever experience colic? Y N How severe? Mild moderate severe

Does your child have any food allergies or intolerances? Please list.
_____
_____
_____
_____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?
_____
_____

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Describe a typical day's diet
Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages (and total quantity) _____

Health and Development
How was your child's health in the first year? Poor Fair Good Excellent Unknown
At what age did your child first
Sit up _____ Crawl _____ Walk _____ Talk _____
Describe your child's sleep pattern_____
_____
_____
How would you describe your child's temperament?_____
_____

How would you describe your child's behaviour and performance at school?
_____
_____

Family History
Indicate if a close relative (parent, sibling) has had any of the following.

	Who?		Who?
Allergies		Diabetes	
Asthma		Kidney disease	
Birth defects		Mental illness	
Juvenile arthritis		Other?	

Do either of the parents have a chronic illness? Y N Please describe:
_____

Environment
Is the child in school daycare home care other _____
What are your child's favorite activities?_____
_____

Does the child exercise regularly? Y N How much, how often?
_____
_____

How much television does your child watch? _____hrs a day/week

How often does your child read (not for school), or How often does someone else read to your child?
___Daily ___Several times a week ___Weekly ___Less than weekly

Does anyone in the child's household smoke? Y N
Are there animals in the home? Y N
How is the child's home heated? _____
Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe._____
_____
_____

How would you describe the emotional climate of the child's home?
_____
_____

Is there anything that you feel is important that has not been covered?
_____
_____
_

Please check if your child is experiencing the following symptoms or write "P" beside the box if your child has experienced these symptoms in the past.

General:

- ❑ Poor appetite
- ❑ Change in appetite
- ❑ Headaches
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Chills and Fever
- ❑ Night sweats
- ❑ Excessive sweating
- ❑ Cravings
- ❑ Intense hunger
- ❑ Intense thirst
- ❑ Anemia
- ❑ Easy Bruising/Bleeding
- ❑ Varicose Veins
- ❑ Swelling of limbs
- ❑ Cold hands or feet

Date of last CBC (complete blood count):
_____

Eyes, Ears, Nose and Throat:

- ❑ Impaired Hearing
- ❑ Earaches
- ❑ Ear infections
- ❑ Ringing in the ears
- ❑ Ear wax build up
- ❑ Sinus infections

Skin and Hair:

- ❑ Rashes
- ❑ Itching
- ❑ Excema
- ❑ Acne, boils
- ❑ Loss of hair
- ❑ Nail changes
- ❑ Dandruff
- ❑ Recent moles
- ❑ Dryness
- ❑ Hives or allergy reaction
- ❑ Colour change
- ❑ Other problems

Cardiovascular:

- ❑ High Blood pressure
- ❑ Low Blood pressure
- ❑ Irregular Heart Beat
- ❑ Dizziness
- ❑ Fainting
- ❑ Chest pain
- ❑ Angina

Muscle, Bone and Joints:

- ❑ Back pain
- ❑ Muscle spasms/cramps
- ❑ Muscle weakness
- ❑ Arthritis
- ❑ Joint pains/stiffness
- ❑ Bursitis

Gastrointestinal:

- ❑ Indigestion
- ❑ Gas and burping
- ❑ Bad breath
- ❑ Heart burn
- ❑ Constipation
- ❑ Diarrhea
- ❑ Incomplete bowel movement
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Recurrent sore throats
- ❑ Frequent colds
- ❑ Tonsillitis
- ❑ Nasal obstruction
- ❑ Post-nasal drip
- ❑ Nose bleeds
- ❑ Eye sensitive to sun
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Night blindness
- ❑ Colour blindness
- ❑ Near/Far sighted
- ❑ Cataracts
- ❑ Itchy/Red eye
- ❑ Blind spots
- ❑ Facial pain/tics
- ❑ Jaw pain or clicks
- ❑ Mercury fillings
- ❑ Sores in mouth
- ❑ Loss of taste

Genito-Urinary:

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Pain on urination
- ❑ Recurrent urinary tract infections
- ❑ Wake at night to urinate
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Kidney infection
- ❑ Sores on genitals
- ❑ Blood in urine

- ❑ Abdominal pain/cramps
- ❑ Nausea
- ❑ Vomiting
- ❑ Chronic laxative use
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Blood in stool (black or red stool)
- ❑ Bloating
- ❑ Ulcers
- ❑ Hernias
- ❑ Intestinal worms
- ❑ Liver disease
- ❑ Gallbladder disease
- ❑ Jaundice

Comments:

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CONSENT FORM

INFORMED CONSENT TO NATUROPATHIC TREATMENT

Naturopathic medicine is the art and science of preventing and treating disease by natural means. Naturopathic Doctors assess the whole person, including physical, mental, and emotional aspects of the individual. Naturopathic Doctors use a variety of therapeutic approaches either alone, or in combination. These include nutritional and lifestyle changes, counseling, botanical medicine, nutritional supplementation, Asian medicine and acupuncture, homeopathy, and physical medicine.

This is to acknowledge that I have been informed and I understand that:

1) Any treatment or advice provided to me as a patient of Dr. Jeannie Doig is not mutually exclusive of any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider.
2) I may at liberty seek or continue medical care from a physician or surgeon or other health care provider qualified to practice medicine.
3) Dr. Jeannie Doig will not suggest or recommend to me to refrain from seeking or following the advice of another health care provider.
4) The treatment and therapies rendered or recommended by Dr. Jeannie Doig may be different from those usually offered by a medical doctor or other licensed health care provider.
5) There are some risks, however rare, to Naturopathic Medicine. These include but are not limited to:
    - Aggravation of pre-existing symptoms
    - Allergic reaction to supplements or herbs
    - Pain, bruising or injury from acupuncture
    - Fainting or puncturing with acupuncture needles

I declare that I have received a full and complete explanation of the treatment or services that I may receive by Dr. Jeannie Doig and hereby authorize and consent to treatment by Dr. Jeannie Doig, ND. I intend this consent to apply to all my present and future care.

_____ _____

Signature of patient Date

_____ _____

Name of patient (printed) Doctor's signature