

DR KATHERINE KEYES - PEDIATRIC INTAKE FORM (16 yrs and under)

MAYA HEALTH CENTRE

#2, 1922 9<sup>th</sup> Avenue SE, CALGARY, AB, T2N 3P9

PH: 403-457-3393 FAX 403-521-5237

[www.dr-keyes.com](http://www.dr-keyes.com)

**PATIENT INFORMATION**

Name: \_\_\_\_\_

Name of guardian: \_\_\_\_\_

Date of birth (day/mo/yr): \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M / F

Email of guardian: \_\_\_\_\_

Address with postal code: \_\_\_\_\_

Tel (home): \_\_\_\_\_ (work): \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Tel (home): \_\_\_\_\_ (work): \_\_\_\_\_

Medical doctor: \_\_\_\_\_ MD Tel: \_\_\_\_\_

Other healthcare providers: \_\_\_\_\_

How did you hear about the clinic? \_\_\_\_\_

**HEALTH INFORMATION**

**Chief Concerns**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

When was your child's last physical exam? \_\_\_\_\_

**Medications**

**Supplements**

\_\_\_\_\_  
\_\_\_\_\_

**Medical history**

**Prenatal:**

Age of parents at conception: Mother \_\_\_\_\_ Father \_\_\_\_\_

Occupation: Father \_\_\_\_\_ Maternity leave taken Y/ N

Mother \_\_\_\_\_ Maternity leave taken Y/ N

Worked how long into pregnancy? \_\_\_\_\_

Adopted, natural or assisted conception? \_\_\_\_\_

Complications of pregnancy (i.e. toxemia, diabetes, bed rest, nausea, vomiting, medication, supplements) \_\_\_\_\_

Significant events or trauma during pregnancy, physical or emotional: \_\_\_\_\_

Amount of exposure of the following during pregnancy:

Cigarette smoke \_\_\_\_\_ Alcohol \_\_\_\_\_

Environmental (i.e. cleaning products, cat litter, well water, new paint): \_\_\_\_\_

**Neonatal (labour and delivery):**

Gestation (indicate if premature or over-due): \_\_\_\_\_

Type of care (ex. obstetric, midwife) and name of practitioner(s): \_\_\_\_\_

Type of birth (vaginal, C-section) \_\_\_\_\_

Complications (breech, vacuum or forceps assisted) \_\_\_\_\_

History of miscarriage, stillbirth, multiple births: \_\_\_\_\_

Any genetic defects \_\_\_\_\_

Duration of labour \_\_\_\_\_ Medication, antibiotics (i.e. for Strep B), supplements given: \_\_\_\_\_

APGAR score (score, note any low scoring sections) \_\_\_\_\_

Birth weight: \_\_\_\_\_ Height: \_\_\_\_\_ Normal weight gain Y N

Neo-natal difficulties (jaundice, respiratory, failure to thrive, blood sugar complications, illness) \_\_\_\_\_

**Feeding:**

Breast fed? If so, how long? \_\_\_\_\_ Reactions \_\_\_\_\_

Substituted? If so, since when? \_\_\_\_\_ Reason(s) \_\_\_\_\_

Weaning:

Age: \_\_\_\_\_ Success: \_\_\_\_\_

Food Introduction:

When: \_\_\_\_\_ What: \_\_\_\_\_

Any adverse reactions: \_\_\_\_\_

Cravings or aversions: \_\_\_\_\_

Current Diet:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Supper: \_\_\_\_\_

Snacks: \_\_\_\_\_

Describe eating environment (i.e. location, timing with rest of family, picky): \_\_\_\_\_

Major Developmental Milestones (please include approximate age at time):

First Roll (from front to back, or back to front) \_\_\_\_\_

First Unassisted Sitting Position \_\_\_\_\_

First Crawl \_\_\_\_\_

First Walk \_\_\_\_\_

First Words \_\_\_\_\_

First Teeth \_\_\_\_\_

Indicate if your child has had any of the following childhood illnesses (circle):

Asthma	Measles	Rheumatic fever
Chickenpox	Mumps	Scarlet fever
Eczema	Polio	Whooping cough
Frequent ear infections or colds	Rubella (German measles)	Other: _____

Immunizations: (Check ✓)

<input type="checkbox"/> DPT	<input type="checkbox"/> Hemophilus influenza B	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Flu shot	<input type="checkbox"/> Tetanus Booster	<input type="checkbox"/> MMR	<input type="checkbox"/> Polio
<input type="checkbox"/> Smallpox	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Other: _____	

Any adverse reactions to vaccinations? Y / N. If yes, explain. \_\_\_\_\_

Please list (with approximate dates) any serious conditions, illnesses or injuries, and any hospitalizations.

**Family history**

Please indicate whether any of your child's family members have, or have had the following:

	Relative		Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	

**Lifestyle**

Does your child exercise? How often? \_\_\_\_\_

Any environmental hazards? Age of house, carpeted floors, air filtered, water type, cleaning products, close to industry, cigarette smoke, pets, etc.? \_\_\_\_\_

Any allergies (food environmental, medications)? \_\_\_\_\_

Please describe the child's home life (ex. family structure, stress level in house, responsibilities/expectations, etc.) \_\_\_\_\_

How is your child's attitude towards school? \_\_\_\_\_

Extracurricular activities \_\_\_\_\_

How would you describe your child's interaction or socialization with others?

Previous (please indicate age) or current bedwetting \_\_\_\_\_  
Nocturnal Events: (Dreams, Nightmares/Terrors, Sleep-Walking, Insomnia, etc.,)? \_\_\_\_\_

**REVIEW OF SYSTEMS**

Circle Conditions That Apply or Have Had in The Past:

General (Fever, Illness, Hospitalization, Injury, Other: \_\_\_\_\_)

Head (Swelling, Rash, Hair loss, Head injury, Other: \_\_\_\_\_)

Eyes (Discharge, Redness, Infection, Eye injury, Other: \_\_\_\_\_)

Ears (Discharge, Infection, Ear injury, Other: \_\_\_\_\_)

Nose (Allergy, Discharge, Bleeding, Injury, Other: \_\_\_\_\_)

Mouth (Lesion, Cavities, Swelling gums, Infection, Other: \_\_\_\_\_)

Skin (Rash, Wart, Infection, Mole/Birth Mark, Other: \_\_\_\_\_)

Neck/Throat (Sore throat, Infection, Swollen glands, Other: \_\_\_\_\_)

Respiration (Cough, Infection, Asthma, Wheeze, Other: \_\_\_\_\_)

Heart (Cyanosis, Sweating, Circulation difficulty, Other: \_\_\_\_\_)

GI (Allergy, Diarrhea, Constipation, Vomiting, Other: \_\_\_\_\_)

Urinary (Rash, Erythema, Discharge, Hematuria, Frequency, Other: \_\_\_\_\_)

Musc/Skel (Limited movement, Loss strength, Fracture, Other: \_\_\_\_\_)

Nervous Sys (Tremor, Lethargy, Irritability, Seizure, H/A, Other: \_\_\_\_\_)

**ADDITIONAL INTAKE FOR ADOLESCENTS**

Tried smoking? \_\_\_\_\_

Recreational Drugs? \_\_\_\_\_

Alcohol (If yes, how many drinks a day/week)? \_\_\_\_\_

Sexually active? \_\_\_\_\_

Depression / Mood Swings / Anxiety / Insomnia / Phobias (circle ones that you have had or currently experiencing)

Female: (if has started to menstruate)

Age of first period? \_\_\_\_\_ Is your period regular? Y / N

Length of monthly cycle (days)? \_\_\_\_\_ Length of period or flow (days)? \_\_\_\_\_ Amount of flow? (light, heavy)

Color of blood? (bright, light, dark red) \_\_\_\_\_ Menstrual cramps? \_\_\_\_\_ Clots? \_\_\_\_\_

Do you use tampons? Y/ N Do you experience PMS? Y / N Low back pain with period? (before, during)

Have you had a PAP? Y/ N Date of last Pap? (month/yr) \_\_\_\_\_/\_\_\_\_\_ Have you ever had an abnormal PAP? Y/ N

Have you ever had a sexually transmitted disease? Y/ N

Have you been pregnant? \_\_\_\_\_ Births? \_\_\_\_\_ Miscarriages? \_\_\_\_\_ Abortions? \_\_\_\_\_

Male:

Hernias/Masses \_\_\_\_\_

Testicular pain \_\_\_\_\_

Sexual difficulties \_\_\_\_\_

Discharges or sores \_\_\_\_\_

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### Declaration and Consent to Treatment

Caution must be taken in physiological conditions such as pregnancy and lactation, in very young children, persons with diabetes, heart, liver or kidney impairment and/or in persons taking multiple medications.

It is important that you inform your Naturopathic Doctor, Dr. Katherine Keyes, immediately of:

- Any disease process from which you currently suffer
- If you are on any medications either prescribed or over-the-counter
- If you are pregnant, suspect you are pregnant, planning to become pregnant or are currently breast feeding

There are some slight health risks associated with treatment by Naturopathic Medicine. These include but are not limited to:

- Homeopathic remedies may occasionally result in the aggravation of pre-existing symptoms. When this occurs the duration is usually short.
- Some patients experience allergic reactions to certain supplements and herbs. Please advise your Naturopathic Doctor of any allergies you may have.
- Pain, bruising or injury from venipuncture or acupuncture
- Accidental burning of the skin from the use of moxa.
- Muscle strains and sprains, and disc injuries from spinal manipulation.
- The very small potential for stroke is a concern in neck manipulation. Patients are thoroughly screened prior to manipulating the neck.
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### **Your Naturopathic Doctor is trained to handle emergencies should the need arise.**

*I understand that my Naturopathic Doctor, Dr. Katherine Keyes will answer any questions that I have to the best of her ability. I understand that results are not guaranteed. I do not expect the naturopath to anticipate and explain all risks and complications. I will rely on the naturopathic doctor to exercise judgment during the course of my treatment which she feels is in my best interest based on the facts which are known. **I also understand that pharmaceutical grade supplements and herbal medicines prescribed and sold by my naturopathic doctor may be a part of my treatment protocol. This is to ensure that the appropriate doses and quality of medicine is administered and immediately available, in order to provide the most effective treatment possible. I also understand that there may be an additional cost for certain diagnostic procedures.***

*With this knowledge I voluntarily consent to the diagnostic and therapeutic procedures mentioned above. I intend for this consent to cover the course of my treatment. I am free to withdraw my consent and discontinue treatment at any time. I also testify that I am able to give legal consent or there is a parent or guardian able to sign on my behalf.*

***If I am unable to make a scheduled appointment I must provide 24 hours advance notice to avoid being charged a missed appointment fee of 100%. I agree to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees as well as any other applicable fees.***

Patient's Full Name (please print): \_\_\_\_\_  
First Middle Last

Date of Consent: \_\_\_\_\_  
Day Month Year

X \_\_\_\_\_

Signature of Patient (or legal guardian)

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Patient Consent Form for Collection, Use and Disclosure of Personal Information  
Your Naturopathic Doctor understands the importance of protecting your personal information.

To help you understand how she does that, here is an outline of how your Naturopathic Doctor may use and disclose this information:

- To assess your health concerns
- To provide health care
- To advise you of treatment options
- To establish and maintain contact with you
- **To inform you of change of location/moving**
- To send you newsletters and other information mailings
- To remind you of upcoming appointments
- **To communicate with other treating health-care providers i.e. MDs, NDs, Osteopaths**
- To allow your Naturopathic Doctor to efficiently follow-up for treatment, care and billing
- To invoice for goods and services
- To process payments
- To collect unpaid accounts
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others
- To be used for research purposes. Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances

By signing this Patient Consent Form, you have agreed that you have given your consent to the collection, use and/or disclosure of your personal information as outlined above.

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*I have reviewed the above information that explains how my Naturopathic Doctor will use my personal information, and the steps that she is taking to protect my information.*

*I agree that my Naturopathic Doctor can collect, use and disclose personal information about \_\_\_\_\_ as set out above in the information about my*

*(Patient Name)*

*Naturopathic Doctor's privacy policies.*

Patient's Full Name (please print): \_\_\_\_\_  
First Middle Last

Date of Consent: \_\_\_\_\_  
Day Month Year

X \_\_\_\_\_  
Signature of Patient (or legal guardian)