



### Pediatric Naturopathic Intake Form

Welcome to our clinic. The pediatric health questionnaire provides valuable information on factors which contribute to the underlying causes of your child's health concerns. Please fill out the questions to the best of your ability and bring the form in with you to your first visit.

#### GENERAL CONTACT INFORMATION

Child's name: \_\_\_\_\_ Blood Type: \_\_\_\_\_  
(last name) (first name) (middle initial)

Age: \_\_\_\_\_ Gender:  Female  Male Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
DD MM YY

Address: \_\_\_\_\_  
(street address) (city) (province) (postal code)

Parent/Guardian Name(s): \_\_\_\_\_

Telephone: Cell \_\_\_\_\_ Work \_\_\_\_\_ Home \_\_\_\_\_

Email: \_\_\_\_\_

How did you hear about Dr. Keyes?  Word of mouth,  Webpage,  Tradeshow,  Other \_\_\_\_\_

Person completing this form (name and relationship) \_\_\_\_\_

Who does the child live with? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
(name) (relationship) (telephone)

Medical Doctor: \_\_\_\_\_ Last physical exam \_\_\_\_\_  
(name) (telephone) (month) (year)

Other Health Care providers: \_\_\_\_\_  
(name) (telephone)

#### HEALTH INFORMATION

What is your child's main health concern? \_\_\_\_\_

Please list any other health concerns (physical, emotional, or mental) in order of importance.

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

How do you rate your child's overall health? Poor Fair Good Excellent

#### Medications/Supplements

Please list all your child's current medications (prescription and over-the-counter).

Medication	Dose/day	How long?	Medication	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Please list all your child's current vitamins/minerals, herbs, or homeopathics.

Supplement	Dose/day	How long?	Supplement	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

How many courses of antibiotics has your child had in the past? \_\_\_\_\_

**Allergies (please list all known)**

Allergy	Items	Reaction
Medication		
Foods		
Environmental/ Animal		

Does your child have a medic alert?      Yes                      No

**Environmental Toxic Exposure**

Has your child ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium etc) while at work, home or travelling?                      Y              N

Does your child live near power lines or a refinery?                                      Y              N

Is your child's home and school environments **not** well-ventilated?              Y              N

Is your child exposed to significant tobacco smoke (home, etc.)?                      Y              N

Is your child frequently exposed to animals (pets, etc.)?                              Y              N

Does your child have mercury dental fillings?    Y              N

Does your child have any surgical implants (medical, cosmetic)                      Y              N

Does your child have any body piercings?    Y              N

Has your child ever had any organ transplants/ blood transfusions?              Y              N

Has there been an event or sickness that your child has never fully recovered from? Please indicate below

**Medical history**

Inquiry	Excellent	Good	Fair	Poor	Unknown
Health of mother at time of conception					
Health of father at time of conception					
Health of mother during pregnancy					
Emotional state of mother during pregnancy					
Mother's diet during pregnancy					

**Birth mother's illnesses during pregnancy (circle)**

Hypertension                      Gestational Diabetes                      Pre-eclampsia                      Eclampsia  
 Bleeding                              Excessive Vomiting / Nausea              Anemia                                      Placenta previa  
 Trauma                                      Maternal rubella                              Maternal toxoplasmosis              Cold / Flu  
 Other: \_\_\_\_\_

**Substances used during pregnancy by birth mother (circle)**

Tobacco                              Alcohol                                      Caffeine                                      Recreational drugs  
 Prescription Medications      Herbal Preparations                      Over the counter drugs              Other: \_\_\_\_\_

**Interventions used during the pregnancy (circle):**      Ultrasound                                      Amniocentesis

**Term length of pregnancy (circle)**

Pre-term (37 weeks or less)              Full term (38-42 weeks)                      Post term (42 weeks)

**Type of labour (circle) :**                      Spontaneous                      Induced

**Type of delivery (circle):**                      Vaginal                                      C-section

**Where did the birth take place?**      Hospital                                      Home                                      Other

**Interventions used during the delivery (circle):**      Epidural                                      Forceps                                      Suction

**Complications with the delivery (circle)**

Difficult delivery      Long 2<sup>nd</sup> stage of labour      Breech delivery      Shoulder dystocia                      Other\_\_\_\_\_

**Interventions administered at birth (circle):**              Vitamin K                                      Eye drops

**At birth:** Weight\_\_\_\_\_ Length\_\_\_\_\_ APGAR Scores\_\_\_\_\_



**Typical Food Intake**

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

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

Dinner: \_\_\_\_\_

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

Cravings: sugar salty foods spicy foods (please list) \_\_\_\_\_

Aversions: \_\_\_\_\_

Glasses of **water** per day? Tap\_\_\_\_ Filtered\_\_\_\_ Distilled\_\_\_\_ Reverse Osmosis \_\_\_\_ Spring\_\_\_\_

Cups per day ? Pop \_\_\_\_ Fruit juice \_\_\_\_ Herbal tea \_\_\_\_ Cow's Milk\_\_\_\_

**Please list any dietary restrictions?**  Vegan  vegetarian  Other \_\_\_\_\_

**Lifestyle Patterns**

Is your child currently in school, daycare, at home? \_\_\_\_\_

How would you describe your child's behavior in school / daycare? \_\_\_\_\_

Does this differ greatly from behavior at home? \_\_\_\_\_

Does your child watch TV? Yes No How often? \_\_\_\_\_

Does your child play video games? Yes No How often? \_\_\_\_\_

Does your child play on the internet? Yes No How often? \_\_\_\_\_

Does your child have family time? Yes No How often? \_\_\_\_\_

Does your child get exercise? Yes No How often? \_\_\_\_\_

What does your child like to do for exercise? \_\_\_\_\_

What are your child's hobbies / interests? \_\_\_\_\_

Please write a short description of your child as he/she is currently. Include strengths, weaknesses, fears and major personality traits:

\_\_\_\_\_

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

\_\_\_\_\_

**General**

**Energy**

Rate your child's energy level between: **(low)** 1 2 3 4 5 6 7 8 9 10 **(high)**.

What time your child's energy the highest? \_\_\_\_\_ / lowest? \_\_\_\_\_

**Sleep** (please fill out as pertains to your child)

Bedtime \_\_\_\_\_ Time wakes \_\_\_\_\_ Hours of sleep per night \_\_\_\_\_

Take naps? \_\_\_\_\_ When? \_\_\_\_\_ How long? \_\_\_\_\_

What position does your child sleep in? \_\_\_\_\_

- Difficulty falling asleep  Does not sleep through the night  Wakes unrefreshed
- Nightmares  Sleeps with a night light  Talks in sleep  Sleep walks

**Temperature** (how does your child tend feel most of the time?)

- Warm  Chilly

**Thirst** (what temperature of liquid does your child prefer to drink?)

- Hot  Cold  Room temp.

**Perspiration** (does your child perspire?)

- Excess  Minimal Where? \_\_\_\_\_

**Bowel Habits**

Frequency of stool \_\_\_\_\_ times per day \_\_\_\_\_ times per week \_\_\_\_\_

**Symptom/ Illness Checklist**

Please check (✓) if your child currently experiences the following or write a (P) if they experienced it in the past:

Symptom Checklist

	Past	Now
Appetite change	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
Bed wetting	<input type="checkbox"/>	<input type="checkbox"/>
Burning urination	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bleeding nose	<input type="checkbox"/>	<input type="checkbox"/>
Chronic bruising	<input type="checkbox"/>	<input type="checkbox"/>
Chronic runny nose	<input type="checkbox"/>	<input type="checkbox"/>
Colic / gas / cramping	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>
Cradle cap	<input type="checkbox"/>	<input type="checkbox"/>
Cries easily	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Diaper rash	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Eczema / Hives	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Nights sweats	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
Stomach aches	<input type="checkbox"/>	<input type="checkbox"/>
Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>
Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Visual disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Childhood Illnesses

	Past	Now
Acute epiglottitis	<input type="checkbox"/>	<input type="checkbox"/>
ADHD / ADD	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis (pink eye)	<input type="checkbox"/>	<input type="checkbox"/>
Congenital diseases	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Head lice	<input type="checkbox"/>	<input type="checkbox"/>
Impetigo	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent ear infections	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>
Thrush	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis / Strep throat	<input type="checkbox"/>	<input type="checkbox"/>
Urinary tract infections	<input type="checkbox"/>	<input type="checkbox"/>
Whooping cough	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Thank you for taking the time to fill out these forms.

*Return to nature. Everything we need to heal is in nature.*



**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.

**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 ND 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 dose 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 will 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. I understand that all supplements, labs and naturopathic fees are non-refundable.***

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

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

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



Dr. Katherine Keyes BA, B.Ed, ND  
DOCTOR of NATUROPATHIC MEDICINE

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**Patient Consent Form for Collection, Use and Disclosure of Personal Information**

Your Naturopathic Doctor, Dr Katherine Keyes, 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 your 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.

*I have reviewed the above information that explains how my Naturopathic Doctor, Dr Katherine Keyes, 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)