Dr. Jill Kazuk
Naturopathic Doctor
www.jillkazuknd.com

1062 Portage Avenue
Winnipeg, MB R3G 0S3
P: (204) 774-5521

PEDIATRIC INTAKE FORM Date: _____

Child's Name:_____ Date of birth: _____
Address: _____ Parents/Guardians of child:_____
_____ _____
City: _____ Province: _____ Telephone (Home) _____
Postal code: _____ (Cell) _____
Birthplace: _____ Email address: _____

How did you hear about us? _____
Emergency contact: _____ Relation: _____ Phone number: _____

HEALTH CONCERNS

Please list the child's most important health concerns, in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

When were they last feeling really well? _____

Are they currently receiving medical care? Yes / No
Medical doctor: _____
Clinic Name: _____
Clinic Address: _____ Clinic Phone: _____

MEDICAL HISTORY

Major Traumas / Surgeries / Injuries / Illnesses *Physical, mental, emotional, or spiritual*

Event _____ year _____ Outcome _____
Event _____ year _____ Outcome _____
Event _____ year _____ Outcome _____
Event _____ year _____ Outcome _____

Allergies

Please list any things the child is allergic or sensitive to and what happens when they are exposed to it:

Drugs: _____
Foods: _____
Environmental/Chemical: _____

Current Medications

Please list any prescription medications, over the counter medications, vitamins or other supplements the child is taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Have they ever used antibiotics? Yes / No If so, how many times have they had antibiotics in their life: _____

Has the child ever experienced any of the following illnesses?

○ Rubella ○ Measles ○ Whooping Cough ○ Scarlet Fever ○ Rheumatic Fever ○ Mumps
○ Chickenpox ○ Asthma ○ Polio ○ Other: _____

Has the child ever experienced any of the following conditions?

○ Diaper Rash ○ Cradle Cap ○ Constipation ○ Diarrhea
○ Heat or cold intolerance ○ Trouble with bedwetting ○ Frequent colds ○ Ear infections

Has the child received any of the following vaccinations?

○ DPT ○ MMR ○ HIB ○ Polio ○ TB ○ Flu
○ Smallpox ○ Chickenpox ○ Pneumovaccine ○ Other:_____

Any adverse reactions to, or chronic illness, following vaccination? _____

HEALTH AND DEVELOPMENT

How was the child's health in the first year? ○ Poor ○ Fair ○ Good ○ Excellent

How is the child's health now? ○ Poor ○ Fair ○ Good ○ Excellent

FAMILY MEDICAL HISTORY

Please list if anyone in the biological family has or had any of the following. If you do not have information about the biological family's medical history, please skip.

Cancer _____ Thyroid Issues _____ Mental Illness _____
Diabetes _____ Asthma _____ Addiction _____
Heart Disease _____ Autoimmune _____ Glaucoma _____
High Blood Pressure _____ Kidney Disease _____ Epilepsy _____
Stroke _____ Osteoporosis _____ Alzheimer's _____

Any other relevant family medical history?_____

DIETARY HISTORY

How was the infant fed? ○ Breast fed ○ Formula (milk/soy/other): _____ ○ Other
Any reactions? _____

Did the child ever experience colic? ○ No ○ Mild ○ Moderate ○ Severe

Does the child have any dietary restrictions? _____

Please describe the child's eating habits (e.g., good appetite, picky eater, etc.): _____

Typical Breakfast:_____

Typical Lunch:_____

Typical Supper:_____

Typical Snacks:_____

SLEEP PATTERNS

What time does the child usually go to bed and wake in the morning?_____

Does the child nap during the day? ○Yes ○No If yes, what time(s) do they nap & for how long? _____

Does the child have nightmares? ○ Yes ○ No If yes, how often?_____

Does the child have any problems associated with sleeping? ○ Yes ○ No
If yes, what kind of trouble do they have (e.g., trouble falling asleep, trouble waking up, etc.)?
_____

SOCIAL PATTERNS

Is the child in: ○ school ○ daycare ○ home care ○ other: _____

How would you describe the child's temperament/personality?_____

How would you describe the child's behavior at school? _____

How would you describe the child's behavior at home?_____

What are the child's interests and favorite activities?_____

Is there anything that you would want to see change? _____

If there is anything else you would like to share at this time, please do so in the space below.

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Informed Consent for Treatment

Naturopathic medicine is the treatment and prevention of diseases and disorders by natural means. Naturopathic doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Using a variety of treatment modalities, gentle, non-invasive techniques stimulate the body's inherent healing capacity.

Even the gentlest therapies have their complications. Certain conditions propose higher risk, such as: pregnancy, lactation, those on multiple medications or who have certain diseases such as diabetes, heart, liver or kidney disease, or are very young. To ensure your safety, it is very important that you inform Dr. Kazuk immediately of:

- any disease process that you are suffering from
- if you are on any medication or over the counter drugs
- If you are pregnant, suspect you are pregnant, actively attempting to become pregnant or if you are breast-feeding

I understand that there are some potential health risks to treatment by Naturopathic Medicine. Although rare, these include but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, bruising or injury from venipuncture.

Cancellation Policy and Financial Responsibility Agreement

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 other applicable fees. I understand that **I must give 48 hours notice to change or cancel an appointment**. If I do not follow this cancellation policy, or simply do not show up for my appointment, I agree to pay the fee associated with the Wolseley Wellness Centre cancellation policy.

Privacy Disclosure and Policies

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless directed by myself or when law requires it. I understand that I may look at my medical record at any time and can request a copy or have a report drawn up by paying the appropriate fee.

I intend this consent form to cover my entire course of treatment. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I DECLARE that I have received a full and complete explanation of the naturopathic medical treatment or services that I may receive at Wolseley Wellness Centre and hereby authorize and consent to treatment.

Patient's Full Name (printed): _____Date: _____

Signature of patient or legal guardian:_____