Dr. Amy Velichka ND
True Potential Health Services

# Pediatric Intake Form

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*Please take time to fill out the following information. It provides a basis for further questioning during the visit and helps with the health assessment. All information is for office use only and is strictly confidential.*

**Date of First Visit:**_____

**Patient Information**

Full Name: _____ Date of Birth (D/M/Y): _____ Age:___ Gender(M/F): _____

Address: _____ City: _____ Postal Code:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Parent's/Guardian's Name: _____

How did you find out about the naturopathic services at this clinic? If referred please indicate from whom.

_____

**Contacts** (in order of preference)

1.Name: _____ Phone: (H)_____ (W)_____(C)_____

Adress:_____ Relationship to child:_____

2.Name: _____ Phone: (H)_____ (W)_____(C)_____

Adress:_____ Relationship to child:_____

With whom does the child live?_____

May messages be left relating to your visits? Y/N Which phone number?_____

**Please List Other Health Care Providers**

| 1. | 2. | 3. |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| (____)_____ | (____)_____ | (____)_____ |

**Current Health Concerns:**

What are your child's health concerns, in order of importance:

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

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

Does your child have any 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) | ☐ Haemophilus influenza B | ☐ Hepatitis B |
| ☐ Tetanus booster; when? | ☐ "Flu" | ☐ Hepatitis A |
| _____ | | |
| ☐ MMR (measles, mumps, rubella) | ☐ Polio | |

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 the 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:_____

**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. 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.)?

_____

_____

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

_____

_____

Does your child: ☐ wake early ☐ have difficulty falling asleep ☐ have night terrors ☐ have no sleep problems

How would you describe your child's temperament?

_____

How would you describe your child's behavior 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 | | Other | |
| Juvenile arthritis | | | |

☐ I don't know the family medical history

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 many hours/week does your child: Watch TV _____ Play on computer or video games? _____

How often does your child read (not for school), or How often does someone 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?

_____

_____

**Informed Consent**

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental and emotional aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's healing capacity.

Naturopathic Doctors are required to obtain informed consent and to make sure the patient (and/or guardian) is aware of possible side effects/risks due to treatment. Dr. Amy Velichka ND uses the following in her practice: diet and nutritional counseling, traditional Chinese medicine and acupuncture, botanical medicine, hydrotherapy, massage, homeopathy, IV therapy, and lifestyle counseling. It is important to know that any treatment or advice provided is not mutually exclusive from any treatment or advice that you may now be receiving or may in the future receive from another licensed health care provider. You are at liberty to continue medical care from a medical doctor or any other health care provider licensed to practice in Saskatchewan.

**Individual diets and nutritional supplements** are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, improved gastrointestinal function, enhanced immunity, and general well-being.

**Botanical medicine** is plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.

**Homeopathy** is a form of medicine based on the Law of Similars; that is, the use of tiny doses of the very thing that causes symptoms in healthy people. These minute doses, of plant, animal, or mineral origin, are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

**Asian medicine** includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

**Hydrotherapy** refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

**Lifestyle counselling** involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During the initial visits, Dr. Amy Velichka will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples for further testing, or blood samples for lab investigation.

Even the gentlest of therapies have their complications in certain physiological conditions such as pregnancy and lactation, in very young children, or those with multiple medications. Some therapies must be used with caution in certain diseases including but not limited to diabetes and heart/liver/kidney disease. It is very important therefore that you inform Dr. Amy Velichka, ND immediately if any of the above apply.

There are some risks to treatment by Naturopathic Medicine. These include but are not limited to aggravation of pre-existing symptoms, allergic reactions to supplements or herbs, pain/bruising/injury from acupuncture and massage, fainting or puncturing of an organ with acupuncture needles.

## Consent to Treatment of a Minor

PATIENT INFO:

First Name:_____ Last Name: _____

Age: _____ Male: ☐ Female: ☐

I, _____ authorize Amy Velichka, Doctor of Naturopathic Medicine, to examine and administer Naturopathic care and treatment to _____whose relationship to me is as a _____.

I have been given an explanation of and understand the nature of the naturopathic medical care and treatment. I authorize Amy Velichka, Naturopathic Doctor, to take whatever measures she considers necessary or desirable in connection with such naturopathic care and treatment.

This consent is modified as follows: _____

_____

My name, address and telephone number, or that of another contact person for the patient (whichever is appropriate) is as follows:

_____

_____

DATED at City, in this Province, this _____day of _____, _____.

(month)(year)

_____ _____

Parent or Guardian of Minor – print name Signature

_____

Witness – print name Signature

*Welcome to Naturopathic Medicine!*