Dr. Kelly Brown drkbrownnd@gmail.com

Birch Wellness Center

34 Carlton Street, Winnipeg, Manitoba R3C 1N9

204 505 0325 (f) 204 505 0327

Pediatric Intake Form

Child's Full Legal Name: (Last, First) _____/_____

Parent's Name: (Last, First):_____/_____

Preferred Name:_____Date of Birth:_____Age:_____

Gender: Female □ Male □ Other□_____ E-mail Address: _____

Address: _____

Telephone: home_____/work_____/cell_____

Emergency Contact:_____

Names of other Healthcare Providers:

Medical Doctor _____ Naturopathic Doctor_____

Chiropractor_____ Others _____

Your Main Health Concerns

Why are you bringing your child to the Naturopath today? _____

What are the most important health concerns? Please list in order of importance:

1. _____

2._____

3. _____

Please list vitamin/mineral/herbal supplements you are taking:

Supplement/Brand	Dose	How long have you been taking this supplement?

Please list all current medications:

Medication	Dose	How long have you been taking this medication?

Check each that you currently use:

Laxatives □ Pain relievers □ Antacids □ Cortisone □

Antibiotics □ Allergy medication □ Thyroid medication □

Sleeping pills □ Anti-depressants □ Hormones □

Please list any past medications:

Your past medical history: (Please list any surgeries or illnesses)

Prenatal History

Mothers age at conception: _____ Health Status (circle) POOR FAIR GOOD EXCELLENT

Fathers age at conception: _____ Health Status (circle) POOR FAIR GOOD EXCELLENT

Any difficulty conceiving? Y/N If yes, please explain:

_____

_____

Did the mother use any of the following during pregnancy?

Tobacco □ Alcohol □ Prescription drugs □ Recreational drugs □

Over the counter medication □ Supplements □ Other □ _____

Birth History

Weight at birth: _____

Type of delievery:

Vaginal □ C-Section □ Induced □ Forceps □

Did your child experience any of the following at or after birth?

Jaundice □ Rashes □ Seizures □ Birth injuries □

How was your infant fed?

Breast □ Formula □

For how long? _____

When were solids introduced? _____

What foods were introduced in the first 12 months? _____

Please list any allergies: _____

Family Medical History

	Father	Mother	Brothers	Sisters	Children	Maternal Grandparents	Paternal Grandparents
Age (if living)							
Current Health							
Age at death							
Cause of death							

Is your child exposed to any toxins or chemicals in your home or at work (mold, chemicals, etc)? _____

Has your child been vaccinated?_____ Which vaccines? _____

Has your child travelled recently and to where (Please include Manitoba/North America)? _____

_____

How physically active is your child? What type of activities do they do?

Diet: (Please complete One week diet diary attached to this form)

Has your child ever been on a restricted diet? If so, what kind? _____

How much water do you drink/day? _____

What else do you drink? (Tea, juice, soda, etc.)/day? _____

How frequently do you move your bowels? _____ Per day/week

Diet Diary- attached to back of intake. Please have mother fill out if breastfeeding.

Please check boxes that apply, if symptoms are current or past recurring problem:

GENERAL

Fatigue □	Change in appetite □	Change in thirst □	Cravings □
Weight gain □	Weight loss □	Poor sleep □	Chills or fever □
Night sweats □	Allergies □	Cancer □	Diabetes □

SKIN AND HAIR

Dryness □	Eczema □	Psoriasis □	Acne □
Recent moles □	Hives/allergic reactions □	Loss of hair □	Thinning of hair □
Dandruff □			

EYES, EARS, NOSE, AND THROAT

Eye pain □	Eye strain □	Blurry vision □	Impaired vision □
Cataracts □	Ear aches □	Ear infections □	Ringing in ears □
Vertigo/dizziness □	Sinus infections □	Nasal obstruction □	Post nasal drip □
Nosebleeds □	Loss of smell/taste □	Sores in mouth □	Mercury fillings □
Jaw pain or clicks □	Recurrent sore throat □	Tonsillitis □	Enlarged glands □
Enlarged thyroid □	Facial pain/tics □	Headaches □	

CARDIOVASCULAR

Chest pain □	Palpitations □	High/low blood pressure □	Heart Attack □
Irregular heartbeat □	Pacemaker □	Congestive heart failure □	Artificial heart valve □
Stroke □	Fainting □	Varicose veins □	Deep leg pain □
Swelling of limbs □	Low iron □	Easy bruising □	

RESPIRATORY

Difficulty breathing □	Shortness of breath □	Chronic cough □	Bronchitis □
Emphysema □	Asthma □	Wheezing □	Coughing blood/phlegm □

MUSCLES, BONES, AND JOINTS

Neck/Back pain □	Juvenille Arthritis □	Bursitis □	Joint pain/stiffness □
Artificial joint □	Muscle pain □	Muscle weakness □	

GASTROINTESTINAL

Nausea□	Vomiting □	Vomiting blood □	Reflux or heartburn □
Constant hunger □	Ulcers □	Abdominal pain/cramping □	Bloating □
Gallbladder stones □	Liver disease □	Intestinal parasites □	Gas □
Constipation □	Diarrhea □	Chronic laxative use □	Rectal pain/burning □
Hemorrhoids □	Blood in stool □		

NEUROLOGICAL

Anxiety □	Depression □	Irritability □	Emotional problems □
Loss of balance □	Poor memory □	Dizziness □	Seizures/epilepsy □
Concussions □	Lack of coordination □	Extremity numbness □	Extremity tingling □
Paralysis □			

INFECTIONS

Strep throat □ Mononucleosis (Mono) □ Tuberculosis □

URINARY

Frequent urination □	Urgency to urinate □	Incontinence □	Pain on urination □
Waking at night to urinate □	Urinary tract infection □		Blood in urine □

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Breakfast							
Lunch							
Dinner							
Other/ Snacks							

Consent Form

Full Legal Name: (Last, First, Middle Initial):_____

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

-Potential allergic reaction to supplements or herbs,

-Some aggravation of pre-existing symptoms as a part of healing when using homeopathic remedies

I understand the Naturopathic Doctor will answer any of my questions that I have, to the best of their ability.

I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to treatment by my naturopath. I understand this consent form will cover the entire course of treatment. I understand I am free to withdraw their consent and discontinue participation in these procedures at any time.

Signature of Patient/Guardian:_____

Date:_____