***Naturopathic Intake Form***

*Mind Body Soul Integrative Clinic*

*#302-1630 Pandosy Street Kelowna, V1Y 1P7*

***T: 250-868-0221*** *F: 250-869-4927*



##   CHILD MEDICAL PROFILE (AGE 12 and younger)

Name:       Date:       Address:       City:

Postal Code:       Date of Birth:       Age:

Parent(s) Contact:

Mother’s Name:

Father’s Name:

Home Phone:

Cell Phone:       Email:

Preferred Method of communication: Home [ ]  Cell [ ]  or Email [ ]

How did you find out about our clinic?

Would you like to receive a quarterly newsletter via e-mail? YES [ ]  NO [ ]

Please list your main health concerns in order of importance:

1.       4.

2.       5.

3.       6.

Medications: Supplements:

 NOW PAST NOW PAST

Aspirin [ ]  [ ]  Vitamins [ ]  [ ]

Tylenol [ ]  [ ]  Minerals [ ]  [ ]

Antibiotics [ ]  [ ]  Fluoride [ ]  [ ]

Other:       [ ]  Now [ ]  Past Other:       [ ]  Now [ ]  Past

Childhood Illnesses:

[ ]  chicken pox [ ]  scarlet fever [ ]  mononucleosis

[ ]  red measles [ ]  rheumatic fever [ ]  ear infection(s)

[ ]  mumps [ ]  strep throat [ ]  tonsillitis

[ ]  rubella [ ]  pneumonia [ ]  other:

Immunizations:

Age Immunizations (shots) Dose Date Given /

 Any Reactions?

2 months DTaP 1 of 3

 Hib (Haemophilus influenzae type b)

 Polio (IPV)

 Hepatitis B

 Pneumococcal (PCV) 1 of 3

 Meningococcal (Men-C) 1 of 3

4 months DTaP / Hib / Polio (IPV) 2 of 3

 Hepatitis B

 Pneumococcal (PCV) 2 of 3

6 months DTaP / Hib / Polio (IPV) 3 of 3

 Hepatitis B

 Flu (Influenza) Yearly

12 months Chicken pox (varicella) 1 dose

 MMR 1 of 2

 Meningococcal (Men-C) 2 of 3

 Pneumococcal (PCV) 3 of 3

18 months DTaP / Hib / Polio (IPV) booster 1 of 1

 MMR 2 of 2

4-6 years DTaP / Polio (IPV) 1 of 1 ­­­

 Chicken pox (varicella) 1 dose

 (*Catch up dose if not previously given and no exposure)*

Grade 6 Hepatitis B *(if not previously given)* 2-3 doses ­­­

 Human Papillomavirus (HPV) 3 doses ­­­

 Meningococcal (Men-C) 3 of 3 ­­­

 Chicken pox (varicella) 1 dose ­­­

 (*Catch up dose if not previously given and no exposure)*

Grade 9 Human Papillomavirus (HPV) 3 doses

 *(If not given previously)*

 TdaP 1 dose

 *(Adult formulation; for age 7 and older)*

Other Shots: Age or Date given:

 H1N1

 Hepatitis A

 Pneumococcal (PPV)

 Seasonal Flu

Prenatal/Birth/Neonatal History:

Birth Weight:       [ ]  premature [ ]  late [ ]  full term

Mother’s Health During Pregnancy:

[ ]  age [ ]  bleeding [ ]  extreme nausea

[ ]  illness [ ]  toxemia [ ]  trauma / injury

[ ]  stress [ ]  x-rays [ ]  high blood pressure

[ ]  diabetes [ ]  medications [ ]  cigarettes

[ ]  alcohol [ ]  drugs [ ]  other:

Place of Birth:

Infant Feeding: [ ]  breast fed: if yes, how long?

 [ ]  formula fed: how long and types of formula?

Age solids began:       What foods?

Food allergy/intolerance(s):

Favourite foods:

Sample daily diet (choose a typical day, include liquids):

Hospitalizations/surgeries/accidents/serious injuries and illnesses (describe each

incident and give dates):

Family History (identify all family members who have had any of the following):

[ ]        alcoholism [ ]        allergies

[ ]        anemia [ ]        arthritis

[ ]        asthma [ ]        diabetes

[ ]        eczema [ ]        epilepsy

[ ]        heart disease [ ]        hearing loss

[ ]        hypoglycemia [ ]        mental illness

[ ]        obesity [ ]        stroke

[ ]        thyroid disorder [ ]        other(s)

Patient’s Health History:

Now Past Never Now Past Never

[ ]  [ ]  [ ]  allergies [ ]  [ ]  [ ]  fatigue

[ ]  [ ]  [ ]  anemia [ ]  [ ]  [ ]  frequent infections

[ ]  [ ]  [ ]  asthma [ ]  [ ]  [ ]  headaches

[ ]  [ ]  [ ]  bedwetting [ ]  [ ]  [ ]  heart murmur

[ ]  [ ]  [ ]  birth defects [ ]  [ ]  [ ]  high fever

[ ]  [ ]  [ ]  colic [ ]  [ ]  [ ]  hyperactivity

[ ]  [ ]  [ ]  cough/wheeze [ ]  [ ]  [ ]  insomnia

[ ]  [ ]  [ ]  croup [ ]  [ ]  [ ]  jaundice

[ ]  [ ]  [ ]  depression [ ]  [ ]  [ ]  learning problem

[ ]  [ ]  [ ]  dry skin [ ]  [ ]  [ ]  stuffy nose

[ ]  [ ]  [ ]  earache(s) [ ]  [ ]  [ ]  thrush

[ ]  [ ]  [ ]  eczema/rash [ ]  [ ]  [ ]  vomiting spells

Please include any other important health history not previously listed:

**Declaration and Consent for Naturopathic Care**

I would like to take this opportunity to welcome you to our clinic. As a naturopathic doctor (ND) I will conduct a thorough case history, a physical exam and may utilize specific blood, urinary or other laboratory reports as part of the treatment work-‐up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, intravenous therapy, and lifestyle counseling to assist the body’s ability to heal and improve the quality of life and health.

**Statement of Acknowledgement**

Printed name of patient:

As a patient of Dr. Emina Jasarevic, ND, I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

• temporary aggravation of pre-‐existing symptoms

• allergic reaction to supplements or herbs or injectible therapies

• pain, fainting, bruising or injury from venipuncture or acupuncture

• muscle strains and spasms, disc injuries from spinal manipulations

I also recognize the following:

* I will be given the opportunity to discuss and consent to any treatment plan.
* Any treatment or advice provided to me as a patient of Dr. Jasarevic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. I understand results are not guaranteed.
* I understand that a record will be kept of my visits. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
* I am responsible for payment at the time services are rendered. Dispensary items and laboratory tests must be paid for in full before leaving the office.
* I am aware that 24 hours notice must be given for all cancelled appointments or a cancellation fee will be applied, in addition to any IV’s drawn up for visit.
* I understand that Dr. Jasarevic reserves the right to determine which cases fall outside of her scope of practice, in which case the appropriate referral will be recommended.
* There is a $30 charge for e-mail correspondence, as patients may need and returned phone calls lasting 5-10 minutes.

 [ ]  I consent to receive naturopathic treatment. I understand this consent is voluntary

 and may be revoked at any time.

Signature of patient or guardian:       Date: