cornerstone naturopathic inc.

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(902) 820-3443
(902) 820-3440

Pediatric Intake Form

Child's name _____ **Date** _____

Date of Birth _____ **(M/D/Y)** **Sex: M ❑ / F ❑**

Who is filling out this form (Name and Relation) _____

Contacts (in order of preference)

Name _____ **Phone**
Address _____ **(H)** _____
_____ **(W)** _____
_____ **Email** _____
Relationship to child _____

Name _____ **Phone**
Address _____ **(H)** _____
_____ **(W)** _____
_____ **Email** _____
Relationship to child _____

Name _____ **Phone**
Address _____ **(H)** _____
_____ **(W)** _____
_____ **Email** _____
Relationship to child _____

May we leave messages relating to your visits? Y ❑ / N ❑ **Which Phone Number?** _____

How did you hear about our Dr. MacLeod? Please check one of the following:

❑ Friend/Family
❑ Referral Within This Clinic
❑ Internet
❑ Print advertisement
❑ Health/Wellness Event
Other _____

What are your child's health concerns, in order of importance to you?

1. _____

2. _____

3. _____

4. _____

5. _____

How would you describe your child's general health? Excellent ❑ Good ❑ Fair ❑ Poor ❑

Other healthcare providers your child is seeing:

Name_____	**Name_____**	**Name_____**
Address	**Address**	**Address**
_____	**_____**	**_____**
_____	**_____**	**_____**
_____	**_____**	**_____**
Phone _____	**Phone _____**	**Phone _____**
Fax_____	**Fax_____**	**Fax_____**

Please indicate any serious conditions, illness or injuries, along with approximate dates:

_____

_____

_____

Which of the following conditions has your child had?

❑ Rubella	**❑ Roseola**	**❑ Impetigo**
❑ Measles	**❑ Scarlet Fever**	**❑ Mononucleosis**
❑ Chicken pox	**❑ Whooping Cough**	**❑ Ear infections**
❑ Mumps	**❑ Strep Throat**	

Does your child have any allergies (medicines, environmental, etc.)?

_____

_____

Please all current medications (prescription, over the counter, vitamins, herbs, etc.)

_____

_____

_____

Please list past prescription medications

_____

_____

Did the mother experience any of the following during pregnancy?

❑ **Bleeding**	❑ **Nausea**
❑ **Diabetes**	❑ **Vomiting**
❑ **High blood pressure**	❑ **Physical or emotional problems**
❑ **Thyroid problems**	**Other**_____

Does anyone in the child's household smoke? Y ❑ / N ❑

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

Does your child have any food allergies or intolerances?

_____

_____

_____

Do either of the parents have a chronic illness? Please describe.

_____

_____

_____

---For the following please print and sign or email and sign in-office---

Consent to share information:

I grant my permission to Dr. Colin MacLeod to share my child's confidential health information with their family doctor and other health professionals as necessary.
Signature: _____ Date: _____

Consent to treatment:

- **I understand that: as a naturopathic doctor, Dr. Colin MacLeod does not guarantee treatment results.**
- **Dr. MacLeod will explain to me the nature of the treatment provided and will answer any questions I have.**
- **I am free to withdraw my consent and discontinue treatment at any time.**

Signature: _____ Date: _____