Thompson Valley NATUROPATHIC CLINIC Inc
Dr. Alison Beach, ND
Dr. Clayton Bostock, ND
Dr. Faren Brogan, ND

kamloopsnaturopath.ca
info@kamloopsnaturopath.ca
778-471-2949 778-471-0445
875 Seymour street, Kamloops, BC, V2C 2H6

HEALTH HISTORY INTAKE FORM - CHILD **Date: _____**

(All information is held absolutely CONFIDENTIAL, please fill out all that you feel comfortable with)

Name:			Care Card (PHN)#:
Birth Date:			Age:
Parents Names:	Mom:	Dad:	Address:
Home Phone:			
Work Phone:			
Cell Phone:			
Parent's Email address:			If needed is it appropriate to contact you by email: circle ***Yes*** or ***No***)

Emergency Contact Information:

Name: _____ Relationship to you: _____

Contact Numbers: _____

Names of other Healthcare Providers: _____

Is your child currently under the care of another Physician?_____

Please list any current medications: _____

_____

Please list any current supplements or remedies? _____

_____

How did you hear about our clinic? _____

What are your child's main concerns today and when did they begin?

_____

_____

Have they been diagnosed? _____

Have there been any improvements made? _____

Past/Recent Surgeries? _____

Past/Recent Trauma (Physical and emotional)?

_____

Does your child have any allergies (to medications, pollen, animals or food)?

_____

Please indicate any other problems you would like to discuss: _____

_____

Past Medical History

If your child has any of the following conditions below, please check the appropriate box – **P**ast or **C**urrent.

Condition	P	C	Condition	P	C	Condition	P	C	Condition	P	C
Acne			Dizzy Spells			Malaria			Tonsilitis		
Allergies			Earaches/Infections			Mononucleosis					
Anemia			Exposure to cigarette smoke			Moodiness			Tuberculosis		
Bed wetting			Epilepsy/seizures			Mumps			Typhoid Fever		
Birth defects			Fatigue			Parasites			Vomiting spells		
Cancer			Frequent Colds and Flu			Pneumonia			Warts		
Chicken Pox			Headache			Rheumatic Fever			Whooping Cough		
Colic			Heart murmur			Rubella			Worms		
Cold Sores			High Fever			Scarlet Fever					
Constipation			Hyperactivity			Skin Disease					
Cough/wheezing			Insomnia			Sinusitis					
Cradle Cap			Jaundice			Strep Throat					
Depression			Learning Disorder			Stuffy nose					
Diarrhea			Low/High BP			Thrush					

Surgeries (year & type)	Hospitalizations (year & reason)	Injuries/Accidents (year & cause)

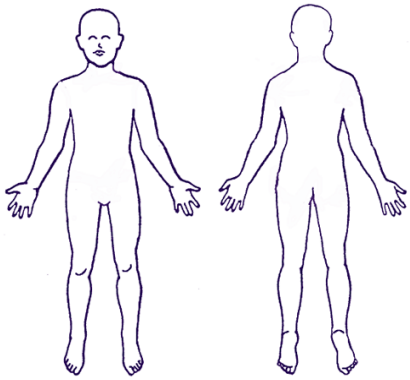
Immunization	Age give	Any Adverse Reactions?
DPT (Diptheria, Pertussis, Tetanus)		
MMR (Measles, Mumps, Rubella)		
Polio		
Haemophilus Influenza Type B (Meninitits)		
Hep-B (Hepatitis B)		

Exam and Imaging History

Indicate date, doctor's name, or place of most recent tests

Physical Exam		**HIV test**	
Pap Smear		**Chest X-ray**	
Prostate Exam		**EKG**	
Mammogram		**STD Screen**	
Colonoscopy		**Cholesterol test**	
TB test		**Blood glucose**	
Bone density test		**Urinalysis**	
Other physical exam		**Fecal Occult Blood**	
Other imaging test		**Other test**	

Circle any painful or distressed areas:



Family Medical History

Has any family member had:	Yes	Which Relative & Age of Onset	Doctor's Notes
Diabetes			
Severe allergies			
Stroke			
Heart Disease			
Heart attack			
Blood Clots in Legs or Lungs			
High Blood Pressure			
High Cholesterol			
Kidney disease			
Osteoporosis			
Hepatitis			
Thyroid Problems			
Colitis/Crohn's Disease			
Tuberculosis			
Birth Defects			
Alcohol or Drug Addiction			
Breast Cancer			
Colon Cancer			
Ovarian Cancer			
Uterine Cancer			
Other Cancer			
Mental Illness/Depression			
Alzheimer's Disease			
Other:			

Lifestyle and Social History

Parents:	Married Separated Divorced	**Doctor's Notes**
Mother's occupation:	Full time: Part time:	
Father's occupation:	Full time: Part time:	
Other guardian (s):	Relationship:	
Number of Siblings		
Daycare, Preschool, School	Hrs per day: Hrs per week:	
Regular Exercise	Type:	

Social	Yes	No	Details	Doctor's Notes
Interacts well with others?				
Good support network of family and friends?			Who?	
What is the child's predominant emotion?				

Lifestyle
Stress Level (please circle): Low Medium High
Stress Source:
What does the child do to relieve stress?
Please rate energy level on a scale from 1-10 (10 = highest energy)

Sleep	Yes	No	Details	Doctor's Notes
Problems falling asleep				
Problems staying asleep				
Regular bedtime?			Typical bedtime?	
Regular wake up time?			Typical wake up time?	
Wake rested in the morning?			Average hours of sleep per night?	
Dreams?				

Diet	Doctor's Notes
Do you follow a particular diet?	
Known food allergies/intolerances?	
What is your child's typical breakfast?	
What is your child's typical lunch?	
What is your child's typical dinner?	
Snacks? Desserts/Treats?	
How many glasses of water consumed per day?	
What other fluids does your child drink and how much per day?	

What is your child's current weight?	
What was your child's weight one year ago?	
What is your child's current height?	

Prenatal/Birth Feeding/Feeding History:

Mother's Health During the Pregnancy with this Patient	Doctor's Notes
_____Age _____Alcohol consumption _____Smoking _____Bleeding _____Stress _____X-rays _____Nausea _____Drugs _____Medications _____Trauma/Injury _____High Blood Pressure _____Other:	
Term: ___Premature ___Full ____ Birth weight	
Was Pregnancy/Birth: ___Easy ___Difficult ____C-section	
Feeding of infant: ___Breast fed – how long? _____ ___Formula fed – how long? _____ Type of Formula _____ Age solids began? _____ Any cow's milk? _____	

Thompson Valley Naturopathic Clinic Inc: Statement of Acknowledgement

Welcome to Thompson Valley Naturopathic Clinic! We are honoured that you have chosen us in your search for optimal health and wellness!

Persons seeking care in our office should understand that Doctors of Naturopathic Medicine are **NOT** Medical Doctors. As such, assessment, diagnosis and treatment of your health concerns may not be typical. If standard medical diagnosis or treatment is required, it must be obtained from a licensed medical doctor.

Naturopathic Medicine uses non-invasive methods for the assessment and treatment of bodily dysfunctions. Naturopathic Medicine emphasises the removal of the underlying cause of disease as opposed to short term alleviation of symptoms. Therefore treatment is usually more detailed and requires longer term commitment and lifestyle change. We ask that each person read, in detail, the following document and ask any questions that he/she may have before treatment is rendered. Your signature acknowledges the following:

1. You understand that Dr. Beach, Dr. Bostock and Dr. Brogan are Naturopathic Doctors, not medical doctors, who work within the Naturopathic scope of practice, and employ some methods which are not orthodox medical practice. If you have any questions regarding the Naturopathic Scope of Practice, please ask.

2. You understand that treatment here and/or referral to other health care practitioners is based upon the assessment of conditions revealed through your personal history and interview, physical assessment, and laboratory testing (where appropriate).

3. While changes in dietary habits are not a prerequisite for treatment, you understand that failure to follow sound nutritional and exercise programs could undermine the expected results.

4. You are not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating your intentions.

5. You accept full responsibility for any fees incurred during care and treatment, and you agree to fully discharge this responsibility **at the time of your visit,** unless prior arrangements have been made. You also acknowledge that we have a **48 hour cancellation policy** and reserve the right to **charge full cost** of the visit for missed appointments, or if insufficient time is given for cancellations.

6. You are accepting/rejecting this care of your own free will and choice. If you have any questions about the treatments suggested, please ask.

7. You understand that you have asked Dr. Beach, Dr. Bostock or Dr. Brogan of Thompson Valley Naturopathic Clinic for help and that they will help to the best of their ability.

8. If you are under the age of 18 years old, we require the signature of your parent or guardian.

I, _____ have read, understood and acknowledge the above statements.
(please print your name)

_____ _____

Date Signature (Parent/Guardian if under 18 years old)