Dr. Gerann Murphy N.D.
Naturopathic Medicine

736 Arlington Park Pl., Kingston, ON K7M 8H9
T: 613.545.0454 E: ArlingtonParkHealth@gmail.com
F: 613.545.2493 W: NaturopathicDoctorKingston.com

Pediatric Intake Form *(Up to 13 Years)*

Every detail you provide on this form will remain confidential, and will contribute to achieving your child's health goals. Where possible, we ask that the child's primary caregiver fill out this form.

Contact Details

Child's Information:

Child's Name: _____ Height: _____ Weight: _____

Date of birth (dd/mm/yy): _____ Age: _____ Gender: _____

Child's Address: _____

Postal Code: _____ Home Tel: _____

Please indicate your relationship to the child: _____

Parent/guardian contact information:

Name: _____

Address: _____

Home Tel: _____ Work Tel: _____

Email: _____

What is the best way for us to contact you? _____

May we leave messages at home or work? _____

How did you hear about Dr. Murphy's naturopathic medical practice? _____

History

Healthcare Practioners:

Please list all other healthcare practitioners caring for your child:

1. _____ Tel: _____
2. _____ Tel: _____
3. _____ Tel: _____

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Health Concerns:

Please list your primary health concerns about your child in order of importance:

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____
4. _____ Date of onset: _____

Medical History

Please list your child's hospitalizations, surgeries, traumas or major illnesses:

1. _____ Date started: _____ Date resolved: _____
2. _____ Date started: _____ Date resolved: _____
3. _____ Date started: _____ Date resolved: _____
4. _____ Date started: _____ Date resolved: _____
5. _____ Date started: _____ Date resolved: _____

Please list any allergies, sensitivities or adverse reactions your child may have (e.g. to medications, foods, chemicals, scents, pets): _____

_____

Please list any medications or supplements (e.g. vitamins, herbal medicines, etc.) your child is **currently taking:**

1. _____ Date started: _____ Dose: _____
2. _____ Date started: _____ Dose: _____
3. _____ Date started: _____ Dose: _____
4. _____ Date started: _____ Dose: _____
5. _____ Date started: _____ Dose: _____

On average, how many times a year is your child on antibiotics? _____

Prenatal History *(Complete if child is under 3 years old or as relevant)*

Were there any complications during the pregnancy (e.g. nausea and vomiting, high blood pressure, gestational diabetes)? _____

_____

_____

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What medications (including supplements, herbal medicines, recreational drugs or alcohol) did the mother take during pregnancy?

1. _____ Dose: _____ Reason: _____
2. _____ Dose: _____ Reason: _____
3. _____ Dose: _____ Reason: _____

Did the mother experience any illness, traumas or hospitalizations during her pregnancy?

1. _____ Date of onset: _____
2. _____ Date of onset: _____
3. _____ Date of onset: _____

What prenatal tests were performed during pregnancy (e.g. ultrasound, amniocentesis)?

1. _____
2. _____
3. _____

Natal History *(Complete if child is under 3 years old or as relevant)*

Your child's delivery was: ☐ Vaginal ☐ C-section ☐ Induced ☐ Early ☐ Late

Your child was delivered at: ☐ Home ☐ Hospital ☐ Other

Were there any complications during labour and/or delivery? Please describe: _____

_____

_____

Please indicate your child's weight at birth: _____ Length: _____

Breastfeeding History *(Complete if child is under 3 years old or as relevant)*

How long was your child breastfed? _____

Did any complications occur during this time? _____

At what age were solid foods introduced? _____

Did any complications occur with the introduction of solid foods? _____

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Development & Behaviour

Please describe any concerns you have about your child's development or behavior:

_____

_____

_____

Lifestyle

Diet:

Please describe a **typical** day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

How much and how often does your child consume the following:

Desserts / sweets: _____ Pop: _____ Fruit juice: _____

Exercise:

Please describe what forms of exercise your child participates in, and how often:

_____

_____

_____

Sleep:

How many hours does your child sleep each night? _____

How many times does he / she wake up in the middle of the night? _____

How often does he / she experience nightmares? _____

Personal:

Please give a brief description of your child's daily routine (e.g. do they attend daycare, public school, wake/sleep schedule, etc.): _____

_____

_____

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Where has your child traveled to outside of this country? _____

_____

_____

What *(if any)* pets reside in the home? _____

Family Health History

Please indicate whether the following health conditions **pertain to anyone in your child's family:**

Condition	Relative	Age of Onset	Details
Heart Problems *(e.g. high blood pressure)*			
Lung Problems *(e.g. asthma)*			
Nervous System Problems *(e.g. seizures)*			
Digestion Problems *(e.g. Celiac disease)*			
Allergies *(moderate / severe)*			
Skin Problems			
Cancer			
Concerns About Weight			
Mental Illness *(e.g. depression)*			
Learning Difficulties			
Drugs / Alcohol Difficulties			
Other			

Emotional Health

Your child's home environment plays a significant role in their health and wellbeing. Please answer the following questions regarding your home and family situation. **Your answers will remain confidential.**

Has your child suffered any emotional traumas (e.g. divorce, death, moving homes)? ☐ Yes ☐ No

Does anyone in your child's home or place of regular attendance smoke? ☐ Yes ☐ No

Is there any alcohol or drug use in your child's home? ☐ Yes ☐ No

Have you ever felt sad or depressed for two weeks or more at a time in the past year? ☐ Yes ☐ No

Do you feel your home is a safe place for your child? ☐ Yes ☐ No

Thank you.

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Informed Consent for Treatment

Naturopathic medicine is a distinct system of primary care that addresses the whole body and root cause of illness and disease. It promotes health by assisting the body's own healing mechanisms according to current medical research and ancient healing knowledge. Naturopathic doctors are primary care providers who integrate standard medical diagnostics with a broad range of natural therapies, including clinical nutrition, herbal medicine, acupuncture, homeopathy and counseling. They work in partnership with other regulated healthcare providers to ensure that patients receive the most effective care possible.

Your child's first naturopathic appointment will generally last 30-60 minutes and may include a physical exam and referral for laboratory tests. Follow-up appointments may range from 15-60 minutes each according to your child's individual health requirements. The first consultation fee is $150 and does *not* include the cost of laboratory testing or prescription items. Follow-up consultation fees are prorated at $150 per hour. OHIP does *not* cover the fees of a naturopathic doctor, however many extended healthcare insurance providers do.

Statement of Acknowledgement

As a parent or legal guardian of _____, I, _____, understand that this form of medicine is based on naturopathic principles and practices. I will inform Dr. Gerann Murphy (N.D.) of all health concerns, medications and medical interventions, including over-the-counter drugs and supplements as relates to my child, because safe care requires that I truthfully and completely disclose of this information.

As a parent or legal guardian of _____, I understand that I am entitled to know about my child's diagnosis and treatment, including costs, benefits, risks and potential side-effects. I am entitled to know consequences of *not* accepting treatment and of alternative courses of action. I am encouraged to request more information as needed, and to take an active role in my child's care. I am aware that I am always at liberty to seek or continue care for my child from another qualified healthcare provider.

I understand that though naturopathic treatments are generally safe and gentle, there may be health risks associated with some naturopathic treatments, including but not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs and bruising or injury during acupuncture.

I understand that Dr. Murphy is not able to guarantee results. I am aware that I am free to withdraw my consent and discontinue treatment at any time. I accept full responsibility for any fees incurred during care and treatment, including a **50% cancellation fee if providing less than 24-hour weekday notice for cancelling appointments** _____ (please initial).

_____ _____

Full Name of Patient Date

_____ _____

Signature of Parent or Legal Guardian Witness

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Consent for Collection, Use and Disclosure of Personal Health Information

You and your child's health privacy is a primary concern. The personal health information disclosed to Dr. Gerann Murphy (N.D.) during your child's appointments will be handled in accordance with current privacy legislation and standards determined by the naturopathic regulatory body, the College of Naturopaths of Ontario. Personal health information includes identifiable information such as age, gender, family status and health history.

Dr. Murphy and administrative staff of Arlington Park Health Professionals will collect, use and disclose information about you and your child for the following purposes:

- To assess your health concerns;
- To provide health care and advise you of treatment options;
- To communicate with other health providers;
- To establish and maintain contact with you;
- To invoice for goods and services, process credit card payments; and
- As required by law.

Administrative staff of Arlington Park Health Professionals will have access to your child's record of personal health information and may come into contact with personal health information that is sent to or from the clinic. They will collect, use and disclose personal health information so as to protect you and your child's privacy and the confidentiality of you and your child's information.

I have reviewed the above information and authorize Dr. Gerann Murphy (N.D.) and administrative staff of Arlington Park Health Professionals to collect, use and disclose personal health information as outlined above.

Name _____ Date _____

Signature _____ Witness _____