DR. SARAH L. SJOVOLD N.D. INC.
LIVSTIL WELLNESS
Naturopathic & Preventive Medicine

PEDIATRIC / ADOLESCENT INTAKE FORM

(CONFIDENTIAL: All information in this form remains confidential and will be released only on your written permission)

PATIENT'S FULL NAME _____ AGE ____ SEX ____ BIRTHDATE month/day/yr _____/_____/_____

NAME YOU PREFER TO BE CALLED _____ PARENT'S NAMES _____

ADDRESS _____ CITY _____ POSTAL CODE _____

HOME PHONE _____PARENT'S WORK PHONE _____(Mother, Father, Other)

PARENT'S EMAIL ADDRESS _____FAMILY PHYSICIAN _____

SPECIALIST _____ PERSONAL HEALTH NO._____

WHO REFERRED YOU TO THIS OFFICE? _____

PRESENT HEALTH PROBLEMS: PLEASE LIST MOST IMPORTANT HEALTH CONCERNS / PROBLEMS

_____

_____

MEDICATIONS:

	Now	Past	Frequency
ASPIRIN	___	___	_____
TYLENOL	___	___	_____
ANTIBIOTICS	___	___	_____
DECONGESTANTS	___	___	_____
_____	___	___	_____

SUPPLEMENTS:

	Now	Past	Frequency
VITAMINS	___	___	_____
MINERALS	___	___	_____
FLUORIDE	___	___	_____
HERBS	___	___	_____
_____	___	___	_____

ALLERGIES: (to medications, pollens, animals or food)

CHILDHOOD ILLNESSES:

___ CHICKEN POX
___ MEASLES
___ MUMPS
___ RUBELLA
___ SCARLET FEVER
___ RHEUMATIC FEVER
___ STREP THROAT
___ PNEUMONIA
___ MONONUCLEOSIS
___ EAR INFECTIONS
___ TONSILLITIS
___ OTHER _____

IMMUNIZATIONS: (age given, any adverse reactions?)

___ DPT (Diptheria, Pertussis, Tetanus)
___ MMR (Measles, Mumps, Rubella)
___ POLIO
___ HAEMOPHILUS INFLUENZA type B (Meningitis)
___ HEP-B (Hepatitis B)

PATIENT'S MEDICAL HISTORY:

	Now	Past	Never
ACNE	___	___	___
ALLERGIES	___	___	___
ANEMIA	_	_	_
ASTHMA	_	_	_
BED WETTING	_	_	_
BIRTH DEFECTS	___	___	___
COLIC	_	_	_
CONSTIPATION	_	_	_
COUGH/WHEEZE	___	___	___
CRADLE CAP	_	_	_
DEPRESSION	___	___	___
DIARRHEA	_	_	_
DIZZY SPELLS	_	_	_
EARACHES	_	_	_
ECZEMA	_	_	_
EXPOSURE TO:			
CIGARETTE SMOKE	___	___	___

	Now	Past	Never
EPILEPSY/SEIZURES	___	___	___
FATIGUE	___	___	___
FREQUENT INFECTIONS	_	_	_
HEADACHES	_	_	_
HEART MURMUR	_	_	_
HIGH FEVER	___	___	___
HYPERACTIVITY	_	_	_
INSOMNIA	_	_	_
JAUNDICE	___	___	___
LEARNING DISORDER	_	_	_
MOODINESS	___	___	___
STUFFY NOSE	_	_	_
THRUSH	_	_	_
VOMITING SPELLS	_	_	_
OTHER _____	_	_	_

SURGERIES (YEAR & TYPE)
_____
_____
_____

HOSPITALIZATIONS (YEAR & REASON) _____
_____
_____

INJURIES/ACCIDENTS (YEAR & CAUSE) _____
_____
_____

OTHER CONDITIONS _____
_____

PLEASE TURN PAGE

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

FATHER (age)* _____ MOTHER (age)* _____ BROTHERS (ages)* _____ SISTERS (ages)* _____

* If deceased, Please list age at death and circle.

IDENTIFY ALL FAMILY MEMBERS WHO HAVE EVER HAD ANY OF THE FOLLOWING (INDICATE FAMILY MEMBER BY F for FATHER, M for MOTHER, B1, B2, S1, etc.).

___ ALCOHOLISM	___ BLEEDING DISORDER	___ HEART DISEASE	___ OBESITY
___ ALLERGIES	___ CANCER of _____	___ HEARING LOSS	___ STOMACH ULCERS
___ ANEMIA	___ COLITIS	___ HIGH BLOOD PRESSURE	___ STROKE
___ ARTHRITIS	___ DIABETES	___ HYPOGLYCEMIA	___ THYROID DISORDER
___ ASTHMA	___ ECZEMA	___ KIDNEY DISEASE	___ TUBERCULOSIS
___ BIRTH DEFECTS	___ EPILEPSY	___ MENTAL ILLNESS	___ OTHER _____

DOES PATIENT HAVE ANY OF THE ABOVE? _____

IF YES, WHICH ONES

_____

PRENATAL / BIRTH / FEEDING HISTORY:

1. MOTHER'S HEALTH DURING THE PREGNANCY WITH THIS PATIENT

___ AGE	___ TRAUMA/INJURY	___ ALCOHOL CONSUMPTION	___ OTHER _____
___ BLEEDING	___ STRESS	___ DRUGS	___ TOXEMIA
___ NAUSEA	___ HIGH BLOOD PRESSURE	___ SMOKING	
___ ILLNESS	___ X-RAYS	___ MEDICATIONS _____	

2. TERM ___ PREMATURE ___ FULL BIRTH WEIGHT _____

3. WAS PREGNANCY / BIRTH ___ EASY? ___ DIFFICULT? ___ C-SECTION?

4. FEEDING OF INFANT

BREAST FED _____ HOW LONG? _____ COW'S MILK? _____

FORMULA FED _____ HOW LONG? _____ TYPE OF FORMULA _____

AGE SOLID FOODS BEGUN _____ WHAT FOODS? _____

ANY FOOD ALLERGIES OR INTOLERANCES? _____ TO WHAT FOODS? _____

5. SAMPLE DAILY DIET (Choose a typical day and include food and liquids)

6. PREVIOUS PREGNANCIES BY NATURAL MOTHER AND ANY COMPLICATIONS

SOCIAL HISTORY:

1. PARENTS: ___ MARRIED ___ SEPARATED ___ DIVORCED

   MOTHER'S OCCUPATION _____ ___ FULL TIME ___ PART TIME

   FATHER'S OCCUPATION _____ ___ FULL TIME ___ PART TIME

2. OTHER GUARDIAN: _____ RELATIONSHIP _____

3. OTHERS RESIDING IN HOME _____ RELATIONSHIP _____

4. DAYCARE/PRESCHOOL/SCHOOL: HOW MANY HOURS EACH DAY? _____ # DAYS OF THE WEEK? _____

5. INTERACTION WITH RELATIVES: WHO? _____ HOW OFTEN? _____

DO YOU HAVE ANY OTHER HEALTH CONCERNS YOU WOULD LIKE TO DISCUSS? PLEASE EXPLAIN.

_____

WHAT IS YOUR INFANT'S / CHILD'S / ADOLESCENT'S DISPOSITION?

_____

INFORMED CONSENT TO TREATMENT

1. I understand that the practitioner will only employ the principles and practices of Naturopathic Medicine for assessment and treatment.

2. I understand that any therapies recommended will be explained to me in full by the practitioner, and that I will give consent to treatment based on informed consent.

3. I understand that the practitioner will recommend medicines when appropriate from an online and onsite dispensary, as well as, from external pharmacies but I am under no obligation to purchase.

4. I understand that I can accept or reject this care by my own free will and choice at any time.

5. I understand that the practitioner is not able to anticipate and explain all risks and complications.

6. I understand that any advice given to me as a patient by the practitioner is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.

7. I understand that I am at liberty to seek, or to continue medical care from another health care provider qualified to practice in BC.

8. I understand that the practitioner is not suggesting to me to refrain from seeking the advice of another health care provider.

9. I understand that the practitioner reserves the right to determine which cases fall outside of her scope of practice, and an appropriate referral will be recommended.

10. I understand that the services offered here are not covered by MSP, and that fees are payable at the time of the appointment, including fees for services, prescriptions, and laboratory tests.

11. I understand that should the practitioner need more time to properly assess and treat during a scheduled appointment that I will be charged for the additional time.

12. I understand that from time to time the practitioner may run behind schedule due to unforeseeable circumstances, and as a result, the start of my scheduled appointment may be delayed.

13. I understand that 48 hours notice is required for appointment cancellation; otherwise, I will be responsible for the cancellation fee.

14. I am not an agent of any private, local, provincial, or federal agency attempting to gather information without so stating.

As a patient of Dr. Sjovold I have read, understood and agree to the above statements.

Signature: _____ Date: _____

INFORMED CONSENT FOR COMMUNICATION

Dr. Sjovold values her relationship with you and would like to send you information electronically relating to her practice. I n order to do this, she is collecting your consent to receive electronic messages from herself in the form of appointment reminders, newsletters, upcoming events and other practice related information. Please take a moment to select either "OPT IN" or "OPT OUT". Opting in will provide Dr. Sjovold consent to communicate with you electronically. Opting out will indicate that you do not wish to receive any electronic communication from us.

☐ **OPT IN** ☐ **OPT OUT**

Signature: _____ Date: _____

Clear Form