

**Dr. Jen Corbeil, ND  
Naturopathic Doctor**

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**PEDIATRIC INTAKE FORM**

**Identifying Information:**

Child's Name: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_

Age: \_\_\_\_\_ School Grade: \_\_\_\_\_ Gender: Male Female Ethnicity: \_\_\_\_\_

Phone Number(s): \_\_\_\_\_

May we leave messages relating to your child's visit? Yes No

Parents' Names: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Emergency Contact phone number (s): \_\_\_\_\_

Who is filling out the form? \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Who is the child living with? \_\_\_\_\_ Is the child adopted? Yes No

Other health care providers (include contact information): \_\_\_\_\_  
\_\_\_\_\_

Child's Health Concerns (list in order of importance): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pregnancy History:**

Health of the parents at conception:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Significant life events occurring in household during pregnancy (with either parent): \_\_\_\_\_  
\_\_\_\_\_

Health of the mother during pregnancy (physical, mental, emotional, spiritual): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mother's age at the child's birth: \_\_\_\_\_ Father's age at the child's birth: \_\_\_\_\_

Mother's diet during pregnancy (please describe typical eating patterns and include any dietary restrictions, i.e. religious, vegetarian, vegan, etc.): \_\_\_\_\_

Significant food cravings and aversions during pregnancy:

Cravings: \_\_\_\_\_

Aversions: \_\_\_\_\_

Prenatal medical care and/or testing received by mother: \_\_\_\_\_

Did the mother experience any of the following during the pregnancy?

- |  |   |
|--|---|
| <input type="checkbox"/> Bleeding                      | <input type="checkbox"/> Diabetes                     |
| <input type="checkbox"/> High blood pressure/Eclampsia | <input type="checkbox"/> Toxemia                      |
| <input type="checkbox"/> Nausea                        | <input type="checkbox"/> Thyroid problems             |
| <input type="checkbox"/> Vomiting                      | <input type="checkbox"/> Physical or emotional trauma |
| <input type="checkbox"/> Bed rest                      | <input type="checkbox"/> Other: _____                 |

Did the mother use any of the following during the pregnancy?

- Tobacco
- Alcohol
- Recreational drugs: \_\_\_\_\_
- Prescription medications: \_\_\_\_\_
- Over-the-counter medications: \_\_\_\_\_
- Supplements: \_\_\_\_\_
- Other: \_\_\_\_\_

Environmental exposures during pregnancy (i.e. new paint, new carpeting, smoke, mold, stress): \_\_\_\_\_

Natural birth or infertility treatment: \_\_\_\_\_ Length of time to conceive: \_\_\_\_\_

Parents' occupations during pregnancy:

Mother: _____	Full-time	Part-time
Father: _____	Full-time	Part-time

Up to what month did the mother work during pregnancy? \_\_\_\_\_

Number of pregnancies: \_\_\_\_\_ Number of deliveries: \_\_\_\_\_ Multiple births: \_\_\_\_\_

**Birth History:**

Place of birth (city, country): \_\_\_\_\_

Setting of birth:      Home                      Hospital                      Other: \_\_\_\_\_

Health care provider attending birth: \_\_\_\_\_

Term length:

- Full
- Premature: \_\_\_\_\_ weeks
- Late: \_\_\_\_\_ weeks

Was the birth (check all that apply)?

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Vaginal   | <input type="checkbox"/> Forceps          |
| <input type="checkbox"/> C-section | <input type="checkbox"/> Vacuum           |
| <input type="checkbox"/> Induced   | <input type="checkbox"/> Anaesthesia used |

Did the child experience any of the following at or shortly after birth?

- Birth defects: \_\_\_\_\_
- Birth injuries: \_\_\_\_\_
- Respiratory difficulties
- Failure to thrive
- Difficulty regulating blood sugar
- Seizures
- Jaundice
- Rashes
- Poor weight gain
- Other: \_\_\_\_\_

Length of labour: \_\_\_\_\_

Child's weight at birth: \_\_\_\_\_

Child's length at birth: \_\_\_\_\_

**Medical History:**

How would you describe your child's general state of health? \_\_\_\_\_

Does your child have any diagnosed medical conditions? \_\_\_\_\_

List all current medications your child is taking (drugs, vitamins, homeopathics, herbs): \_\_\_\_\_

\_\_\_\_\_

Please indicate if and when your child has had the following illnesses:

Illness	Never had	Mild	Average	Severe
Chicken Pox				
Ear Infection				
Impetigo				
Measles				
Mononucleosis				
Mumps				
Roseola				

Illness	Never had	Mild	Average	Severe
Rubella (German measles)				
Scarlet fever				
Strep throat				
Whooping cough				

Please indicate any surgeries (including circumcision), hospitalizations, accidents, or other serious illnesses that your child has ever had, with approximate dates: \_\_\_\_\_

\_\_\_\_\_

Please list all previous prescription medications your child has taken: \_\_\_\_\_

\_\_\_\_\_

How many times has your child been treated with antibiotics? \_\_\_\_\_

Please list any known allergies your child experiences (medications, environmental, food)? \_\_\_\_\_

\_\_\_\_\_

Any anaphylactic allergies?      Yes      No      Does your child have an EpiPen?      Yes      No

Has your child been vaccinated for the following:  
(\*PLEASE BRING IMMUNIZATION CARD TO APPOINTMENT\*)

- |   |  |
|---|--|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Polio                         |
| <input type="checkbox"/> MMR (measles, mumps, rubella)        | <input type="checkbox"/> HIB (Haemophilus influenza B) |
| <input type="checkbox"/> Tetanus booster                      | <input type="checkbox"/> "Flu" vaccine                 |
| <input type="checkbox"/> Hepatitis A                          | <input type="checkbox"/> Chicken Pox                   |
| <input type="checkbox"/> Hepatitis B                          | <input type="checkbox"/> Other: _____                  |

Did any vaccinations cause an adverse reaction (please provide details): \_\_\_\_\_  
\_\_\_\_\_

What medical screening tests has your child had (blood, cardiovascular, X-Rays, vision)? \_\_\_\_\_  
\_\_\_\_\_

How does your child behave when they are ill? \_\_\_\_\_  
\_\_\_\_\_

**Developmental History:**

Please indicate the age and ease for the following milestones:

- |                        |                           |
|------------------------|---------------------------|
| Sitting: _____         | Dressing self: _____      |
| Rolling over: _____    | Reading: _____            |
| Crawling: _____        | Puberty: _____            |
| Walking: _____         | Breast development: _____ |
| Talking: _____         | Menstruation: _____       |
| First Tooth: _____     | Growth spurt: _____       |
| First Word: _____      | Voice change: _____       |
| What was it? _____     | Body hair: _____          |
| Toilet training: _____ |                           |

Describe the social habits of your child (plays alone, lots of friends, shares well, friends all older/same age):  
\_\_\_\_\_  
\_\_\_\_\_

Behavioural concerns: \_\_\_\_\_

Concentration/memory/learning concerns: \_\_\_\_\_  
\_\_\_\_\_

How is their performance at school? \_\_\_\_\_

How do you know when your child is upset? \_\_\_\_\_  
\_\_\_\_\_

How would you describe your child's temperament? \_\_\_\_\_  
\_\_\_\_\_

Has your child experienced any significant life events, positive or negative (moves, divorce, trauma, celebrations, travel):  
\_\_\_\_\_  
\_\_\_\_\_

**Food History:**

How was your child fed as an infant?

- Breastfed. How long? \_\_\_\_\_
- Formula. What type? \_\_\_\_\_
- Other: \_\_\_\_\_

Were there any concerns when weaning your child off the above? \_\_\_\_\_

Indicate what age your child was introduced to the following foods:

- |                    |                   |
|--------------------|-------------------|
| Dairy: _____       | Grains: _____     |
| Eggs: _____        | Bread: _____      |
| Beans, Soy: _____  | Fruit: _____      |
| Meat: _____        | Vegetables: _____ |
| Nuts, Seeds: _____ |                   |

Does your child have any food cravings (past or present)? \_\_\_\_\_

Does your child have any food aversions (past or present)? \_\_\_\_\_

Does your child have any food allergies/ intolerances (colic, bloating, mood changes, rashes, phlegm)? \_\_\_\_\_

Please describe a typical day's diet (include beverages):

- Breakfast: \_\_\_\_\_
- Lunch: \_\_\_\_\_
- Snack: \_\_\_\_\_
- Supper: \_\_\_\_\_
- Dessert: \_\_\_\_\_

Is your child a picky eater?                      Yes      No

Does the family eat together?      Yes      No

Where do they eat (at the table, in front of TV)? \_\_\_\_\_

How often does the child eat out? \_\_\_\_\_/month      Where? \_\_\_\_\_

**Sleep History:**

How many hours of sleep does your child get? \_\_\_\_\_ hours

How many hours of sleep does your child need? \_\_\_\_\_ hours

What is your child's bedtime? \_\_\_\_\_      Wake time? \_\_\_\_\_

Do they nap?      Yes      No      Sometimes

Does your child sleep through the night?      Yes      No      Sometimes

Does your child wet the bed?      Yes      No      At what age did they stop? \_\_\_\_\_ years old

Does your child sleep with a night light?      Yes      No      For how long did/do they? \_\_\_\_\_ years

Does your child sleep with the window open, closed, or does it vary? \_\_\_\_\_

Do they sleep covered or uncovered? \_\_\_\_\_      Number of blankets? \_\_\_\_\_

Does your child have nightmares? Yes No Unsure Night-terrors? Yes No Unsure

Describe any known recurrent dreams that your child has: \_\_\_\_\_  
 \_\_\_\_\_

What is your child's sleep position? \_\_\_\_\_  
 What was it as an infant? \_\_\_\_\_

**Environmental History:**

Where has your child lived and at what ages? \_\_\_\_\_  
 \_\_\_\_\_

To where has your child traveled? \_\_\_\_\_

Describe your child's reaction to changes in location/house/environment: \_\_\_\_\_  
 \_\_\_\_\_

Where does your child spend the day?

- Home
- School
- Day care
- Home-schooling
- Other: \_\_\_\_\_

Does your child, or have they ever, lived near:

- Airport
- Industrial area
- Highway/freeway
- Factory
- Farm
- Power plant

Do you know of any toxins or hazards that the child is regularly exposed to (at home, school, work)?

\_\_\_\_\_  
 \_\_\_\_\_

Provide details of the following potential household items:

	Present in home? (yes/no)	Type of product	Frequency of exposure/use
Heating			
Pets			
Air filters			
Air conditioning			
Cleaning products			
Carpets			
Cigarette smoking			

What type of water is drunk at home? Tap Distilled Filtered Spring RO

How would you describe the emotional climate of the child's home? \_\_\_\_\_  
 \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_  
 \_\_\_\_\_

How often does your child exercise? \_\_\_\_\_ hours/week What activities? \_\_\_\_\_

How often does your child watch TV/play computer? \_\_\_\_\_ hours/week

How much does your child read? \_\_\_\_\_ hours/week

How is your child disciplined and by whom? \_\_\_\_\_  
 \_\_\_\_\_

**Family History:**

Please list any major illnesses, medical conditions, and cause and age of death (as applicable):

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Siblings: \_\_\_\_\_

Maternal grandparents: \_\_\_\_\_

Paternal grandparents: \_\_\_\_\_

Other: \_\_\_\_\_

**Review of Systems:**

Please check which apply and give details as appropriate (timing, intensity, characteristics).

	Past	Now	Details:
<b>Skin:</b>			
Rashes			
Bruising			
Eczema, hives			
Dandruff			
Acne, boils			
<b>Head:</b>			
Headache			
Head injury, concussion			
<b>Eyes :</b>			
Impaired vision			
Itching			
Discharge			
<b>Ears:</b>			
Impaired hearing			
Infections, discharge			
Dizziness			
<b>Nose and Sinuses:</b>			
Frequent colds			
Hay fever			
Stiffness			
<b>Mouth and Throat:</b>			
Cavities			
Bleeding gums			
Frequent sore throat			
<b>Chest:</b>			
Cough			
Wheezing			
Asthma			
Chest infections			
Palpitations			
Exercise intolerance			
<b>Abdomen :</b>			
Nausea, vomiting			
Gas, bloating			
Bowel movements (# /day & description)			
Diarrhea, constipation			
Urinary tract infections			
Frequent urination			
<b>Extremities:</b>			
Walking difficulties			
Muscle weakness			
Fractures, sprains			
<b>Generals :</b>			
Fever, chills			
Fatigue			
Seizures			
Phobias, fears, anxieties			

## CONSENT TO SERVICES FORM

### FEE SCHEDULE (as of September 15, 2010):

**Initial visit** (90-120 minutes): \$145

**Follow-up visits** (generally 30-45 minutes): \$75

**Brief/Acute visits** (15 minutes): \$30

**Youth visits (18 and under):** 15% off of regular rate; and note that visit lengths are generally shorter

**Acupuncture visits** (30-45 minutes): \$65

(Initial acupuncture visit if not already a naturopathic patient (60 minutes): \$90)

**Craniosacral therapy and Reiki sessions:** \$75 per hour

**Telephone Consultations\*:** 15 minutes or longer: follow-up visit fees apply

*\* Please note that telephone consultations are generally intended for follow-up consultation and clarification of treatment protocols. Telephone consults are offered to new patients only after an initial visit has been conducted and a treatment plan has been initiated.*

A sliding scale is available, and any special financial arrangements should be made directly with Dr. Jen Corbeil in advance of consultation.

### **Herbal Dispensary & Naturopathic Medicines:**

Jen may recommend that you take certain products as part of your treatment plan. Please note that you are free to choose where you purchase the recommended products, but that certain professional product lines are only available through licensed Naturopathic Doctors. All associated costs will be made aware to the client upon recommendation of specific health products.

### **Booking Appointments:**

Please schedule your appointments in advance, and plan to arrive for appointments on time. Visits that begin late due to a patient's late arrival will be charged the full visit fee.

### **Payment for Services:**

Payment for services is due at the end of each visit and a receipt will be given when payment is received.

Please retain this receipt for your insurance or income tax claims, if applicable. Fees may be paid by cash, cheque, Visa, MasterCard or debit. A surcharge of \$35.00 will apply to all NSF cheques. Please note that refunds are not available for medical services rendered, including lab tests performed. Extended health benefit plans often offer limited coverage for naturopathic medicine. Plans and policies differ, so please check with your provider regarding your coverage and claim procedures.

**Cancelled and Missed Appointments:**

**Please ensure to give at least 24 hrs. cancellation notice.** This will allow for consideration of other patients who would also like to schedule an appointment. For appointments cancelled on the same day or missed appointments, a \$40.00 fee will be charged. Consideration will be given to unforeseeable circumstances.

**Confidentiality:**

Everything that you communicate, directly or indirectly, to Jen Corbeil, ND is confidential, unless you give written permission to disclose information to a third party. Confidentiality is respected at all times. It is important to note that there are exceptions to confidentiality that include the legal and/or ethical obligations to:

1. report incidents of child abuse (physical, sexual or emotional) and neglect;
2. comply with a court ordered subpoena;
3. prevent harm to yourself or another person should such plans be disclosed;
4. report a health professional who has sexually abused a patient

**In Case of Emergency:**

Emergency medical services are not offered by Jen Corbeil, ND. In case of an emergency, patients should dial 911, or proceed to the Emergency Department of the nearest hospital.

**Statement of Acknowledgment**

I, \_\_\_\_\_ have read, understood and agree to the contents herein:  
(Print name)

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**CONSENT TO TREAT FORM**

**Statement of Consent**

Name (please print): \_\_\_\_\_

As a patient of this practice I have read the information and understand that the form of medical care is based on Naturopathic Medical principles. I acknowledge that my Naturopathic Doctor, Jen Corbeil, ND, endeavours to provide the best possible diagnosis and course of treatment, but that no warranty is made with respect to any treatment, action, or medical advice given, as many factors will be important in determining actual results. I also recognize that even the gentlest therapies potentially have their

complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over-the-counter drugs and supplements. The slight health risks of some naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reactions to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains; disc injuries from spinal manipulations.

I also acknowledge that I have the ability to accept or reject this care of my own free will and choice. I give permission and consent to Jen Corbeil, ND, to provide naturopathic consultation, assessment and/or treatment to me [and/or my child \_\_\_\_\_ who is my son/daughter].

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*\*Thank you for taking the time to fill out these forms. Please bring the completed forms in this package with you on your child's first visit.\**