Dr. Glenna Calder ND
8523 Route 19 Port Hood, NS
B0E 2W0
(902) 787-3388
info@beachstonewellness.ca

Pediatric Intake Form

Thank you for taking the time to fill out this form for your child. As an ND, I integrate the unique physical and emotional aspects of your child into his/her treatment program, and the information obtained in this form is of great importance in understanding your child's overall health and well-being. Any questions you may have will be addressed on the first visit.

Child's full name_____ Age_____ Date of Birth_____ Sex? (M/F)_____
Address_____City_____Postal Code_____
Phone_____ Email address_____
Full name of Mother/Guardian _____ Phone (H)_____
Occupation & Location_____ Phone(W)_____ Fax_____
Full name of Father/Guardian _____ Phone (H)_____
Occupation & Location_____ Phone(W)_____ Fax_____
Marital status of parents_____
Please indicate any special living arrangements your child may have_____
Emergency Contact/Number_____ Emergency Contact/Number_____
Names of siblings & ages _____
Family Physician_____ Other Health Care Practitioners_____
How did you hear about this clinic?_____

Health Concerns (in order of importance)?

1.	**2.**	**3.**
4.	**5.**	**6.**

Medical History

Date of last physical exam_____ Height_____ Weight_____ Blood Type_____
Hours of sleep per night?_____ Bedtime?_____ Sleeping problems?_____
Current Medications and Dosages (including over the counter)_____
_____
Past Medications_____
How many times has your child been treated with antibiotics?_____
Current Vitamins, Minerals, Supplements or Herbal products and Dosages_____
_____
Does your child have any allergies?_____ To what?_____
Does your child experience frequent colds and/or flues (now or in the past)?_____
Has your child had X-rays?_____ If so, when and why?_____
Has your child had labwork or other medical testing in the last year? _____ List and explain _____
_____ _____

Please circle which of the following diseases your child has had: *Measles German Measles Chicken Pox Mumps Whooping Cough Strep throat Impetigo Scarlet Fever Mononucleosis Other*_____

Please circle which vaccinations your child has had: *Tetanus Pertussis Diptheria Polio Measles Mumps Rubella Varicella Hepatitis B Influenza Other*_____
Please note any reactions to these vaccinations (fever, etc)_____

Dr. Glenna Calder ND
8523 Route 19 Port Hood, NS
B0E 2W0
(902) 787-3388
info@beachstonewellness.ca

Medical History Continued

Event	Age	Event	Age
1.		2.	
3.		4.	
5.		6.	

Age of mother at conception_____ Mother's health at the time (please circle) *Excellent Good Fair Poor*
Medications taken at conception and during the pregnancy (prescription and over-the-counter)_____
_____
Vitamins/Supplements/Herbs taken at conception and during pregnancy_____
_____
Was this a particularly emotional time for the mother? (Explain)_____

Please circle which of the following the mother experienced during the pregnancy: *Nausea Vomiting Bleeding Diabetes Thyroid Problems High Blood Pressure Pre-Eclampsia Eclampsia Physical Trauma Emotional Trauma* Other_____

Were cigarettes, alcohol or recreational drugs used?_____ Which/How often?_____

•**Biological Father** (where possible)
Age of father at conception_____ Father's health at the time (please circle) *Excellent Good Fair Poor*
Medications/Supplements taken by the father at the time of conception_____
Was this a particularly emotional time for the father? (Explain) _____

Labour History

Place of Birth_____ Vaginal Delivery or C-Section?_____ Length of Labour_____
Was the pregnancy (please circle): *Full term Premature Past term* Were there any complications?_____
Were any medications/interventions used? (ie pitosin, forceps, etc)_____

Neonatal History

Weight_____ Length_____ APGAR scores_____ Any concerns at birth?_____
Was this child breast-fed?_____ Until what age?_____ If no, what formula was given?_____
Were there any feeding problems?_____ Were solid foods given before 6 months of age?_____
Please indicate the approximate age at which the following were introduced: *Formula & Type* _____
*Fruit*_____ *Vegetables*_____ *Soy*_____ *Milk*_____ *Eggs*_____ *Wheat*_____ *Meat*_____
Please explain any adverse reactions_____

Dr. Glenna Calder ND
8523 Route 19 Port Hood, NS
B0E 2W0
(902) 787-3388
info@beachstonewellness.ca

Nutritional Habits

Please describe a typical day's diet for your child:
Breakfast_____
Lunch_____
Dinner_____
Snacks_____
Beverages_____
Please list your child's favorite foods_____

Development and Social Interaction

Do you feel that your child was delayed in reaching any of the following milestones (please circle)? *Holding head* *Smiling* *Rolling over* *Sleeping through the night* *Sitting* *Crawling* *Speaking* *Walking* *Toilet Training* *Reading* *Writing*
Do you feel that this child is growing at an acceptable rate physically, mentally, and emotionally? (Explain)_____
_____
Has your child ever been evaluated for (please circle*)* *Hearing* *Speech* *Language* *Other* Explain_____
How would you describe your child's academic achievement?_____
How would you describe your child's social interaction with peers?_____
How would you describe your child's temperament?_____
Does your child throw tantrums or have any destructive or odd interests which concern you? (Explain)_____
_____
Does your child suffer from any of the following (please circle) *Nightmares* *Daydreaming* *Nervousness* *Moodiness* *Unusual Fears* *Easy crying* *Separation anxiety* *Sleepwalking* *Hyperactivity* *Memory loss* *Fainting* *Seizures*
Explain_____
Has this child ever been a victim of mental, emotional, physical or sexual abuse?_____
Explain_____

Environment

Are there any pets in the child's home?_____ Does he/she have seasonal allergies? _____
Is he/she affected by any of the following? (Please circle) *Perfumes* *Molds* *Trees* *Grasses* *Weeds* *Molds* *Dust* *Animals*
Does anyone smoke inside the child's home?_____
Does your child live/sleep in a basement?_____ Near a farm?_____ On a farm?_____
Approximately what year was your child's home/ dwelling built?_____ How is it heated?_____
Do you use chemicals on your lawn/garden?_____ What is your source of drinking water?_____
Is your child exposed to any chemicals/hazardous materials on a daily basis?_____
Can you think of anything in your child's home/school environment which might adversely affect his/her health (Explain)_____
_____

Dr. Glenna Calder ND
8523 Route 19 Port Hood, NS
B0E 2W0
(902) 787-3388
info@beachstonewellness.ca

Family Medical History: Please check the appropriate box if any family members have had the following conditions

	Mother	Father	Sister/Brother	Grandparents	Other Relative
Autoimmune Disease (Lupus, etc)					
Alcoholism					
Allergies/Asthma					
Anemia					
Arthritis					
Cancer					
Depression/Mood swings					
Diabetes					
Eczema/Psoriasis					
Epilepsy					
Heart Disease					
Hyperactivity					
Kidney Disease					
Learning Disability					
Psychological Disorder					
Other					

Is there anything else that you feel I should know about your child? Please comment.

Dr. Glenna Calder ND
8523 Route 19 Port Hood, NS
B0E 2W0
(902) 787-3388
info@beachstonewellness.ca

Informed Consent

Dr. Calder utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the bodies own ability to heal and to improve the quality of life and health through natural means.
Dr. Calder will conduct a thorough case history. A physical exam, blood and/or urinary lab report may be used as part of the treatment work up.

Statement of Acknowledgment

As a patient of Dr. Calder, I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions, or in very young children, or in 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 not limited to; aggravation of pre -existing symptoms, allergic reaction to supplements, or herbs; pain, fainting, bruising or injury from venipuncture, injections, or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

I understand that a fee may be charged for any missed appointments, or cancellations with less than 24 hour notice.

Fees and Cancellation Policy

Initial Naturopathic Pediatric Visit- 45 minutes- $190.00 (17 years of age and younger)
Pediatric Naturopathic Visit- 30 minutes- $100

Naturopathic medical services are covered under most extended health care plans. Check your policy for details. We will provide a receipt upon payment that you can submit with your claim.
Our confirmation emails **does not eliminate the responsibility** of the patient to take note of and attend their appointments. We require 24 hours notice if you wish to avoid a missed appointment fee for you visit. This is the same price of your visit.
If you need to cancel an appointment, please leave a message on our voice-mail at 902-787-3388
We appreciate you understanding and cooperation.
I have read and understand the cancellation policy

_____	_____	_____
Guardian's Name	Guardian's Signature	Date

_____	_____	_____
Patient Name	Patient's Signature	Date

Welcome to Beachstone Wellness!