Integrated Health Clinic™
working together for your health FORT LANGLEY, BC

NEW PATIENT INTAKE FORM - **YOUTH** (Ages 0 - 13)

Thank you for taking the time to fill out this intake form so that we can provide you with the highest standard of care.

Today's Date: _____ /_____ /_____ Date of Birth: _____ /_____ /_____
MM DD YYYY MM DD YYYY

Child's Name: _____ Preferred name: _____
(First) (Middle) (Last)

Name of person filling out form: _____ Relationship: _____

Age: _____ Gender: _____ Wt: _____ Ht: _____ Care Card #: _____

Home Address: _____ City: _____ Postal Code: _____

Parent's Phone Numbers: Home _____ Work _____ Cell _____

Parent's Email: _____

Emergency contact: Name _____ Home # _____ Cell # _____

How did you hear about us? _____

Family Physician: _____

Other Health Care Provider(s): _____

Allergies, if known (medical, environmental, foods):_____

Number of antibiotic treatments: _____

Screening tests your child has had, if applicable (e.g., blood, hearing, vision):

_____

_____

Current Medication(s) & dosage (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

_____

_____

Past prescription medications:

_____

_____

Family Health History - Has a close relative (parent, grandparent, sibling) has had any of the following:

- ☐ Unknown, my child was adopted
- ☐ Allergies
- ☐ Arthritis, e.g., Juvenile
- ☐ Asthma
- ☐ Diabetes
- ☐ Eczema
- ☐ Kidney disease
- ☐ Cancer; Type/s: _____
- ☐ Mental illness
- ☐ Skin disease
- ☐ Tuberculosis

Any other medical conditions? _____

Please list your child's health concerns, in order of importance to you:

1. _____ 3. _____
2. _____ 4. _____

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Child's general state of health: Excellent / Good / Fair / Poor

Past serious conditions, illnesses, injuries, and/or hospitalizations, with approximate dates:

_____

Which of the following has your child had?

	Never	Mild	Average	Severe
Chicken Pox	☐	☐	☐	☐
Ear Infections	☐	☐	☐	☐
Impetigo	☐	☐	☐	☐
Measles	☐	☐	☐	☐
Mononucleosis	☐	☐	☐	☐
Mumps	☐	☐	☐	☐
Roseola	☐	☐	☐	☐
Rubella, German measles	☐	☐	☐	☐
Scarlet fever	☐	☐	☐	☐
Strep throat	☐	☐	☐	☐
Whooping cough	☐	☐	☐	☐

Immunization History:

☐ My child has not been immunized
☐ DPT (diptheria, pertussis, tetanus)
☐ Haemophilus influenza B
☐ MMR (mumps, measles, rubella)
☐ Hepatitis A
☐ "Flu"
☐ Hepatitis B
☐ Polio

History of adverse reaction(s) to immunization: ☐ Y ☐ N _____

Prenatal Health of the Parents:

(Describe if applicable)

	Unknown	Poor	Good	Excellent
Health of mother at conception	☐	☐	☐	☐
Health of father at conception	☐	☐	☐	☐
Health of mother during pregnancy	☐	☐	☐	☐
Mother's diet during pregnancy	☐	☐	☐	☐

Mother's age at child's birth: _____

Did the mother receive prenatal care: ☐ Y ☐ N Unknown (my child is adopted)

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Experienced by mother during pregnancy:

- ☐ Bleeding
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Nausea
- ☐ Thyroid problem
- ☐ Trauma, physical or emotional
- ☐ Vomiting
- ☐ Other: _____

Used by the mother during the pregnancy?

Tobacco Alcohol Recreational drugs: _____

- Prescription medications: _____
- Over-the-counter medications: _____
- Supplements: _____
- Other: _____

Does either parent have a chronic disease? ☐ Y ☐ N Description: _____

Birth History

- Term length: ☐ Full ☐ Premature: _____wks ☐ Late: _____wks Length of Labour:_____
- Child's weight at birth: _____
- Method of Delivery: ☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps ☐ Anesthesia used

Experienced by child at or shortly after birth?

- ☐ Jaundice
- ☐ Rashes
- ☐ Seizure
- ☐ Birth defect: _____
- ☐ Birth injury: _____
- ☐ Other complication(s): _____

Diet

- Breast fed, how long? _____
- Formula, Type: (milk/soy/other) _____
- Foods introduced before 6 months, with month if known: _____
- Foods introduced at 6-12 months: _____
- Did your child ever experience colic? ☐ Y ☐ N Severity: ☐ mild ☐ moderate ☐ severe
- Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

Typical diet, generally:

- Breakfast: _____
- Lunch: _____
- Dinner: _____
- Snacks: _____
- Beverages, type & amount: _____

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Health & Development:

- Child's health in the first year: ☐ Unknown ☐ Poor ☐ Good ☐ Excellent
- At what age did your child first, if known & applicable:
  Sit up_____ Walk _____
  Crawl_____ Talk_____
- Describe your child's sleep pattern: _____
- Describe your child's temperament? _____
- Describe your child's behavior and performance at school? _____
  (if applicable)

Environment

- Child is in: ☐ school ☐ daycare ☐ home care ☐ other _____
- Child's parents are ☐ married ☐ separated ☐ divorced ☐ other _____
- If parents do not live in the same home, what is the living arrangement for the child? _____

_____

- What are the child's favorite activities? _____
- Does the child exercise regularly? ☐ Y ☐ N Frequency & length of time? _____
- How much television does your child watch? _____ hours per ___day or ___week
- Child reads, or is read to: ☐ daily ☐ several times a week ☐ weekly ☐ less than weekly
- Does anyone in the child's household smoke? ☐ Y ☐ N Animals in the home: ☐ Y ☐ N
- How is the child's home heated? _____
- Toxins or other hazards the child is regularly exposed to: _____
- How would you describe the emotional climate of the child's home? _____
- Is there anything that you feel is important that has not been covered? _____

_____

We currently accept VISA, Mastercard, AMEX and Debit. We are unable to accept cheques.

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Informed Consent to Treatment

1. **I understand that the practitioners at this health centre are Naturopathic Physicians, and will use only natural, non-invasive methods of assessment and treatment.**
2. **I understand that any advice given to me as a patient at Integrated Health Clinic is not mutually exclusive from any treatment or advice I may now, or in the future, be receiving from another health care provider.**
3. **I understand that I am at liberty to seek, or to continue medical care from another qualified health care provider.**
4. **I understand that the Naturopathic Physician reserves the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.**
5. **I understand that I am accepting or rejecting this care by my own free will.**
6. **I understand that no employee or physician at Integrated Health Clinic is suggesting to me to refrain from seeking the advice of another health care provider.**
7. **I understand that the services offered here are not covered by MSP, and that fees are payable at the time of appointment, including fees for services, prescriptions, and laboratory tests.**
8. **I understand that a minimum of 24 hours notice is required for appointment cancellations, otherwise I will be responsible for payment of a cancellation fee of 50% of the service fee. No-Shows will be billed at 100% of the service fee.**
9. **I understand that any therapies recommended will be explained to me in full by the physician, and that I will give consent to treatment based on informed consent.**

I, _____ have read, understood and agree to the above statements.

Signature: _____ Date:_____

Integrated Health Clinic™
Cancer Care Centre FORT LANGLEY, BC

Informed Consent for Communication

We value our relationship with you and would like to send you information electronically relating to Integrated Health Clinic. In order to do this, we are collecting your consent to receive electronic messages from us in the form of *appointment reminders*, newsletters, upcoming events and other clinic information. Please take a moment to select either "OPT IN" or "OPT OUT". Opting in will provide Integrated Health Clinic 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:_____

Thank you for taking the time to complete this intake form. We look forward to working with you to optimize your health and well being.

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