Simmonds McMurrer Naturopathic Clinic

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Child's Name: _____ Date of Birth: _____

Health Card #:_____Insurance Provider:_____Naturopathic coverage_____ $/year

Parent's Names: _____Email: _____

Phone (home): _____ (work):_____ (cell):_____

Address: _____How did you hear about us?_____

Your child's pediatrician and/or Medical Doctor? _____Specialists:_____

What is your primary concern regarding your child's health? _____

What else would you like to see changed in his/her health? _____

What medication(s) is your child currently on?

Medication	Reason	How long

What supplements or vitamins does your child take on a regular basis?

Supplement (including dose)	Supplement (including dose)

What was the level of health of both parents prior to conception?

Father: Poor _____ Fair _____ Good _____ Excellent _____

Mother: Poor _____ Fair _____ Good _____ Excellent _____

What was the level of health of the mother during pregnancy? Poor ____ Fair ___Good ___Excellent ___

Comments: _____

What supplements did you take during pregnancy?

Supplement	Dose

Did you use any of the following during pregnancy?

Cigarettes: Yes ____ If yes, # times/day? ____ No ____ **Vaping: Yes ____ If yes, # times/day? ____ No ____**

Alcohol: Yes ____ If yes, # times/day? ____ No ____ **Cannabis: Yes ____ If yes, # times/day? ____ No ____**

Other drugs: Yes ____ If yes, # times/day? ____ No ____

What medications were you on during pregnancy?

Prescribed	Over the counter

How was your diet during pregnancy?
Poor _____ Fair _____ Good _____ Excellent _____

Birth of the child, please check all those that apply: _____induction _____epidural ____vaginal birth ____C-section birth

Were there any complications: _____

What vaccinations has your child had?

Vaccination	Age	Adverse reaction

Was the baby breastfed? Yes ___No ___If yes, how long was the baby breastfed? _____

What level of health did the baby have within the first 6 months? Poor _____ Fair ____ Good _____Excellent _____

Did he/she have colic? Never: ____ Occasionally: ____ Often: ____ Treatments used? _____

What was the first liquid, apart from breastmilk or water? _____ If formula, indicate brand _____

What solid foods were first introduced and at what age?

Food	Age

What was your child's first illness that was given medical attention?

Illness	Age	Treatment

Please indicate if your child has had any of the following diseases; Roseola, Rubella, Chicken Pox, Mumps, Scarlet Fever, Pertussis (whooping cough), Strep throat, Impetigo, Mononucleosis_____

_____

How many times has your child been treated by antibiotics? _____ Type of antibiotics? _____

List all the medications your child has taken in the past and for what purpose.

Illness	Age	Medication	Adverse reaction

Please give a detailed history of the present health concern and symptoms.

_____

_____

_____

What are your observations about your child's temperament?

_____

Was your child's physical development;

Slower than average _____ Average _____ Faster than average _____

Was your child's emotional/mental development;

Slower than average _____ Average _____ Faster than average _____

How was your child's behavior and performance in school?

_____

Are the child's parents;

Married _____ Common law _____ Separated _____ Divorced _____ Remarried _____

Do any members of the household smoke? Yes _____ No _____

Do either the child's mother or father have a chronic illness? What is their general state of health?

Mother_____

Father_____

Are there brothers and/or sisters? Please list name, age, and state of health. _____

_____

What is the emotional state of the child's home presently? _____

Family History

Are there any of the following diseases in grandparents, parents, or siblings:

Diabetes: _____ type I or II? _____ Cancer: ____ Heart Disease:_____ Mental illness:_____ Alzheimer's Disease: _____

High blood pressure: _____ Thyroid disease: ____ Kidney disease: ____ Chronic pain/inflammation:_____

Digestive disorders: _____ if yes, what? _____ Tuberculosis: _____ Arthritis:_____ if yes, which type? _____

NATUROPATHIC DECLARATION AND CONSENT TO TREATMENT

This is to acknowledge that I have been informed and understand:

1. Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider.
2. I understand that Naturopathic Medicine is a comprehensive approach to health and illness and focuses on prevention and the use of natural, non-invasive methods of treatment and assessment.
3. I understand that any recommended treatments will be explained to me by the naturopathic doctor and that I will give consent to treatment based on informed consent.
4. I am at liberty to seek and/or continue medical care from a medical doctor or other qualified health care provider.
5. I am aware that no part of my treatment or testing is covered by Health PEI and that I am solely responsible for payment.
6. Payment is to be made in full at the time of my treatment. We will provide you with a receipt for submission to your insurance company when services are rendered.
7. Cancellation Policy: If you cannot make a scheduled appointment, please **call 24 hours in advance to reschedule**. Patients will be charged the full fee for a missed appointment.

I _____have read, understood, and agree to the above statements.

Patient's Full Name (please print)

Signature: _____Date of Consent: _____

Patient or legal guardian Day /Month/Year