Paediatric Intake

Please note: This questionnaire will cover many areas of your child's health. You are not required to answer all of these questions, although they are meant to help the practitioner provide you with individualized treatment recommendations. All information shared will be kept strictly confidential.

Date : _____
Child's Name : _____ **Date of Birth :** _____
Parents Name : _____
Address : _____
City : _____ **Province :** _____ **Postal Code :** _____
Phone : _____ **Best Time to Call :** _____
Child's Height : _____ **Child's Weight :** _____ **Blood Type :** A B AB O ?
Child's Weight at Birth : _____
Child's Chief Health Concerns. Please indicate date of onset : _____
_____
_____
_____

Prenatal Health :
Health at time of conception: 1-5 (5 being excellent health)
Mother: 1 2 3 4 5
Father: 1 2 3 4 5
Mother's health during pregnancy: 1 2 3 4 5
Mother's age at the time of child's birth: _____ Prenatal care: Y/N
Duration of Pregnancy: _____weeks

Did mother experience any of the following during pregnancy?
- Bleeding
- Nausea/Vomiting
- Physical Trauma (including forceps, epidural, c-section)
- Toxemia
- High Blood Pressure
- Emotional Trauma/Stress
- Thyroid Issues

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Did mother use any of following during her pregnancy?

- Alcohol: _____
- Recreational Drugs: _____
- Prescription Medications: _____
- Other Medications: _____
- Tobacco:_____
- Supplements:_____

Neonatal Health History:

APGAR Scores: 1 Minute: 5 Minutes
Birth: C-Section_____ Breech:_____

Has your child suffered any of the following:

- Infections: _____
- Rashes: _____
- Jaundice: _____
- Other: _____

Infant feeding: Breast fed? How long? _____
Formula? Describe: _____
Milk? cow goat soy nut other
Age of introduction to solid foods: _____
What foods were introduced first? _____
Was/is the child colicky? Explain: _____

Your child's Diet: _____
_____
_____

Herbs/Vitamins/Medications Child is Currently Taking:

_____
_____
_____
_____

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Vaccinations: Please check off:

○ MMR
○ DPT
○ Hepatitis
○ ChickenPox
○ Measles
○ Typhoid
○ Other : _____

Allergic responses to any? _____

Has your child had any difficulty with the following: (Please check off)

○ Blood pressure
○ Breathing
○ Urination, Bowel movements
○ Skin
○ Bleeding
○ Vision
○ Hearing (ear infections? tubes?)
○ Learning
○ Headaches
○ Nausea/Vomiting
○ Appetite
○ Chicken Pox
○ Ear Infections
○ Frequent Colds
○ Measles
○ Mumps
○ Pneumonia
○ Strep Throat
○ Tonsillitis
○ Whooping Cough

Is your child in daycare? _____

How is the emotional climate of the home (happy, sad, busy etc)? _____
_____

Describe the emotional disposition of your child. _____
_____
_____
_____

Is there anything else we may have missed? _____
_____
_____
_____

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List any Medical Conditions that other Doctors have Diagnosed in your Child

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

Surgeries :

Year	Type of Surgery	Reason

Other Hospitalizations :

Year	Reason

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Family Health History

Including : Allergies, Asthma, Heart Disease, High Blood Pressure, Cancer, Diabetes, Depression, Other Mental Illness, Drug Abuse, Alcoholism, Kidney Disease and Any Other Relevant Health Problems.

	Age	**Significant Health Problems**		**Age**	**Significant Health Problems**
Father			Grandmother (m)		
Mother			Grandfather (m)		
Sibling			Grandmother (p)		
Sibling			Grandfather (p)		
Sibling			Other		
Sibling			Other		

Thank you for taking the time to fill out this intake form. I realize that it is a long and time-consuming process, however, it will help us give you the best possible care.

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PLEASE READ THE FOLLOWING AND SIGN BELOW

CANCELLATIONS & NO SHOWS:
I understand that in the unlikely event of cancellation; Jennifer Pottruff DO(EU), NMD, DBM, RH requires full 24-hour cancellation from me. I understand that I am responsible for full payment of the appointment if the appointment is cancelled with less than 24 hours notice prior to my appointment or I do not show up for my appointment. I also understand that this fee is non-transferrable.

TARDINESS :
I understand that I am to arrive on time for my appointments. I also understand that my session time may be shortened if I am late for my appointment. I will not be discounted or refunded for the shorter amount of session time received.

ACKNOWLEDGEMENT OF FEES :
A reminder, fees are expected at the time of service.

FEE SCHEDULE :

Osteopathy or Herbal Visit
New Patient Visit : $ 100
Follow-up : $ 60

INFORMED CONSENT TO NATURAL HEALTH TREATMENT
Natural medicine is the treatment and prevention of diseases by natural means.

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Manual Osteopaths & Medical Herbalists assess the whole person, including physical, mental, emotional and spiritual aspects of the individual. Manual Osteopaths & Medical Herbalists used a variety of therapeutic approaches, either alone, or in combination. These include nutritional and lifestyle counseling, nutritional supplementation, manual osteopathy, botanical medicine, and homeopathy.
This is to acknowledge that I have been informed and I understand that:

I _____ understand that Jennifer Pottruff DO(EU), NMD, DBM, RH is **NOT** a medical doctor, naturopath or dietician and that she is not legally able to diagnose disease. As such, I acknowledge that is is my responsibility to seek medical diagnosis and advice for my pre-existing, present and future conditions. In consulting with Jennifer Pottruff DO(EU), NMD, DBM, RH, I am exercising my right to choose a complementary method of health support through which to address my total well-being. I realize that outcomes vary for individuals and as with my medical treatment, effectiveness is not guaranteed. I realize that there are some risks, **however rare**, to Natural Medicine. These include but are not limited to: aggravation of pre-existing symptoms or allergic reaction to herbs or supplements. I agree to pay all fees present in the current rate schedule. Insurance plans may cover the services of a Manual Osteopath or Medical Herbalist, receipts are issued at the time of payment to submit to the insurance company for reimbursement. I am here, on this and any subsequent visits, solely on my own behalf and not as an agent for any government, medial or professional agency on a mission of entrapment or investigation. I have fully read this waiver and I sign of my own free will.

I declare that I have received a full and complete explanation of the treatment or services that I may receive by Jennifer Pottruff DO(EU), NMD, DBM, RH and hereby authorize and consent to treatment by Jennifer Pottruff DO(EU), NMD, DBM, RH. I intend this consent to apply to all my present and future natural health care.

Guardian Signature : _____
Print Name : _____ Date : _____

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