Naturopathic Intake Form

Dr Emina Jasarevic ND
Naturopathic Physician

Dr. Mind Body Soul Integrative Clinic
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CHILD MEDICAL PROFILE (AGE 12 and younger)

Name _____ Date _____
Address _____
City _____ Postal Code _____
Date of Birth _____ Age _____

Parent(s) Contact
Mother's Name _____
Father's Name
Home Phone _____ Cell Phone _____
Email _____

Preferred Method of communication: Home ☐ Cell ☐ or Email ☐

How did you find out about our clinic? _____

Would you like to receive a monthly newsletter via e-mail? YES ☐ NO ☐

Please list your main health concerns in order of importance:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Medications:

	NOW	PAST
Aspirin	_____	_____
Tylenol	_____	_____
Antibiotics	_____	_____
Other	_____	_____

Supplements:

	NOW	PAST
Vitamins	_____	_____
Minerals	_____	_____
Fluoride	_____	_____
Other	_____	_____

Childhood Illnesses:

__ chicken pox
__ red measles
__ mumps
__ rubella
__ scarlet fever
__ rheumatic fever
__ strep throat
__ pneumonia
__ mononucleosis
__ ear infection(s)
__ tonsillitis
__ other_____

Immunizations:

Age	Immunizations (shots)	Dose	Date Given / Any Reactions?
2 months	DTaP	1 of 3	_____
	Hib (Haemophilus influenzae type b)		
	Polio (IPV)		
	Hepatitis B		
	Pneumococcal (PCV)	1 of 3	_____
	Meningococcal (Men-C)	1 of 3	_____
4 months	DTaP / Hib / Polio (IPV)	2 of 3	_____
	Hepatitis B		
	Pneumococcal (PCV)	2 of 3	_____
6 months	DTaP / Hib / Polio (IPV)	3 of 3	_____
	Hepatitis B		
	Flu (Influenza)	Yearly	_____
12 months	Chicken pox (varicella)	1 dose	_____
	MMR	1 of 2	_____
	Meningococcal (Men-C)	2 of 3	_____
	Pneumococcal (PCV)	3 of 3	_____
18 months	DTaP / Hib / Polio (IPV) booster	1 of 1	_____
	MMR	2 of 2	_____
4-6 years	DTaP / Polio (IPV)	1 of 1	_____
	Chicken pox (varicella)	1 dose	_____
	(*Catch up dose if not previously given and no exposure)*		
Grade 6	Hepatitis B *(if not previously given)*	2-3 doses	_____
	Human Papillomavirus (HPV)	3 doses	_____
	Meningococcal (Men-C)	3 of 3	_____
	Chicken pox (varicella)	1 dose	_____
	(*Catch up dose if not previously given and no exposure)*		
Grade 9	Human Papillomavirus (HPV)	3 doses	_____
	(If not given previously)		
	TdaP	1 dose	_____
	(Adult formulation; for age 7 and older)		
Other Shots:			Age or Date given:
	H1N1		_____
	Hepatitis A		_____
	Pneumococcal (PPV)		_____
	Seasonal Flu		_____

Prenatal/Birth/Neonatal History:

Birth Weight_____ ___ premature ___ late ___ full term

Mother's Health During Pregnancy:

__ age	__ bleeding	__ extreme nausea
__ illness	__ toxemia	__ trauma / injury
__ stress	__ x-rays	__ high blood pressure
__ diabetes	__ medications	__ cigarettes
__alcohol	__ drugs	__ other _____

Place of Birth _____

Infant Feeding: __ breast fed: if yes, how long? _____

__ formula fed: how long and types of formula?_____
Age solids began: _____ What foods? _____
Food allergy/intolerance(s): _____
Favourite foods: _____

Sample daily diet (choose a typical day, include liquids):
_____
_____
_____

Hospitalizations/surgeries/accidents/serious injuries and illnesses (describe each incident and give dates):
_____
_____
_____

Family History (identify all family members who have had any of the following):

_____ alcoholism	_____ allergies
_____ anemia	_____ arthritis
_____ asthma	_____ diabetes
_____ eczema	_____ epilepsy
_____ heart disease	_____ hearing loss
_____ hypoglycemia	_____ mental illness
_____ obesity	_____ stroke
_____ thyroid disorder	_____ other(s)

Patient's Health History:

Now	Past	Never		Now	Past	Never	
____	____	_____	allergies	____	____	_____	fatigue
____	____	_____	anemia	____	____	_____	frequent infections
____	____	_____	asthma	____	____	_____	headaches
____	____	_____	bedwetting	____	____	_____	heart murmur
____	____	_____	birth defects	____	____	_____	high fever
____	____	_____	colic	____	____	_____	hyperactivity
____	____	_____	cough/wheeze	____	____	_____	insomnia
____	____	_____	croup	____	____	_____	jaundice
____	____	_____	depression	____	____	_____	learning problem
____	____	_____	diarrhea	____	____	_____	moodiness
____	____	_____	dry skin	____	____	_____	stuffy nose
____	____	_____	earache(s)	____	____	_____	thrush
____	____	_____	eczema/rash	____	____	_____	vomiting spells

Please include any other important health history not previously listed:
_____
_____

Declaration and Consent for Naturopathic Care

I would like to take this opportunity to welcome you to our clinic. As a naturopathic doctor (ND) I will conduct a thorough case history, a physical exam and may utilize specific blood, urinary or other laboratory reports as part of the treatment work-up. I integrate supportive therapies like nutrition, herbal medicine, homeopathy, acupuncture, intravenous therapy, and lifestyle counseling to assist the body's ability to heal and improve the quality of life and health.

Statement of Acknowledgement
Printed name of patient: _____

As a patient of Dr. Emina Jasarevic, ND, I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications. The information I have provided is complete and inclusive of all health concerns including possibility of pregnancy and all current medications, including over the counter drugs. Slight health risks of some naturopathic treatments include, but are not limited to:

- temporary aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs or injectible therapies
- pain, fainting, bruising or injury from venipuncture or acupuncture
- muscle strains and spasms, disc injuries from spinal manipulations

I also recognize the following:

- I will be given the opportunity to discuss and consent to any treatment plan.
- Any treatment or advice provided to me as a patient of Dr. Jasarevic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare providers. I understand results are not guaranteed.
- I understand that a record will be kept of my visits. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am responsible for payment at the time services are rendered. Dispensary items and laboratory tests must be paid for in full before leaving the office.
- I am aware that 24 hours notice must be given for all cancelled appointments or a cancellation fee will be applied, in addition to any IV's drawn up for visit.
- I understand that Dr. Jasarevic reserves the right to determine which cases fall outside of her scope of practice, in which case the appropriate referral will be recommended.
- There is a $45 charge for e-mail correspondence, as patients may need and returned phone calls lasting 5-10 minutes.

I consent to receive naturopathic treatment. I understand this consent is voluntary and may be revoked at any time.

Signature of patient or guardian: _____ Date: _____