Jiselle Griffith BSc., N.D.
Naturopathic Doctor

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Naturopathic Pediatric Intake Form

Name: ____
Date of Birth (MM/DD/YY): ______________________
Gender: __________________
Age: ___________________

Home Address(es): ____
____

Parents's Email: **1.** ____
2. ____

Parents's Name & Phone #:
Home: 1. _____________________________________ 2.________________________________
Work: 1. _____________________________________ 2.________________________________
Cell: 1. _____________________________________ 2.________________________________

Parents are (circle): Married Common-Law Separated Divorced Co-parenting
Other Caregivers Name & Phone (Anyone directly involved in patient's care and may attend ND visits)**:** ____
____
____

Family Doctor: __________________________ **Phone:** __________________________
Pediatrician : _____________________ **Phone:** ___________________________

Your reasons for seeking Naturopathic Care:

1. _____________________________________
2. _____________________________________
3. _____________________________________

What factors do you think are causing or contributing to these health concerns?

1. ____
2. ____
3. ____

Medical History

List all accidents, surgeries & hospitalizations, include reason and date occurred

1. ____
2. ____
3. ____
4. ____

Last Physical Exam ____________________ **Last Eye Exam:** ____________________
Last Routine Bloodwork _________________ **Last Dental Visit:** ___________________

Known Allergies (foods, medications, environmental):
____

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____

Current Prescription Medications:

Medication	Dosage	Reason for taking	Date Started

Current Supplements (vitamins, minerals, homeopathic, herbs):

Supplement	Dosage	Reason for taking	Date Started

Please circle

Y(Yes) indicates the child gets the problem regularly; N (No) indicates the child never had the problem; P(past) indicates the child had the problem in the past but not in the last 6 months.:

Ear infections Y N P
Colds Y N P
Strep Throat Y N P
Eczema Y N P
Asthma Y N P

How many times has your child taken antibiotics in their life? ____________________

Vaccinations

Y(Yes) has had all shots/boosters indicated; N (No) never received the vaccine; P(Partial) has had some but not all shots required for the vaccine:

MMR Y N P
DTaP Y N P
HepB Y N P
Hib Y N P
Meningitis C Y N P
Varivax (Chickenpox) Y N P
Poliio Y N P
Pneumococcal Y N P
Gardasil (HPV) Y N P
Influenza/Flu Y N P

Any other Vaccinations?: ____
Any reactions to vaccines? Please describe: ________________________________
____

FAMILY HISTORY (if known)

Family Member	Health Issues (e.g. cancer, heart disease, stroke, diabetes, arthritis, mental health, substance abuse, etc)	Current Age, or age of death
Mother		
Father		

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Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sibling		
Sibling		
Other family		

Prenatal Health
Age of biological mother at conception: __________________
Number of full-term pregnancies for biological mother: __________________
Number of miscarriages/stillbirths for biological mother: _________________

Mother's Health During Pregnancy & Labour

Nausea & Vomiting	Y	N	Preeclampsia	Y	N
Diabetes	Y	N	Anemia	Y	N
High Blood Pressure	Y	N	Positive for GBS	Y	N
Emotional Stress	Y	N			

If yes please describe: ____
____

Length of labour:_______________________________
Interventions (e.g. induction, epidural, vacuum, C-section): ____________________________
____

Health of child at birth: ____

Developmental Milestones
Any concerns about delayed developmental milestones (speech, teething, walking, etc)?:___
____

******Anything else you would like me to know about your child's health?:**
____
____
____
____

N.D. NOTES:

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Minor Consent Form

Naturopathic medicine is the treatment and prevention of disease by natural means. Naturopathic doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are used with children in order to support and stimulate the body's inherent healing capabilities. Naturopathic treatments include nutritional interventions, supplements, botanical medicine, homeopathy, hydrotherapy, traditional Chinese medicine mind-body medicine and counseling.

I hereby request and authorize Jiselle Griffith N.D., to perform diagnostic tests and provide naturopathic treatments to ___________________________________.

As of this date, I have the legal right to select and authorize health care services to the minor child named above.

Signature of Parent/Guardian: ______________________________________

Please print your name: ____

Relationship to patient: ____

Witness signature: ____

Date: ________________________