WINDSOR ESSEX NATUROPATHIC CARE
Dr. Sara Henderson, BSc (Hons), ND – Naturopathic Doctor

CHILD INTAKE FORM
Dr. Sara Henderson, BSc, ND

Name: _____ Date:_____
Date of Birth: _____ Sex: M/F
Postal Code:_____ City:_____
Address: _____ email:_____
Mother name: Fathers Name: _____
If parents are separated, child live primarily with:_____
Phone: (home)_____ (cell)_____

Emergency Contact
Name:_____ Phone:_____
Relation:_____

How did you hear about Dr. Henderson? _____

FEE SCHEDULE	ADULT	CHILD
Consultation (1-1.5 Hours)	$150	$130
Second Visit (45 min)	$100	$80
Follow-up Visits (30 min)	$55	$55

I.V. Therapy $85

Please note that supplements may be prescribed to you to improve your health condition, and they can be purchased from our in-house dispensary, or elsewhere.

EXTENDED HEALTH CARE:

Plan Name:_____ Policy #_____ member ID _____
Plan Name: _____ Policy#_____ member ID _____

Please note if your insurance allows assignment of benefits we will bill directly, otherwise payment is due at time of visit, and we will provide you with an itemized receipt.
Please note that you are responsible for any fees that are not covered by your extended health care provider.

CONSENT TO DIAGNOSTIC TECHNIQUES AND TREATMENT:

I consent to have diagnostic techniques performed by Sara Henderson, ND as deemed necessary to my case. These include a physical exam, orthopedic tests, laboratory tests, Chinese diagnosis, and history taking.
I consent to have treatment techniques performed as deemed necessary to my case. These include clinical nutrition, botanical medicine, homeopathy, hydrotherapy, traditional Chinese medicine, lifestyle counselling, and spinal manipulation.

Signature:_____

Main Health Concern:

_____

How long has this condition persisted? _____
Previous treatments and results:_____

Other health concerns, in order of importance to you:
1._____ 2._____
3._____ 4._____

Medical History:
How would you describe child's general state of health? Excellent Good Fair Poor
Please indicate their energy level out of 10? Morning _____ Mid day_____ Evening_____

Please indicate any serious conditions, illnesses, injuries, or hospitalizations, along with date:

_____ _____
_____ _____
_____ _____

Do you have any allergies (medicines, environmental, food, etc.)?

_____ _____
_____ _____
_____ _____

Please list all current medications (over the counter and prescribed) and supplements:

_____ _____
_____ _____

Immunizations:

Polio	Y N	Pertussis	Y N
Tetanus Shot	Y N	Diphteria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N

Any adverse reactions? Y N If yes, what?_____

Does your child get regular screening tests done by another doctor (allergy testing, blood tests, etc.)?
Y/N

How many days per week does your child eat fast food?_____
Does your child have any dietary restrictions?_____
How long was your child breast fed? _____

Describe a typical day's diet:
Breakfast:_____
_____
Lunch:_____
Dinner:_____
_____
Snacks:
_____
Beverages: _____

How often does your child have a bowel movement? _____
Please describe its appearance:_____
How often does your child urinate per day?_____
How often does your child experience gas/belching? _____

Family History:
Indicate if a close relative (parent/child/sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Arthritis		Other mental illness	
Asthma		Drug/Alcohol abuse	
Heart disease		Thyroid condition	
High Blood Pressure		Kidney disease	
Cancer		Other	
Diabetes		Other	

Is your child involved in any extracurricular activities?
_____

How many hours of sleep does your child get at night?
Does your child wake during the night? Y/N If yes, at what time?_____

How would you describe the emotional climate in your home?_____

Is your child currently in daycare?_____
Do you have any concerns regarding their daycare? _____

Please describe your child's behaviour on a regular basis:
_____

Is there anything that you feel is important that has not been covered?
_____
_____