MICHELLE STHAMANN, ND

CATHEDRAL WELLNESS

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

(Please print clearly)

Child Intake
(Please print clearly)

Contact Information

Child's Name: ____

Date: ____

Date of birth: __________________________ (M/D/Y)

Preferred Pronoun: He She other__________

Who is filling out this form in relation to the child (name and relation to child)?
____

With whom does the child live? _______________________________________

Contacts in order of preference:

1)

Name: ______________________________________ Relationship to child: _____________

Address:____

Apt/unit#:________________________________

City: ___________________________ Province: _______ Postal Code:____________

E-mail: ____

Telephone number: Home:____________ Work:____________ Cell:________________

2)

Name: ______________________________________ Relationship to child: _____________

Address:____

Apt/unit#:________________________________

City: ___________________________ Province: _______ Postal Code:____________

E-mail: ____

Telephone number: Home:____________ Work:____________ Cell:________________

3)

Name: ______________________________________ Relationship to child: _____________

Address:____

Apt/unit#:________________________________

City: ___________________________ Province: _______ Postal Code:____________

E-mail: _______________________________________

Telephone number: Home:____________ Work:____________ Cell:________________

How would you identify your gender identity (please check all appropriate boxes):
__ Female ___ Male ___ Transgender ___________ Alternative: ___________ __ Prefer not to answer

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Other health care providers the child is seeing:

Name:____

Specialty:____________________________________

Phone #: (__________)___________________________________

Date of last visit: ______________

Name:____

Specialty:____________________________________

Phone #: (__________)__________________________________

Date of last visit: ______________

Have you ever consulted for your child (Please check all that apply):

__ Naturopathic doctor __Acupuncturist __Nutritionist __Counselor

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Medical history

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

1) ______________________________

2) ______________________________

3) ______________________________

4) ______________________________

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

1) ______________________________

2) ______________________________

3) ______________________________

4) ______________________________

Please list all current medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

1) ________________

2) ________________

3) _________________

4) ________________

5) ________________

6) ________________

Please list past prescription medications/natural health products:

____

____

How many times has you child been treated with antibiotics?
____

Which of the following has your child had? (N-never, M-mild, A-average, S-severe)

N M A S Rubella (german measles) Roseola N M A S

N M A S Measles Scarlet Fever N M A S

N M A S Chicken Pox Whooping Cough N M A S

N M A S Mumps Strep Throat N M A S

What screening tests has your child had (Blood, hearing, vision, etc.)
____

Please indicate what immunizations you have had:

DPT (diphtheria, pertussis, tetanus) ___ Haemophilus influenza B _____ Hepatitis A ______
Tetanus booster; when? ______"Flu" _________Hepatitis B ________________ MMR (measles, mumps, rubella) ___________Polio _______ Smallpox __________

Other _____________________________________

Please indicate if any caused adverse reactions: __________________________________

Prenatal Health

What was the age of the mother at child's birth?_______________ What was the age of the father at child's birth? ____________________________________

What was the health of the parents at conception?

Mother: poor fair good excellent unknown

Father: poor fair good excellent unknown

Did the mother receive prenatal care? Y N Unknown

Did the mother experience any of the following during pregnancy? Circle any of the following:

Bleeding High blood pressure Nausea Vomiting Diabetes Thyroid Problems Physical or Emotional Trauma

Did the mother use any of the following during pregnancy? Circle any of the following:

Tobacco Prescription Medication Alcohol Over the Counter Medications Supplements Recreational Drugs

Birth History

Term length Full Premature: _________ wks Late _________ wks
Length of labour: ________________ Weight at birth ____________________ Length at birth _________________ Any complications? ____

Was the birth: Vaginal/C-Section Induced Forceps Anesthesia used

Did the child experience any of the following at or shortly after birth?
Jaundice Rashes Seizures

Birth injuries:____

Birth defects: ____

Other ____

Diet

How was your infant fed? Breastfed, how long?______________ Formula. Milk/Soy/other: ___________________________

What foods were introduced:
Before 6 months? (please list approximate month as well)

____
____

6-12 Months?

____
____

Did your child ever experience colic? Yes No How severe? Mild moderate severe

Does your child have any food allergies or intolerances? Please list.

____
____Does your child have any dietary restrictions (religious, vegetarian/vegan etc)?

____
____

Describe a typical day's diet:

Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____
Beverages (and total quantity): ____

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first: Sit up _________________
Walk: ____________________ talk _________________

Crawl ___________________ First tooth__________________

Describe your child's sleep pattern:____
____

How would you describe your child's temperament?

____

How would you describe your child's behavior and performance at school?

____
____

Personal and Family History

Please check the “yes” box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please circle **Past** if the condition is resolved, or **Current** if it is on-going and current

	Yes (✓)	Relation Please circle	Dates Resolved		Yes (✓)	Relation Please circle	Dates Resolved
Alcoholism/Drug addiction		FMSGC	Past Current	High Blood pressure		FMSGC	Past Current
Allergies		FMSGC	Past Current	Heart Disease		FMSGC	Past Current
Anemia		FMSGC	Past Current	Hepatitis		FMSGC	Past Current
Arthritis		FMSGC	Past Current	Headaches		FMSGC	Past Current
Asthma		FMSGC	Past Current	Kidney disease		FMSGC	Past Current
Cancer		FMSGC	Past Current	Stroke		FMSGC	Past Current
Diabetes		FMSGC	Past Current	Tuberculosis		FMSGC	Past Current

Eczema		FMSGC	Past Current	Osteoporosis		FMSGC	Past Current
Epilepsy		FMSGC	Past Current	Others:		FMSGC	Past Current
Depression/other Mental Illness		FMSGC	Past Current				

_____ I don't know my family medical history

Environment

Is the child in: School daycare homecare
other:___________________________________

What are your child's favourite activities
?____
____

Does your child exercise regularly? Y / N

What do they do for exercise, how much, how often?
____
____

How much:
Television does your child watch? ____________________ hours a day/week

Computer time does your child have? ____________________ hours a day/week

Video game time does your child play? ____________________ hours a day/week

Tablet time does your child have? ____________________ hours a day/week

Cell phone time does your child have? ____________________ hours a day/week

How often does your child read (not for school), or how often does someone read to your child?
¨ Daily ¨ Several times a week ¨ Weekly ¨ Less than weekly

Does anyone in the child's household smoke? Y N

Are there animals in the home Y N

How is the child's home heated? Natural Gas Oil Electric Wood Other: ___________

Do you know of any toxin or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe:

____
____

Is the child regularly or has ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials? Please describe:

____
____

Is your child particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc.)?
____
____

How would you describe the emotional climate of your child's home?

____
____

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

Thank you for filling out this comprehensive intake form. I look forward to working with you to regain control over your own health and wellness.

Dr. Michelle Sthamann, ND

Consent to Treatment of Minor

Patient Info:

First Name: ____

Last Name: ____

Age: ____

Male : or Female: ____

I have been given an explanation of and understand the nature of the naturopathic medical care and treatment. I, _____________________ (your name), authorize __________________________ (print name), Naturopathic Doctor, to take whatever measures he/she considers necessary or desirable in connection with such Naturopathic care and treatment to treat __________________________ (print name), a minor.

This consent is modified as follows:

My name, address and telephone number, or that of another contact person for the patient (whichever is appropriate) is as follows:

____

____

DATED at Regina, in the Province of Saskatchewan, this ______ day of ,________________ . (month) ___________ (year).

Michelle Sthamann, Naturopathic Doctor

____

Parent or Guardian of Minor – print *Witness – print name* *Signature*

MICHELLELENA
wellness