Dr. Melissa Bradwell, ND

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PEDIATRIC INTAKE FORM

Date: _____ PHN: _____

Child's Name: _____

Male ☐ Female ☐ Date of Birth (D/M/Y): _____/_____/_____ Age: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Child's Pediatrician/MD: _____

Current Height: _____ Current Weight: _____

Parent / Guardian Contact Information:

Name: _____ Relationship to Child: _____

Address (if different than above): _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell: _____

Work: _____ E-mail: _____

Health History:

How would you rate this child's health? A. Excellent B. Good C. Fair D. Poor

Chief Concern(s):

1) _____

2) _____

3) _____

4) _____

Allergies (food, drugs, animals, herbs, other): _____

_____

Previous Hospitalizations/Surgeries/Serious Illnesses/Complications (include date and location):

_____

_____

Previous Medications (include name, strength, dose, date and duration):

_____

_____

Previous Vaccinations	Date	Child's Reaction (e.g. fever, redness at site, fatigue)
☐ Hep B		
☐ DTaP or DTP		
☐ Hib		
☐ MMR		
☐ Varicella		
☐ Other (please list)		

Vitamins or Herbs (include name, strength, dose, date, and duration):

_____

_____

Pre-natal History:

Did you exercise throughout your pregnancy? _____

Fertility Issues (please list any problems with conception, miscarriages, abortions, use of fertility drugs etc.):

_____

_____

Medications taken during labour and delivery? If yes, please list

_____

_____

Weight Gain during Pregnancy: _____

Diet & Cravings during Pregnancy: _____

_____

General health during pregnancy (circle): A. Excellent B. Good C. Fair D. Poor

How did you feel about the pregnancy? _____

Was there external stress at any time during the pregnancy at home? Work? Please explain:

_____

_____

Nausea / Vomiting during Pregnancy: □ Yes □ No
If yes, how long, and what were the triggers (food, smells, etc.) _____

_____

Medications / Supplements taken during Pregnancy: _____

_____

Mother → Height: _____ Weight: _____ General Health: _____ Age: _____

Father → Height: _____ Weight: _____ General Health: _____ Age: _____

Birth History:

Child's Birth-Weight: _____ Birth Length: _____ Length of Pregnancy (weeks): _____

Child's APGAR Test Scores: _____

If any, describe complications at birth (vaginal birth/C-section, length of labor, epidural, forceps, vacuums, etc.):

_____

_____

Immediately after birth, was there a support network for you (midwives, family)? (Someone to help with any breast feeding issues etc.) Please explain. _____

_____

Child's History:

Breast-feeding: □ Yes □ No If yes, how long, any problems? _____

Mother: any tenderness, insufficient supply? _____

Baby: difficulty latching, disinterest? _____

Formula: □ Yes □ No If yes, what kind? _____

Reactions to Formula: _____

Food introduction: Please list the foods introduced, date introduced (approximately), and any reactions (if any) to the food.

_____

_____

_____

What were/are the child's sleep patterns? When did they change? When did they start sleeping through the night? Any bed-wetting?

_____

_____

Milestones:	**Age:**		**Age:**
▪ Sitting up	_____	▪ Walking	_____
▪ Crawling	_____	▪ Talking	_____
▪ Teething	_____	▪ Potty-trained	_____

Childhood Illnesses:	**Age:**		**Age:**
☐ Chicken pox	_____	☐ Rubeola	_____
☐ Whooping Cough	_____	☐ Mumps	_____
☐ Rubella	_____	☐ Other _____	

Do you have any pets? If so, please list and for how long. _____

_____

Is your child involved in any extracurricular activities? If so, please list. _____

_____

Family History:

Please list ages, health problems, and if passed, please indicate age and cause of death:

	Age	Health Problems (e.g. allergies, congenital conditions, cancer)	Age at Death	Cause of Death
Mother				
Father				

Brother(s)				
Sister(s)				
Grandmother (Mother's side)				
Grandfather (Mother's side)				
Grandmother (Father's side)				
Grandfather (Father's side)				

PLEASE WRITE DOWN ANY OTHER ISSUES YOU'D LIKE TO DISCUSS

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CONSENT FORM

Full Name (please print): _____

As a patient of Dr. Melissa Bradwell, I understand that the form of medical care that I will receive is based on naturopathic principles, practices, and therapies. These may include, but not limited to: IV therapy, nutritional counseling, botanical medicine, traditional Chinese medicine (acupuncture, herbs, cupping), homeopathy, hydrotherapy, and counseling. As with any therapy, including conventional medicine, I understand that no treatment is guaranteed to be successful. I also understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless it is requested by law. Though naturopathic therapies are proven safe when used correctly, I recognize the potential risks that include, but are not limited to: aggravation of pre-existing symptom, allergic reactions to supplements or herbs, pain, fainting or bruising from IV therapy, venipuncture or acupuncture, inconvenience or lifestyle changes.

I have read and understand the above statement, accept the risk and thereby consent to treatment.

I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information without stating.

I accept full responsibility for any fees incurred during care and treatment.

Signature:_____ Date:_____

Witness:_____ Date:_____

Parent/guardian's name (please print): _____

Signature of parent/guardian: _____