Gaia Integrative Clinic
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Child-Patient Information and Consent Form

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____
Suite/Apt./Unit No: _____
City: _____ Province: _____
Postal Code: _____

Gender: Male Female Age: _____ Date of Birth: _____
Month / Day / Year

Name of Primary Caregiver: _____
Relationship to Patient: _____
Work Phone:_____ Extension: _____
Home Phone: _____ Mobile Phone: _____
Fax Number:_____ Other Phone: _____
E-mail: _____
Preferred contact method: _____
May we leave a message? _____

Family Doctor or Pediatrician:
Name: _____ Phone Number: _____
Address: _____

Emergency Contact
Name: _____ Phone Number: _____
Relationship: _____

How did you hear about Gaia Integrative Clinic?

Referral	Website	Newspaper	Yellow Pages
Advertisement	Friend/Family	Other:_____	

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I, (print your name) _____ , acknowledge that as the parent or guardian of (print child's name) _____,a new patient of this clinic, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. I intend this consent form to cover the entire course of treatment my child receives at Gaia Integrative Clinic. With this knowledge, I understand and acknowledge that I may ask questions regarding my child's treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement in your child's condition.

I hereby consent to the collection, use and/or disclosure of my child's personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to my child. I further understand that my child's personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

_____

(parent/guardian's printed name)

_____ _____

(parent/guardian's signature) (date)

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Pediatric Intake Form

Please list your present health concerns in order of importance:

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

Please list any current and previous medications (over the counter and prescription) and supplements (including vitamins, homeopathic and herbal remedies):

_____
_____
_____
_____

Immunization History

VACCINE	DATE	ADVERSE REACTIONS (i.e. - fever, nausea, vomiting, seizures, behavior changes)
DPT-HIIB		
MMR		
Meningitis		
HPV		
Hep-B		
Flu Vaccine		
Chicken Pox		
Polio		
Other		

Childhood Illnesses

	DATE(S)	COMMENTS
Chicken Pox		
Ear Infections		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Rubella		
Scarlet Fever		
Strep Throat		
Whooping Cough		
Other		

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Allergies (include medications, animals, foods, seasonal, pollens etc.)

_____
_____
_____

Patient's Medical History (please check all that apply):

CONDITION	YES	COMMENTS
Asthma		
Cough/Wheeze		
Frequent Infections		
Earache		
Exposure to Cigarette Smoke		
Colic		
Constipation		
Diarrhea		
Vomiting		
Heart Murmur		
Anemia		
Acne		
Eczema		
Cradle Cap		
Jaundice		
Thrush		
Warts		
Epilepsy/Seizures		
High Fever		
Bed Wetting		
Fatigue		
Insomnia		
Dizzy Spells		
Headaches		
Hyperactivity		
Moodiness		
Learning Difficulties		
Depression		
Other		

Surgeries and Hospitalizations (include dates and details): _____
_____
_____

Current Height/Length: _____ Current Weight: _____

Prenatal/Natal History
**if the patient was adopted, please provide as much information as is known*

Mother's Age During Pregnancy: _____
Number of Children: _____

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Father's Age During Pregnancy: _____
How many weeks was the pregnancy? _____

Mother's Health During Pregnancy (check all that apply):

CONDITION	YES	COMMENTS
Alcohol Consumption		
Bleeding		
Cravings		
Depression		
Diabetes		
Exercise		
High Blood Pressure		
Illness		
Nausea		
Over the Counter Medication		
Prescription Medication		
Physical/Emotional Trauma		
Recreational Drugs		
Supplements		
Smoking		
Stress		
Travel		
Thyroid Condition		
Toxemia		
Weight Gain (how much)		
X-Rays		
Other		

Were there any fertility issues surrounding the patient's conception? Y or N
If yes, describe: _____
_____

Briefly describe Mother's diet during pregnancy and prenatal care received (include mediations and supplements):
_____
_____
_____

Briefly describe Father's health during the pregnancy: _____
_____
_____

Did Mother work during the pregnancy? Y or N
If yes, specify occupation and when she stopped working: _____

Briefly describe the pregnancy and birth (include emotional climate of pregnancy as well as length of labour and any complications):
_____
_____
_____

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Circle all that apply: hospital birth OB/Gyn | home birth | vaginal delivery midwife | c-section doula | antibiotics epidural | induction forceps | vacuum

Did Mother experience Post-Partum Depression? Y or N
Details: _____

Natal History

Birth Weight; _____ Birth Length: _____ Head Circumference: _____
APGAR Score: _____ Birth Defects: Y or N If yes, specify _____

Dietary Information

Was the patient breast-fed? Y or N
If yes, how long? _____
If no, describe alternative: _____
Type of Formula: _____
Age Solid Foods Introduced: _____
What foods were introduced before 6 months? _____
_____
What foods were introduced between 6-12 months? _____
_____

Are there any Food Allergies or Intolerances? Y or N
If yes, describe: _____
Describe patient's appetite: _____

24 Hour Diet Diary:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____

Describe any dietary restrictions (vegetarian, vegan, religious etc.)? _____

Developmental History

Describe patient's health in their first year:
_____
_____
_____

At what age did the patient first:
Sit-up: _____ Crawl: _____ Talk: _____
Potty Training: _____ Walk: _____

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Describe patient's dental history including teething, dental visits and cavities:
_____
_____

Describe the patient's typical schedule, including sleep habits: _____
_____

Social History

Parents: Married:_____ Separated:_____ Divorced: _____
Patient lives with: _____
Other's living in the home: _____
Mother's Occupation: _____ F/T or P/T
Father's Occupation: _____ F/T or P/T

Day Care/School
On average how much time does the patient spend at day care/school? _____

Describe the patient's behaviour and performance at school (include teacher comments and relationships with other children): _____
_____
_____

How many hours per day does the patient spend:	HRS
Watching Television	
Reading	
Playing Videogames	
Surfing the Internet	
Playing Outside	
Doing Homework	
Organized Sports/Lessons	

Briefly describe the patient's personality and general disposition: _____
_____

Home Environment

Describe your living environment (ex: house, apartment, new, old)
_____

Is the patient exposed to any of the following (circle all that apply):
cigarette smoke pets mold chemicals (ex: paint)

Describe the emotional climate of your home: _____
_____

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Family History

Please indicate if there is a family history of any of the following:

CONDITION	Relative	CONDITION	Relative
Alcoholism		Epilepsy	
Allergies		Heart Disease	
Anemia		High Blood Pressure	
Asthma		Kidney Disease	
Arthritis		Mental Illness	
Bleeding Disorders		Obesity	
Cancer		Stroke	
Colitis		Thyroid Conditions	
Diabetes		Tuberculosis	
Eczema		Other:	

Does the patient have any of the above conditions: Y or N
If yes, describe: _____

Please list any other comments or concerns: _____
_____
_____
_____
_____

Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of a treatment protocol specific to your child's healthcare needs.

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