

Nature's Touch Naturopathic Clinic

Dr. Maria Papasodaro, ND
A Healing Place: 247 Main St. North
Brampton, ON
L6X 1N3

Thank you for calling to inquire about an appointment with Dr. Maria Papasodaro at Nature's Touch Naturopathic Clinic.

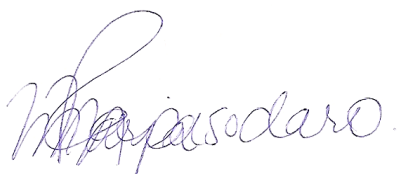
Enclosed is a detailed intake questionnaire. Please fill out the questionnaire and bring it with you to your appointment. The first visit is about one hour in length. The cost of the initial visit is \$150. Follow up visits are about 30 minutes in length and the cost is \$65 + tax.

The first visit includes a review of the detailed intake questionnaire and physical exam. Please bring copies of any blood work or laboratory reports that have been taken within the last six months.

Nature's Touch Naturopathic Clinic is located at *A Healing Place*: 247 Main St. North, Brampton which is between Queen St and Vodden St. The office accepts all standard methods of payment. Most extended health care providers cover Naturopathic treatments; please check with your provider to determine the amount this is covered under your policy. There is free parking at the building, David St or Rosedale Ave. Note that our offices are scent free to respect those clients with allergies or sensitivities.

I look forward to meeting with you. Kindly give us a call at (905) 459-4385 or email from www.naturestouchnd.ca if you have any questions.

Wishing you good health,

A handwritten signature in blue ink that reads "M. Papasodaro". The signature is fluid and cursive, with the first name "M." and the last name "Papasodaro" clearly legible.

Maria Papasodaro
Doctor of Naturopathic Medicine

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Pediatric Intake Form

(please print clearly)

Child's Name: _____ Gender: _____ Age: _____ Date of birth: _____

Height: _____ Weight: _____

Address: _____

House/Apartment/Condo: _____

City: _____ Province: _____ Postal Code: _____

Phone (home): _____ (work): _____

Who is filling out this form? (Name and relationship)

Who does the child live with?

E-mail Address: _____

Would you like to receive free emailed articles written by Maria Papasodaro, ND: _____

Doctor/Pediatrician/ Specialist: _____

****Naturopathic medicine works the best when the doctor has a complete picture of the physical, emotional and mental symptoms. Therefore, please take the time to thoroughly complete this health questionnaire.****

Emergency Contact Information

Name and relation to child: _____

Address: _____

Phone # (home): _____ Work: _____ Cell: _____

May we leave messages relating to your visits? Y / N Which Phone Number? _____

Referred by:

How did you hear about our Clinic? Please check one of the following:

- Newspaper Article/Ad
- Corporate Health/Wellness Event/ Presentation
- Nature's Touch Open House
- A Healing Place staff
- Centennial college faculty
- Friend
- Family
- Nature's Touch patient
- Other _____

Referred by: _____

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Context of Care

1 a. Why did you choose to come to this clinic?

b. What do you know about my approach?

2a. What three expectations do you have from this visit to my clinic?

b. What long term expectations do you have from working with my clinic?

c. What expectations do you have of me personally as your physician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. a) What behaviors or lifestyle habits does your child currently engage in regularly that you believe support their health? (please list)

b) What behaviors or lifestyle habits does your child currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your child's health and in adhering to the therapeutic protocols which we will be sharing with you?

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6. Who do you know that will sincerely support your child consistently with the beneficial lifestyle changes you will be making?

7. What does your child LOVE to do?

Primary Health Concerns

In your opinion, what are your child's most important health concerns?

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

Prenatal Health:

Age of biological mother at the time of the child's birth: _____

Number of previous pregnancies carried to term: _____

Number of previous pregnancies not carried to term (miscarriage, stillborn, abortions) _____

Was the pregnancy planned? Y N Pounds gained during the pregnancy: _____

Describe mother's diet during pregnancy, any food cravings? _____

Did mother exercise during pregnancy? Y N How much and what type? _____

Emotional state of mother during pregnancy: _____

Supplements and medications used during pregnancy: _____

Complications during pregnancy and any tests performed: _____

Prenatal Health- Father's Health before Conception

Father's age at child's birth: _____

Did the father smoke prior to conception? Y N During the pregnancy? Y N

If yes, what amount: _____

Did the father use drugs or alcohol preconception? Y N

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If yes, type and amount:

Please check if any of the following occurred during the biological mother's pregnancy:

Difficulty getting pregnant		Hypertension	
Infertility drugs used		Diabetes	
In vitro fertilization		Pre-eclampsia	
Drink alcohol		Bleeding	
Smoke tobacco before conception		Excessive vomiting, nausea >3 weeks	
Smoke tobacco during pregnancy		Travel	
Have a viral infection		Colds/Flus	
Have a yeast infection		Group B strep infection	
Have amalgam fillings put in teeth		Have house exterminated	
Have any amalgams removed from		Have house painted	
How many fillings in teeth during		Chemical exposure	
Have an x-ray		Family Support	

Natal History:

Place of birth: Hospital ____ Home ____ Clinic ____ Other _____

Delivered by whom? _____

Length of pregnancy (weeks): _____ Was pregnancy: EASY DIFFICULT

Describe _____

Length of labor: _____ Induced ____ Caesarian ____ Interventions used (eg. forceps, vacuum, c-section)? _____

Length of hospitalization for mother: _____ Baby: _____

Describe any physical or emotional complications with the delivery: _____

Did breastfeeding begin immediately? Y N. If no, when did it begin? _____

Please place a check mark beside any of the following conditions that applied to your baby at birth

Seizure ____	Respiratory distress ____	Jaundice ____	Problems with feeding ____
Vitamin K Administered ____	Antibiotic Eye Drops ____	Congenital Abnormalities ____	Respiratory Abnormalities ____

Describe any complications for the mother or the baby after the birth: _____

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Baby's birth weight: _____ Baby's birth length: _____ Head circumference _____
 APGAR Scores: _____

Developmental History:

Please indicate the approximate age for the followings:

Weaned		Absent bedwetting		Took first steps	
Sitting up		First words		Walked alone	
Crawling		Spoke clearly		Dressed self	
Pulled to stand		Ate solid foods		Tied shoe laces	
Potty trained		Fed self		Rode 2-wheeled bike	

Please explain any developmental problems: _____

Is this impression shared by others caring for your child? (doctors, caretakers, friends etc) Y N

Medical History/Review of Systems:

Please put an N if your child has the condition now, P for in the past, B for both)

Abdominal bloating		Diphtheria		Meningitis	
Acne		Dizziness		Mitral valve prolapse	
Allergies-Seasonal		Earaches		Mononucleosis	
Allergies-Environmental		Early menses (<age 12)		Multiple Sclerosis	
Anal fissures		Eczema		Mumps	
Anemia		Encephalitis		Nose bleeds	
Anxiety		Eye crusting		Palpitations(fast heart rate)	
Appendicitis		Fevers		Paralysis	
Asthma		Frequent infections		Pleurisy	
Back aches		Frequent runny nose		Pneumonia	
Bladder infection		Headaches		Polio	
Body odour		Heart murmur		Psoriasis	
Bronchitis		Hemorrhoids		Recurring ear infections	
Cancer		Herpes		Rheumatic fever	
Cerebral Palsy		High blood pressure		ringing in the ears	
Conjunctivitis		HIV		Roseola	
Cold sores		Hives/rashes		Rubella	
Colic		Hyperthyroid		Scarlet fever	
Colitis		Hypoglycemia		Seizures	
Constipation		Hypothyroid		Severe head injury	
Cough/wheezing		Indigestion/ Gas		Strep throat	
Cradle cap		Influenza		Tonsillitis	
Croup		Impetigo		Ulcers	
Diaper rash		Jaundice		Vitilgo	

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Diabetes		Joint pain		Vomiting	
Diarrhea		Measles		Whooping cough	

Hospitalizations/Surgeries and dates:

Congenital abnormalities:

Dental History:

Was the process of teething was difficult for your child? Y N Age of first teeth: _____

Has your child been to the dentist? Y N Is your child's toothpaste fluoridated? Y N

Does your child grind teeth? Y N Do their gums bleed? Y N

Describe any dental work done:

Describe your child's oral hygiene practice:

Vision History:

Has your child's eyes been checked? Y N Does your child wear glasses? Y N

Does your child have poor eye contact? Y N

Describe any vision problems: _____

Bowel/Urinary Habits:

Frequency of stool: _____ times per day, _____ times per week

Describe the stool _____

Does your child have pain on passing stool? Y N

Have you noticed any abnormalities in your child's stools? (colour changes, consistency, undigested foods) _____

Does your child experience any urinary tract infections? Y N

Urinary odor: Y N Urinary hesitancy: Y N Urinary urgency: Y N

Sleep:

Time child wakes up at _____ time child goes to sleep at _____ How many hrs./night _____

Position child sleeps in _____ Temperature of child while sleeping _____

I would rate my child's sleep as: _____ (Scale of 1-10, Where 10 is excellent and 1 is poor.)

Please check if your child experiences the following:

	YES	NO	COMMENTS
Dreams/nightmares			
Naps (time and length)			
Refreshed after sleeping			
Uninterrupted sleep			
Wakes often			
Wakes for food			
Wakes up irritable			
Night sweats			

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sleepwalking			
Bed wetting			

Immunization Record

Vaccination	Age	Date	Adverse Reactions
DPT- Diphtheria, tetanus, pertussis			
OPV- Oral Polio Vaccine			
MMR- Measles, Mumps, Rubella			
Hepatitis			
Hemophilus B			
Influenza			
Meningoc.			
Varivax (Chicken pox)			
Tetanus			
Other:			

If a sibling of the child has had an adverse reaction to any of the above vaccinations please describe reaction below:

Medication/Supplements/Antibiotics:

	Past/Current	Dose	Duration	Side Effects	Why
1.					
2.					
3.					
4.					

Family History:

Mother's side	Mother	Father	Grandfather	Grandmother	Siblings
Age or If deceased: at what age?					
Cause of death?					
Father's side					
Age or If deceased: at what age?					
Cause of death?					

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	Family Member (s)
Addiction	
Allergies	
Asthma	
Autoimmune disorder	
Bleeding disorder	
Cancer	
Diabetes	
Epilepsy	
Stroke	
Heart disease	
Other:	

Diet History:

Typical diet for your child:

Breakfast:-

Lunch:

Dinner:

Snacks:

Beverages:

My child was: Breast fed _____ formula _____ both _____ for how long? _____
If on formula, what type was used (milk, soy, other)?

Solid foods were introduced at age _____

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

Please indicate foods that were newly introduced and any adverse reactions (eg. Colic, bloating, gas, diarrhea, constipation, nausea, vomiting, or rashes):

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____

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Current food allergies:

Dietary restrictions (eg. vegetarian, religious)

Food cravings

Is your child thirsty? Y N Drink temperature they prefer: _____

Meals eaten per day _____ Child is a picky eater: Y N

Child's appetite in general

Social/Home Involvement:

Who takes care of the child primarily? _____ Does the child have a babysitter/nanny? Y N

How are problem behaviors, generally handled?

What are the family's favourite activities?

Does your child get along with other children? Y N

Explain _____

Does your child get along with adults? Y N

Explain _____

How much time does your child spend in front of the TV/Computer? _____

What extra activities is your child involved in?

List any chemicals, fumes, dust, pesticides that your child is repeatedly exposed to (including cigarette smoke, molds in the house):

Trauma (Physical, Emotional, Sexual):

Education:

My child is currently in: daycare _____ school _____ home _____

How is your child's behaviour in daycare/school?

Type of school: _____ Grade: _____ What grades do they usually receive? _____

Behaviour/Emotions:

Please check which behaviours/emotions your child exhibits:

Affectionate		Crying spells		Head banging	
Generous		Depression		Organized	
Shares		Shy/Timid		Hurts animals	
Confident		Talks back		Lies frequently	
Cooperative		Short attention span		Thumb sucking	
Irritable		confidence		Tantrums	
Moody		Memory difficulty		Poor attention	

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Frustrated easily		Low self-esteem		Hyperactive	
Restless		Anxiety		Pica (dirt, ice, paint, plastic)	
Angry		Separation anxiety		Bites nails	
Rage		Introvert		Prefers to play alone	
Aggressive		extravert		Prefers to play with others	
Defiant		Imaginary friends		Attachment to dolls	
Sad		Bullies/Threatens		Selfish	

Grief:

List major experiences of grief/loss in your child's life:

Fears:

What fears does your child have?

How do they react to their fears?

****Thank you for taking the time to fill out this intake form. Any information received will remain confidential.****