Ashleigh Higgins BSc, ND
Georgina Naturopathic Doctor

Phone: 905-476-4746
E-mail: ashleighhigginsnd@gmail.com
Web: www.ashleighhigginsnd.com

Pediatric Intake Form

Patient Information

Name: ____________________ Date: ____/____/____ (dd mm yy)

Age: ____________ DOB: ____/____/____ (dd mm yy) Sex/Gender: ____________________

Parent/Guardian Information

Name: ____________________	Name: ____________________
Relationship: ____________________	Relationship: ____________________
Phone: ____________________	Phone: ____________________

Contact Information

Street: ____________________

City: ____________________ Province: ____________ Postal Code: ____________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ May we leave messages on your voicemail? ☐ Y/ ☐ N
If so, which phone number(s): ☐ Home/ ☐ Cell/ ☐ Work

Email: ____________________

May we contact you by email? ☐ Y/ ☐ N Preferred method of contact: ☐ Home/ ☐ Cell/ ☐ Work/ ☐ Email

Other Health Care Providers

Name: ____________	Name: ____________	Name: ____________
Specialty: ____________	Specialty: ____________	Specialty: ____________
Phone: ____________	Phone: ____________	Phone: ____________
Date of last visit: ____________	Date of last visit: ____________	Date of last visit: ____________

Ashleigh Higgins BSc, ND
Georgina Naturopathic Doctor

Phone: 905-476-4746
E-mail: ashleighhigginsnd@gmail.com
Web: www.ashleighhigginsnd.com

Health Concerns and Goals

Please list your current health concerns and goals, in order of priority, below?
This list is not written in stone, and will constantly be re-evaluated as your treatment progresses.

1. ______________________ 4. ______________________

2. ______________________ 5. ______________________

3. ______________________ 6. ______________________

Health History

Please list any hospitalizations, surgeries and diagnoses you have received (past or present).

1. ______________ Year:_______ 4.______________ Year:_______

2.______________ Year:_______ 5.______________ Year:_______

3.______________ Year:_______ 6.______________ Year:_______

Allergies and Sensitivities

Allergies (anaphylactic)		Sensitivities	
1. __________	4. __________	1. __________	4. __________
2. __________	5. __________	2. __________	5. __________
3. __________	6. __________	3. __________	6. __________

Medications

Please list your medications below. The reason you are taking the medication is asked simply because medications are often used to treat more than one condition. If you need more space, please write on the back of the intake form.

1.__________ Dose: __________ Duration:__________ Reason:__________

2.__________ Dose: __________ Duration:__________ Reason:__________

3.__________ Dose: __________ Duration:__________ Reason:__________

4.__________ Dose: __________ Duration:__________ Reason:__________

5.__________ Dose: __________ Duration:__________ Reason:__________

6.__________ Dose: __________ Duration:__________ Reason:__________

Phone: 905-476-4746
E-mail: ashleighhigginsnd@gmail.com
Web: www.ashleighhigginsnd.com

Supplements and Natural Health Products

Please list your supplements below. The reason you are taking the supplement is asked simply because supplements are often used to treat more than one condition. If you need more space, please write on the back of the intake form. If the ingredients are quite complex, just list the brand or bring the bottle to your first visit.

1.__________ Dose: __________ Duration:__________ Reason:__________

2.__________ Dose: __________ Duration:__________ Reason:__________

3.__________ Dose: __________ Duration:__________ Reason:__________

4.__________ Dose: __________ Duration:__________ Reason:__________

5.__________ Dose: __________ Duration:__________ Reason:__________

6.__________ Dose: __________ Duration:__________ Reason:__________

Family History

Please note which, if any, of your family members have been affected by the following conditions:

Diabetes:__________ Mental health conditions:__________

High blood pressure:__________ Autoimmune disease:__________

Heart disease:__________ Other:__________

General Health Information

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

Do you get regular screening tests done by another doctor? (blood tests, etc.)? ☐ Y / ☐ N

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? __________

Additional Information

Is there any additional information you would like to provide?__________

____

____

Referrals

How did you find out about me?__________

Ashleigh Higgins BSc, ND
Georgina Naturopathic Doctor

Phone: 905-476-4746
E-mail: ashleighhigginsnd@gmail.com
Web: www.ashleighhigginsnd.com

Review of Systems

Please check **C** for any symptoms you are currently experiencing and **P** for any symptoms you experienced in the past.

Musculoskeletal:
- Tremors or Cramps - ☐ C/ ☐ P
- Swollen Joints - ☐ C/ ☐ P
- Pain or Weakness of Muscles - ☐ C/ ☐ P

Cardiovascular:
- Chest Pain - ☐ C/ ☐ P
- Poor Circulation - ☐ C/ ☐ P
- Swelling of Hands, Ankles, Feet - ☐ C/ ☐ P
- Irregular Heart Beats - ☐ C/ ☐ P
- Dizziness or Shortness of Breath - ☐ C/ ☐ P

Head and Respiratory:
- Asthma or Wheezing - ☐ C/ ☐ P
- Allergies - ☐ C/ ☐ P
- Blurred Vision or Visual Changes - ☐ C/ ☐ P
- Eye Pain - ☐ C/ ☐ P
- Loss of Hearing - ☐ C/ ☐ P
- Earaches - ☐ C/ ☐ P
- Ringing in the Ears - ☐ C/ ☐ P
- Sore Throat - ☐ C/ ☐ P
- Headaches - ☐ C/ ☐ P
- Migraines - ☐ C/ ☐ P

Immune:
- Frequent Colds, Flus, or Infections - ☐ C/ ☐ P
- Swollen Glands - ☐ C/ ☐ P
- Long Recovery After Infections - ☐ C/ ☐ P

Skin:
- Poor Wound Healing - ☐ C/ ☐ P
- Easy or Unexplained Bruising - ☐ C/ ☐ P
- Rashes - ☐ C/ ☐ P
- Eczema - ☐ C/ ☐ P
- Psoriasis - ☐ C/ ☐ P
- Itching - ☐ C/ ☐ P
- Dryness - ☐ C/ ☐ P
- Oily Skin - ☐ C/ ☐ P
- Acne - ☐ C/ ☐ P
- Frequent Skin Infections - ☐ C/ ☐ P

Digestion:
- Gas or Bloating - ☐ C/ ☐ P
- Abdominal Pain or Cramping - ☐ C/ ☐ P
- Heartburn / Acid Reflux - ☐ C/ ☐ P
- Difficulty Swallowing - ☐ C/ ☐ P
- Nausea or Vomiting - ☐ C/ ☐ P
- Poor Appetite - ☐ C/ ☐ P
- Excessive Appetite - ☐ C/ ☐ P
- Loose Stools or Diarrhea - ☐ C/ ☐ P
- Undigested Food in Stool - ☐ C/ ☐ P
- Blood in the Stool - ☐ C/ ☐ P
- Mucus in the Stool - ☐ C/ ☐ P
- Constipation - ☐ C/ ☐ P
- Irregular Bowel Movements - ☐ C/ ☐ P
- Pain or Itching of the Anus - ☐ C/ ☐ P

Sleep:
- Difficulties Falling Asleep - ☐ C/ ☐ P
- Difficulties Staying Asleep - ☐ C/ ☐ P
- Waking Unrefreshed - ☐ C/ ☐ P

Genitourinary:
- Blood in Urine - ☐ C/ ☐ P
- Frequent Urination - ☐ C/ ☐ P
- Difficulty Controlling Urine - ☐ C/ ☐ P
- Urgency - ☐ C/ ☐ P
- Bedwetting- ☐ C/ ☐ P
- Bladder Infections - ☐ C/ ☐ P

General
- Fevers or Chills - ☐ C/ ☐ P
- Tremors - ☐ C/ ☐ P
- Poor balance - ☐ C/ ☐ P
- Weight loss - ☐ C/ ☐ P
- Weight gain - ☐ C/ ☐ P
- Fatigue - ☐ C/ ☐ P
- Night sweats - ☐ C/ ☐ P
- Change in appetite - ☐ C/ ☐ P
- Difficulty Focusing - ☐ C/ ☐ P
- Poor Memory or Concentration - ☐ C/ ☐ P

Ashleigh Higgins BSc, ND
Georgina Naturopathic Doctor

Phone: 905-476-4746
E-mail: ashleighhigginsnd@gmail.com
Web: www.ashleighhigginsnd.com

Review of Systems, Continued

Please check **C** for any symptoms you are currently experiencing and **P** for any symptoms you experienced in the past.

Emotional

- Depression - ☐ C/ ☐ P
- Anxiety - ☐ C/☐ P
- Phobias - ☐ C/ ☐ P
- Mood swings - ☐C/☐P

Maternal/Prenatal Health:

- Term length:___________________________
- Birth weight:___________________________
- Type of Birth:__________________________
- Was/is the child breastfed?_______________
  - How long__________________________

Please list any pharmaceutical or recreational drugs taken by the mother during the pregnancy, including tobacco and alcohol: _______________
____

Immunizations

- Please check the child's immunizations:
  - ☐ MMR (Measles, Mumps, Rubella)
  - ☐ DPT (Diphtheria, Pertussis, Tetanus)
  - ☐ Influenza (Flu shot)
  - ☐ Chickenpox
  - ☐ HepA
  - ☐ Hep B
  - ☐ Tetanus (as a single)
  - Others: ____________________________

Please list any health concerns not otherwise mentioned_______________________________

About These Forms

For your first visit, please fill these intake forms out ahead of time. You can either email them to me, or print them, bringing them with you to your visit.

The last two pages of the intake require your signature, I will print these pages and you can sign them in the office!

If you are a Mac user, whose PDF viewing program is Preview, you may experience trouble filling in the forms, and I would recommend using adobe instead.

Ashleigh Higgins BSc, ND
Georgina Naturopathic Doctor

Phone: 905-476-4746
E-mail: ashleighhigginsnd@gmail.com
Web: www.ashleighhigginsnd.com

Consent to Treatment of Naturopathic Medicine

Consent to treatment is an ongoing process, lasting the entire duration of the doctor-patient relationship. In order to obtain your consent, I will explain the following to you about possible treatment options:

- The nature of the treatment
- The reasons for treatment
- The risks of treatment
- Alternatives to undergoing this treatment and associated risks
- The risks of not undergoing treatment
- That the patient has the power to terminate treatment at any time

If you become incapacitated, and can no longer give your consent, consent from a substitute decision maker will be required before treatment can be initiated. Only in the case of an emergency may treatment be provided without consent.

I, ____, attest that the information provided on this intake form is correct to the best of my knowledge, and I consent to the treatment as I understand it. I understand that I am free to ask questions, and that I may withdraw my consent at any time.

Patient Name (please print):____

Parent Signature:_______________________________________ Date: __________________

Ashleigh Higgins BSc, ND
Georgina Naturopathic Doctor

Phone: 905-476-4746
E-mail: ashleighhigginsnd@gmail.com
Web: www.ashleighhigginsnd.com

Patient Consent for Collection, Use and Disclosure of Personal Information

This privacy policy outlines what is done to ensure that your privacy and personal information are protected:

- Only necessary information is collected.
- I will never share your information without your consent.
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols (this includes cloud-based electronic medical records).
- Privacy protocols comply with privacy legislation and standards of naturopathic doctor's regulatory body, The Board of Directors of Drugless Therapy.

I am committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To assess your health concerns, provide health care and advise you of treatment options.
- To establish and maintain contact with you, in order to: remind you of upcoming appointments, follow-up after treatments, collect unpaid accounts and follow-up on billing.
- To complete claims for insurance purposes, invoice for goods and services, and process credit card payments.
- To comply with all regulatory and legal requirements, including; court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to themselves or others.
- To be used for educational and research purposes. Your identity will be protected at all times and if necessary, identifying information will be altered to protect your privacy in all the above instances.

I, ____, have reviewed the above information that explains how Ashleigh Higgins, ND, will use my personal information and the steps that are taken to protect my information.

I consent to the collection, use and disclosure of my personal information as set out in the above privacy policies.

Patient Name (please print):____

Parent Signature:____ Date: __________________