STEPHANIE PELTZ
NATUROPATHIC DOCTOR

PEDIATRIC INTAKE FORM (Birth to 5 years)

Patient's name: _____ Age: _____ Date of first visit: _____
Date of Birth (month/day/year): ____/____/____
Parent's name: _____ Other Parent's name: _____
Address: _____ City: _____
Province: _____ Postal Code: _____
Phone number (home): (_____)_____ (Parent's work) (_____)_____
Parent's e-mail address: _____
How did you hear about Dr. Stephanie Peltz, ND? _____
Child's GP or Pediatrician: _____
Legal Gender: ☐ female ☐ male ☐ other Gender Identity: _____

Current health concerns: _____
_____
_____

MEDICAL HISTORY (please indicate)

☐ Chicken pox	☐ Measles	☐ Rheumatic Fever	☐ Rubella
☐ Scarlet fever	☐ Pneumonia	☐ Whooping Cough	☐ Mumps
☐ Roseola	☐ Strep throat	☐ Ear Infections	☐ Impetigo
☐ Hand Foot and Mouth		☐ Mononucleosis	

☐ other (please list): _____

What screening tests has your child had? (blood, hearing, vision, etc): _____

Serious Illnesses/Injuries/Surgeries/Hospitalizations (please list): _____

List of all current medications (prescription, over the counter, vitamins, herbs, homeopathics):
_____
_____

List of any past prescription medications: _____
_____

IMMUNIZATIONS (please indicate)

☐ MMR	☐ DPT	☐ Polio	☐ H. Influenza B
☐ Hepatitis B	☐ Pneumococcal	☐ Meningococcal	☐ Hepatitis A
☐ Chicken Pox	☐ Other: _____		

☐ My child is up to date for all immunizations recommended in BC for his/her age
Any adverse reactions to vaccines: ☐ Y ☐ N
If yes, please describe: _____

FAMILY HISTORY (please indicate)

☐ Heart disease	☐ Hypertension	☐ Cancer	☐ Diabetes	☐ Arthritis
☐ Celiac disease	☐ Mental illness	☐ Allergies	☐ Asthma	☐ Tuberculosis
☐ Birth abnormality	☐ Eczema	Other: _____		

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BIRTH MOTHER'S PRENATAL HISTORY

Mother's age at child's birth _____
Mother's health during pregnancy? _____
Were any of the following experienced during pregnancy?

☐ Bleeding	☐ Nausea/Vomiting	☐ Physical/emotional trauma
☐ High blood pressure	☐ Thyroid problems	☐ Gestational diabetes
☐ Medications	☐ Cigarettes, alcohol, drug consumption	

CHILD'S BIRTH HISTORY

Term: ☐ Full ☐ Premature Weeks late/early _____ Birth weight: _____
Length of labor: _____ Any complications? _____
Birth: ☐ Vaginal ☐ C-section ☐ Induced ☐ Forceps ☐ Anesthesia

Did your child have any of the following problems shortly after birth?

☐ Birth abnormality	☐ Cerebral palsy	☐ Colic	☐ Birth injuries	☐ Seizures
☐ Fever	☐ Blue baby	☐ Jaundice	☐ Rashes	

☐ Other (explain) _____

Feeding: Breastfed? ☐ Y ☐ N How long? _____
Formula? ☐ Y ☐ N If yes: ☐ Cow's milk ☐ Soy ☐ Other (explain) _____

Child's sleep patterns _____

How would you describe your child's temperament?_____

Food or environmental allergies (if known) _____

Any dietary restrictions (due to religion, ethics, preference, etc)? _____
Age began solids: ____ Which foods? _____
Age began: Sitting _____ Crawling _____ Walking _____ Talking _____

SYMPTOMS (mark **Y** if current, **P** significant past symptom)

☐ Hives	☐ Eczema	☐ Bleeding gums	☐ Nose bleeds
☐ Acne	☐ High fevers	☐ Chronic rash	☐ Easy bruising
☐ Diarrhea	☐ Sore throats	☐ Headaches	☐ Jaundice
☐ Wheezing	☐ Anemia	☐ Burning of urine	☐ Flat feet
☐ Vomiting	☐ Frequent urination	☐ Heart murmur	☐ Joint pain
☐ Hearing loss	☐ Dizzy spells	☐ Stomach aches	☐ Nervous
☐ Frequent colds	☐ Constipation	☐ Bleeding tendency	☐ Gas
☐ Bloody urine	☐ Cries easily	☐ Motion / Car sickness	☐ Night sweats
☐ Nightmares	☐ Sleep problems	☐ Light sensitivity	☐ Hair loss
☐ No appetite	☐ Canker sores	☐ Body/breath odor	☐ Cough
☐ Motion/car sickness	☐ Excessive fatigue	☐ Unusual fears	

☐ Other: _____

What expectations do you have from this visit with me? _____
_____

What long-term expectations do you have for working with me? _____
_____

Thank you. I look forward to helping your child in any way I can.

STEPHANIE PELTZ
NATUROPATHIC DOCTOR

As a naturopathic physician my treatments involve gentle, typically non-invasive techniques to stimulate the body's inherent healing capacity. As your naturopathic doctor I will take a thorough case history, may do a relevant screening physical examination, and if required evaluate blood, urine, saliva, or stool samples. It is important that you inform me of any change in your health status while under my care, as this may necessitate changes to your naturopathic treatment plan such as any new disease process or diagnosis, if you are prescribed a new medication or over the counter drug, or if you become pregnant or are breastfeeding. There are some slight health risks to treatment by naturopathic medicine.

These include but are not limited to:

• Aggravation of pre-existing symptoms.
• Allergic reactions to supplements, herbs or intravenous therapy contents.
• Pain, bruising and injury from venipuncture or acupuncture.
• Dizziness, lightheadedness or nausea from IV therapy and acupuncture.

I understand that a confidential health record will be kept of the health services provided to me. This record will not be released to others unless so directed by myself or required by law. If appropriate (and with my explicit consent) I understand that you, as my naturopathic doctor, may discuss my case with other healthcare providers. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications.

Cancellation policy - I understand that if I fail to appear for my scheduled appointment or cancel with less than 24 hours notice (one business day) I will be charged a Missed Appointment Fee of the full cost of my missed visit.

I understand that opened remedies and lab tests prescribed are non-refundable.

I hereby consent to receive Dr. Stephanie Peltz's quarterly email newsletter which contains information about clinic events, health conditions, current health news, and healthy recipes
☐ Yes ☐ No

I hereby consent to email communication with Dr. Stephanie Peltz as needed
☐ Yes ☐ No

I intend this consent form to cover the entire course of my treatment and understand that I am free to withdraw my consent at any time. With this knowledge, I voluntarily consent to naturopathic care with Dr. Stephanie Peltz:

Patient Name: (Please Print)_____

Signature of Patient or Parent/Guardian:_____

Date: _____

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