Dr Ayla Wilson ND

Pediatric (6+ yrs) Naturopathic Intake Form

Personal Information

Name _____ Date of First Visit _____
Mom's Name _____ Dad's Name _____
Address _____
City _____ Province _____ Postal Code _____
Telephone # (Parent's home)_____ Parent's work # _____
Parent's Cell # _____ Parent's e-mail Address _____
Age _____ Date of Birth (M/D/Y)_____ Gender: female ____ male ____
Has any other family member already been a patient at the clinic? _____
How did you hear about Dr. Wilson? _____

Child's GP _____
Specialists seen by the child _____
Screening Tests _____

Child's Health Concerns:

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

Child's Medical History:

____ Chicken pox ____ Scarlet fever ____ Roseola ____ Mononucleosis ____ Measles
____ Pneumonia ____ Strep throat ____ Impetigo ____ Mumps ____ Whooping Cough
____ Ear Infections ____ Rubella ____ Rheumatic fever
____ Other (please list) _____

Has your child been treated with antibiotics? Yes / No Number of times? _____ Date of most recent_____

Major Illnessess/Accidents/Surgeries/Hospitalizations:

_____
_____
_____

Current Medications (Over The Counter and Perscription):

_____
_____
_____

Current Supplements (Herbal, Homeopathic, Vitamin/Mineral, etc):

_____
_____
_____

Immunizations:

____ MMR ____ Polio ____ DPT ____ Smallpox ____ H. Influenza B ____ Influenza

____ Hep B ____ Hep A ____ Varicella

____ Other (please list): _____

Adverse Reaction To Vaccine? Yes / No Please Describe: _____
_____

Family History:

____ Heart Disease ____ Diabetes ____ Hypertension ____ Cancer ____ Arthritis

____ Celiac Disease ____ TB ____ Birth abnormality ____ Allergies ____ Eczema

____ Asthma ____ ADHD ____ Autism ____ Mental Illness ____ Substance Abuse

____ Other (please list): _____

Child's sleep patterns _____ _____
How would you describe your child's temperament?_____
How would you describe your child's behavior and performance at school? _____
_____
Does your child exercise regularly? Yes / No If yes, how often? _____

Food or environmental allergies (if known): _____
Anaphylaxis? Yes / No To What? _____
Any dietary restrictions (religious, vegetarian, vegan, etc.)? _____

Describe child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages (type and quantity): _____

Symptoms:

Mark with a C if Current. Mark with a P if experienced as a significant symptom in the Past.

____ Hives	____ Burning of urine	____ Bloody urine	____ Anemia
____ Eczema	____ Frequent urination	____ Cries easily	____ Seizures
____ Bleeding gums	____ Heart murmur	____ Nervous	____ Hair loss

____ Nose bleeds	____ Vomiting spells	____ Sleep problems	____ Dizzy spells
____ Acne	____ Night sweats	____ Febrile seizures	____ Cough
____ High fevers	____ Stomach aches	____ Sensitive to light	____ Excessive fatigue
____ Chronic rash	____ Jaundice	____ Body/breath odor	____ Joint pains
____ Hearing loss	____ Easy bruising	____ Motion/car sickness	____ Wheezing
____ Diarrhea	____ Flat feet	____ No appetite	____ Unusual fears
____ Sore throats	____ Constipation	____ Nightmares	____ Bleeding tendency
____ Headaches	____ Gas	____ Canker sores	____ Frequent colds

Consent Policy

I hereby consent to receive treatment by Dr. Ayla Wilson, ND. I understand that Dr. Ayla Wilson is a licensed Naturopathic Physician providing nutritional and lifestyle counseling, acupuncture and traditional oriental medical care, naturopathic spinal manipulations, botanical/herbal medicine, homeopathic medicine, Bowen technique, and intravenous/intramuscular injections.

Cancellation Policy

I understand that I am solely responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

Email Correspondence

*Please note that I will not sell, rent, or share your email address

Yes / No I would like to receive free newsletters from Dr. Ayla Wilson, ND

Yes / No Dr. Ayla Wilson ND may correspond with me at the above email address if necessary

Signature: _____

(Parent or Guardian)

What expectations do you have from this visit to our clinic?

What long-term expectations do you have from working with our clinic?

What expectations do you have of me as your physician?

Thank you for your time in providing this information.