

Dr. Tasnim Adatya, Naturopthic Physician
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PEDIATRIC INTAKE FORM

Care Card Number: _____ Date: _____

Female

Male _____ Birthdate: ____/____/____ Age ____
first name middle name last name day/month/year

Mother's Name _____ Father's Name _____

Home Address _____
street city/province postal code

Home Phone _____ Work Phone _____

Referred by _____

Child and current doctor/ND/Etc. Please include name/ phone number (if known).

Reason for appointment _____

MEDICATIONS	Now	Past		Now	Past
Aspirin	___	___	Antibiotics	___	___
Tylenol	___	___	Anti-histamine	___	___
Decongestant	___	___	Other	___	___
Ibuprofen	___	___			

Any allergies to medications? Please describe: _____

MEDICAL HISTORY

CHILHOOD ILLNESSES

___ Chicken Pox ___ Scarlet Fever ___ Tonsillitis, approx. no. ____
___ Measles ___ Pneumonia ___ Ear infections no. ____
___ Mumps ___ Frequent Colds ___ Other (please list)
___ Rubella ___ Rheumatic Fever

Has your child had any of the following tests?:

	When	Where	Results
Electroencephalogram (EEG)	_____	_____	_____
Psychological Evaluation	_____	_____	_____
Hearing	_____	_____	_____
Speech/ Language	_____	_____	_____

Injuries/ Surgeries/ Hospitalizations (please list): _____

IMMUNIZATIONS

Measles Polio MMR Smallpox Diphtheria Mumps
 DPT Tetanus Influenza other (list _____)

FAMILY HISTORY

Heart Disease Diabetes Birth Defects Allergies Cancer
 Hypertension Arthritis Tuberculosis Mental Illness

Previous pregnancies by natural mother, miscarriages or complications?

Mother's age at child's birth? _____

Mother's health during pregnancy?

Bleeding Physical or emotional trauma Nausea
 Illnesses Medications Hypertension
 Diabetes Thyroid problems Cigarettes, alcohol, drug consumption

BIRTH HISTORY

Term: Full _____ Premature _____ Late _____

Length of labor _____ Complications? _____

Has your child had any of the following problems?

Jaundice Diarrhea Birth Defects Rashes Colic
 Blue Baby Cerebral Palsy Allergies Seizures Fever
 Birth Injuries Other (explain _____)

Weight at birth _____ Present weight _____ Length at birth _____ Present length _____

Child's sleep patterns (first year) _____

Food intolerances (if any) _____

Feeding: Breastfed? _____ How long? _____ Formula? _____ Milk/soy? _____

Age child began solid foods _____

Age began: Sitting _____ Crawling _____ Walking _____ First words _____

SYMPTOMS (mark "+" if current, X for past symptoms)

<input type="checkbox"/> Hives	<input type="checkbox"/> Burning of urine	<input type="checkbox"/> Bloody urine
<input type="checkbox"/> Eczema	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Cries easily
<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Nervous
<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Vomiting spells	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Acne	<input type="checkbox"/> Anemia	<input type="checkbox"/> Night sweats
<input type="checkbox"/> High fevers	<input type="checkbox"/> Stomach aches	<input type="checkbox"/> Sensitive to light
<input type="checkbox"/> Chronic rash	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Body/breath odor
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Motion/ car sickness
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Flat feet	<input type="checkbox"/> No appetite
<input type="checkbox"/> Sore throats	<input type="checkbox"/> Constipation	<input type="checkbox"/> Nightmares
<input type="checkbox"/> Gas	<input type="checkbox"/> Frequent headaches	<input type="checkbox"/> Canker sores
<input type="checkbox"/> Frequent colds	<input type="checkbox"/> Bleeding tendencies	<input type="checkbox"/> Unusual fears
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Joint pains	<input type="checkbox"/> Excessive fatigue
<input type="checkbox"/> Cough	<input type="checkbox"/> Dizzy spells	<input type="checkbox"/> Hair loss

DIET

Please describe your child’s typical daily diet:

PERSONALITY

Please describe your child’s personality briefly:

Thank you. Welcome to the clinic. I look forward to working with you in helping your child achieve optimal health.

Dr. Tasnim Adatya, N.D.

OFFICE POLICY REGARDING FEES AND INSURANCE COVERAGE

OUR FEE POLICY IS A REFLECTION OF THE SPECIALISED PROCEDURES INCORPORATED IN THIS OFFICE AND ALLOWS US TO GIVE WHAT WE FEEL TO BE THE HIGHEST QUALITY OF NATUROPATHIC CARE.

Fees

Payment for naturopathic services is expected at the time of treatment.

B.C. Medical

The provincial government removed MSP coverage for naturopathic services on January 1, 2002. MSP coverage is no longer available for most patients. Those on premium assistance or who are treaty status Indian may qualify for partial re-imburement.

Extended Medical

With the MSP change on January 1, 2002, some extended healthcare plans will now permit subscribers to claim the full cost of naturopathic services, therefore receiving a larger re-imburement. You will need to check the contract with your insurance company. This office does not deal directly with private insurance companies.

ICBC

For ICBC cases the patient is responsible for the fee at the time of treatment and can then submit the receipt to their adjuster for reimbursement.

Cancellation and missed appointment

This office requires a minimum of **forty-eight (48) hours** notice to cancel any appointment. **A 50% appointment fee will be charged for missed or rescheduled appointments with insufficient notice.**

BC residents are required to sign the agreement below:

I have been informed of the billing procedures of this office and agree to pay the full office fee for services rendered by Dr. Tasnim Adatya ND. I understand that upon submission of the appropriate claim forms that I will be reimbursed by the Medical Services Plan of BC at an established rate and that this rate is of a lesser amount than the office fee.

Date

Parent or guardian’s signature