Infinity Health Inc.
Dr. Alexina Mehta, ND
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Vancover BC
V6K 4S2

PEDIATRIC INTAKE FORM (Birth- 10 years)

Patient's name: _____Date of first visit:_____

Age:_____ Date of Birth: _____/_____/_____ Gender: female/male

Mother's name:_____ Father's name: _____

Address:_____City:_____ Postal Code_____

Phone #(home): (_____)_____ Parents # (work)(_____)_____

Parents e-mail address: _____

Would you like to receive Dr. Alexina Mehta's newsletter on the latest cutting edge natural health tips? ☐ Yes

Please note you are welcome to unsubscribe from the newsletter whenever you wish.

How did you hear about us? _____

Name of Dr.'s Office/Hospital/Clinic where your child's health records are kept:
_____

Reason for referral or presenting problems: _____
_____

MEDICATIONS	Now	Past
Aspirin Antibiotics	Y/N	Y/N
Tylenol Anti-histamine	Y/N	Y/N
Decongestant Other	Y/N	Y/N
Ibuprofin	Y/N	Y/N

Allergies to medicines _____

MEDICAL HISTORY (Please circle)

Chicken pox	Scarlet fever	Tonsillitis
Measles	Pneumonia	Ear infections
Mumps	Frequent colds	Rubella
Rheumatic fever	other (please list) _____	

Has your child had any of the following tests? Please indicate: When, Where, Results
Electroencephalogram_____Psycho
logical evaluation_____._.
Hearing _____

Speech/Language_____
Injuries/Surgeries/Hospitalizations (please list): _____
_____

IMMUNIZATIONS
_____ Measles _____ Polio _____ MMR _____ Smallpox _____ Diphtheria
_____ Mumps _____ DPT _____ Tetanus _____ Influenza
Others (list) _____
Any adverse reactions? Y N What ? _____

FAMILY HISTORY

_____ Heart disease	_____ Diabetes	_____ Birth defects
_____ Hypertension	_____ Arthritis	_____ Tuberculosis
_____ Cancer	_____ Allergies	_____ Mental illness

PRE-NATAL HISTORY

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 _____ Cigarettes, alcohol, drug consumption
_____ Illnesses _____ Medications
_____ Hypertension _____ Thyroid concerns _____ Diabetes

BIRTH HISTORY
Term: Full /Premature /Late / Weight at birth _____
Length of labor _____ Complications? _____

Did your child have any of the following after birth? (Please circle)

Birth defects/Birth injuries/ Blue baby
Cerebral palsy/Seizures /Jaundice
Colic /Fever /Rashes
Other (explain)
_____
Child's sleep patterns (first year)
_____
Food intolerances (if any) _____

Feeding: Breast fed? how long?_____Formula? milk / soy

Age began solid foods _____ Which foods? _____

Age began: Sitting____ Crawling____ Walking____ Talking____

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

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

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To Drink: _____

Thank you for Filling out this form. We look forward to working with your child.

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CONSENT FORM

Dear patients:

Naturopathic examination includes: physical and clinical diagnosis, traditional Chinese medical diagnosis, energetic testing and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, manual muscle therapy, craniosacral therapy, bowen therapy, clinical nutritional, lifestyle counselling, and mind-body awareness,.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side effects. I also understand that there is no guarantee or warranty for a specific cure result.

I am aware that 24 hours notice must be given for all cancelled appointments or the full fee for the visit is due. I understand that I am responsible for payment at the time services are rendered. Dispensary items and lab tests must be paid for in full before leaving the office.

Signature x_____ Date x_____

Doctor's Signature x_____ Date x_____

PARENTAL CONSENT (if applicable)

If you are under the age of 19 parent consent is required for naturopathic treatment.

Signature of Parent/Guardian x_____ Date x_____

Thank you. We look forward to working with you.