

**Dr. Jacqui Fleury ND**PH (306) 373-5209 | FAX (306) 373-5207  
#3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6  
truepotentialhealth@gmail.com | truepotentialhealth.com**PEDIATRIC INTAKE FORM (BIRTH TO 12 YEARS)**

*Our professional association requires us to maintain contact information for our patient records. No information will be provided to any other individual or group without your express permission. E-mail will only be used by our office to inform you of office events and will not be distributed for any other use.*

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: Female / Male

Parent/Guardian's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Telephone (home): \_\_\_\_\_ (work): \_\_\_\_\_

Parent's email address: \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

Has any other family member already been a patient at this clinic? \_\_\_\_\_

**Contacts** (in order of preference):

1. Name: \_\_\_\_\_ Ph: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

2. Name: \_\_\_\_\_ Ph: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

With whom does the child live? \_\_\_\_\_

May messages be left relating to your visits? Y/N Which phone number? \_\_\_\_\_

**Please List Other Health Care Providers** (name, type of care, phone/contact information):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Name of doctor's office/hospital/clinic where your child's health records are kept: \_\_\_\_\_

\_\_\_\_\_

**Dr. Jacqui Fleury ND**PH (306) 373-5209 | FAX (306) 373-5207  
#3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6  
truepotentialhealth@gmail.com | truepotentialhealth.com**HEALTH HISTORY QUESTIONNAIRE**

What are your child's most important health problems? Please list in order of importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Does your child have a contagious disease at this time? Y / N

If yes, what? \_\_\_\_\_

How would you describe your child's general state of health?      Excellent      Good      Fair      Poor Does  
your child have any allergies?

- Food: \_\_\_\_\_
- Medications: \_\_\_\_\_
- Environmental: \_\_\_\_\_

Please list all current medications and supplements your child is taking (incl. herbs, vitamins, and homeopathics):

---

---

---

Please list any past medications your child has taken: \_\_\_\_\_

How many times has your child been treated with antibiotics? \_\_\_\_\_

**MEDICAL HISTORY (please indicate severity: 1 – mild, 2 – moderate, 3 – severe)**

|                   |                       |  |
|-------------------|-----------------------|--|
| _____ Chicken pox | _____ Scarlet fever   | _____ Tonsillitis, approx no. of times: _____    |
| _____ Measles     | _____ Pneumonia       | _____ Ear infections, approx no. of times: _____ |
| _____ Mumps       | _____ Frequent colds  | _____ Strep throat, approx no. of times: _____   |
| _____ Rubella     | _____ Rheumatic fever | _____ Other: _____                               |

Has your child ever had any of the following? (please indicate when, where, and the results)

Electroencephalogram (EEG): \_\_\_\_\_

Psychological evaluations: \_\_\_\_\_

Hearing test: \_\_\_\_\_

Speech/language tests: \_\_\_\_\_

Other tests or evaluations not listed: \_\_\_\_\_

\_\_\_\_\_

**Dr. Jacqui Fleury ND**

PH (306) 373-5209 | FAX (306) 373-5207  
 #3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6  
 truepotentialhealth@gmail.com | truepotentialhealth.com

Injuries/surgeries/hospitalizations (please list): \_\_\_\_\_

### IMMUNIZATIONS

☐ MMR      ☐ DPT      ☐ Chicken pox      ☐ Polio      ☐ Rubella  
☐ Measles      ☐ Diphtheria      ☐ Small pox      ☐ Mumps      ☐ Tetanus  
☐ H. influenza      ☐ Flu shot      ☐ Others: \_\_\_\_\_

Adverse reactions: Y / N

Please describe: \_\_\_\_\_

### FAMILY HISTORY

☐ Heart disease      ☐ Diabetes      ☐ Birth defects      ☐ Kidney Disease  
☐ Hypertension      ☐ Arthritis      ☐ Tuberculosis      ☐ Other (please list):  
☐ Cancer      ☐ Allergies      ☐ Asthma  
☐ Mental illness      ☐ Osteoporosis      ☐ Juvenile Arthritis  
☐ I don't know the family medical history

Do either of the parents have a chronic illness? Y/ N (please describe):

\_\_\_\_\_

\_\_\_\_\_

### PRENATAL HISTORY

What was the health of the parents at conception?

- Mother:    Poor    Fair    Good    Excellent    Unknown
- Father:    Poor    Fair    Good    Excellent    Unknown

What was the health of the mother during the pregnancy?      Poor    Fair    Good    Excellent    Unknown

What was the mother's age at child's birth? \_\_\_\_\_

How was the mother's diet during pregnancy?      Poor    Fair    Good    Excellent    Unknown

Did the mother receive prenatal medical care? Y / N / Unknown

Did the mother experience any of the following during the pregnancy:

☐ Bleeding    ☐ High blood pressure    ☐ Nausea    ☐ Vomiting    ☐ Diabetes    ☐ Thyroid problems  
☐ Physical or emotional trauma    ☐ Other \_\_\_\_\_

Previous pregnancies, miscarriages, or complications by natural mother? \_\_\_\_\_

\_\_\_\_\_

Did mother receive prenatal care? Y / N      Prenatal Vitamins? Y / N

**Dr. Jacqui Fleury ND**PH (306) 373-5209 | FAX (306) 373-5207  
#3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6  
truepotentialhealth@gmail.com | truepotentialhealth.com

Did the mother use any of the following during the pregnancy? (please check and list detail)

☐ Tobacco ☐ Alcohol ☐ Recreational Drugs: \_\_\_\_\_  
☐ Prescription Medications: \_\_\_\_\_  
☐ Over-the-counter medications: \_\_\_\_\_  
☐ Supplements: \_\_\_\_\_  
☐ Other: \_\_\_\_\_

**BIRTH HISTORY**Term: ☐ Full ☐ Premature (list wks) \_\_\_\_\_ ☐ Late (list wks) \_\_\_\_\_

Length of labor: \_\_\_\_\_ Type of birth (home, hospital, C-section) \_\_\_\_\_

Complications: \_\_\_\_\_

Interventions (forceps, drugs/anesthesia, induced, etc.): \_\_\_\_\_

Birth city &amp; province: \_\_\_\_\_ Birth time: \_\_\_\_\_ Birth weight: \_\_\_\_\_

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

☐ Rashes ☐ Birth injuries ☐ Blue baby ☐ Fever  
☐ Jaundice ☐ Seizures ☐ Cerebral palsy ☐ Birth defects  
☐ Other: \_\_\_\_\_

Did your child ever experience colic? Y / N How severe? *mild moderate severe***HEALTH AND DEVELOPMENT**

How was your child's health in the first year? Poor Fair Good Excellent Unknown

At what age did your child first:

Sit up \_\_\_\_\_ Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Talk \_\_\_\_\_

Please describe your child's sleep pattern:

Does your child: ☐ wake early ☐ have difficulty falling asleep ☐ have night terrors ☐ have no sleep problems  
How would you describe your child's temperament?

How would you describe your child's behavior and performance at school?



**Dr. Jacqui Fleury ND**

PH (306) 373-5209 | FAX (306) 373-5207  
#3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6  
truepotentialhealth@gmail.com | truepotentialhealth.com

## ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any  
environmentals? \_\_\_\_\_

### **Symptoms Experienced During Allergic Reaction:**

|                                       |   |   |  |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Hives        | <input type="checkbox"/> Burning urine      | <input type="checkbox"/> Bloody uring       | <input type="checkbox"/> Eczema        |
| <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"/> Asthma        |
| <input type="checkbox"/> Acne         | <input type="checkbox"/> Anemia             | <input type="checkbox"/> Night sweats       | <input type="checkbox"/> High fevers   |
| <input type="checkbox"/> Jaundice     | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Chronic rash       | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Diarrhea     | <input type="checkbox"/> Hearing loss       | <input type="checkbox"/> Easy bruising      | <input type="checkbox"/> Sore throats  |
| <input type="checkbox"/> Flat feet    | <input type="checkbox"/> No appetite        | <input type="checkbox"/> Body/breath odor   | <input type="checkbox"/> Constipation  |
| <input type="checkbox"/> Nightmares   | <input type="checkbox"/> Frequent colds     | <input type="checkbox"/> Bleeding tendency  | <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          | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Allergies     |

## ENVIRONMENT

Is the child in: ☐ school ☐ daycare ☐ home care ☐ other \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

Does the child exercise regularly? Y / N How much, how often? \_\_\_\_\_

How many hours/week does your child: watch TV \_\_\_\_\_ play on computer or video games? \_\_\_\_\_

How often does your child read (not for school) or how often does someone read to your child?

☐ Daily ☐ Several times a week ☐ Weekly ☐ Less than weekly

Does anyone in the child's household smoke? Y / N Are there animals in the home? Y / N

How is the child's home heated? \_\_\_\_\_

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)?

Please describe: \_\_\_\_\_

How would you describe the emotional climate of the child's home?

\_\_\_\_\_  
\_\_\_\_\_

**Dr. Jacqui Fleury ND**PH (306) 373-5209 | FAX (306) 373-5207  
#3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6  
truepotentialhealth@gmail.com | truepotentialhealth.com**DIET**

Infant Feeding: \_\_\_ Breast fed (how long): \_\_\_\_\_ \_\_\_ Formula (type): \_\_\_\_\_

What foods were introduced before 6 months? (Please list approximate month as well.)

---

---

---

6–12 months?

---

---

---

Does your child have any food allergies or intolerances? Please list.

---

---

Does your child have any dietary restrictions (religious, vegetarian/vegan, etc.)?

---

---

Please describe your child's typical daily diet:

Breakfast: \_\_\_\_\_

Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snack: \_\_\_\_\_

Beverages (type and total quantity): \_\_\_\_\_

**Dr. Jacqui Fleury ND**

PH (306) 373-5209 | FAX (306) 373-5207

 #3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6

truepotentialhealth@gmail.com | truepotentialhealth.com

**REVIEW OF SYSTEMS**

| 0 = never                |   | 1 = occasionally |   | 2 = frequently              |                                  | 3 = all the time |       |
|--------------------------|---|------------------|---|-----------------------------|----------------------------------|------------------|-------|
| <b>MENTAL/ EMOTIONAL</b> |   |                  |   | <b>Frequent colds</b>       |                                  |                  |       |
| Mood Swings              | 0 | 1                | 2 | 3                           | Nose Bleeds                      | 0                | 1 2 3 |
| Irritability             | 0 | 1                | 2 | 3                           | Stiffness                        | 0                | 1 2 3 |
| Hyperactivity            | 0 | 1                | 2 | 3                           | Hayfever                         | 0                | 1 2 3 |
| Introvert/extrovert      | 0 | 1                | 2 | 3                           | Sinus problems                   | 0                | 1 2 3 |
| Motion/car sickness      | 0 | 1                | 2 | 3                           | Loss of smell                    | 0                | 1 2 3 |
| Anxiety/nervousness      | 0 | 1                | 2 | 3                           | <b>MOUTH AND THROAT</b>          |                  |       |
| Cries easily             | 0 | 1                | 2 | 3                           | Frequent sore throat             | 0                | 1 2 3 |
| Unusual fears            | 0 | 1                | 2 | 3                           | Canker sores                     | 0                | 1 2 3 |
| Sleep problems           | 0 | 1                | 2 | 3                           | Breath odor                      | 0                | 1 2 3 |
| Nightmares               | 0 | 1                | 2 | 3                           | <b>RESPIRATORY</b>               |                  |       |
| <b>ENDOCRINE</b>         |   |                  |   | <b>Cough</b>                |                                  |                  |       |
| Heat/cold intolerance    | 0 | 1                | 2 | 3                           | Wheezing                         | 0                | 1 2 3 |
| Fatigue                  | 0 | 1                | 2 | 3                           | Asthma                           | 0                | 1 2 3 |
| Excessive thirst         | 0 | 1                | 2 | 3                           | Bronchitis                       | 0                | 1 2 3 |
| Excessive hunger         | 0 | 1                | 2 | 3                           | <b>CARDIOVASCULAR</b>            |                  |       |
| Low blood sugar          | 0 | 1                | 2 | 3                           | Heart disease                    | 0                | 1 2 3 |
| High blood sugar         | 0 | 1                | 2 | 3                           | Murmurs                          | 0                | 1 2 3 |
| <b>SKIN</b>              |   |                  |   | <b>URINARY</b>              |                                  |                  |       |
| Rashes                   | 0 | 1                | 2 | 3                           | Frequent urination               | 0                | 1 2 3 |
| Eczema, Hives            | 0 | 1                | 2 | 3                           | Bed wetting                      | 0                | 1 2 3 |
| Acne, Boils              | 0 | 1                | 2 | 3                           | <b>GASTROINTESTINAL</b>          |                  |       |
| Itching                  | 0 | 1                | 2 | 3                           | Belching/passing gas             | 0                | 1 2 3 |
| <b>HEAD</b>              |   |                  |   | <b>Stomach aches</b>        |                                  |                  |       |
| Headaches                | 0 | 1                | 2 | 3                           | Constipation                     | 0                | 1 2 3 |
| Head Injury              | 0 | 1                | 2 | 3                           | Diarrhea                         | 0                | 1 2 3 |
| Dizzy spells             | 0 | 1                | 2 | 3                           | Bowel Movements                  | How often? _____ |       |
| High fevers              | 0 | 1                | 2 | 3                           | <b>MUSCULOSKELETAL</b>           |                  |       |
| <b>EYES</b>              |   |                  |   | <b>Joint pain/stiffness</b> |                                  |                  |       |
| Glasses or contacts      | 0 | 1                | 2 | 3                           | Muscle spasms/cramps             | 0                | 1 2 3 |
| Tearing or dryness       | 0 | 1                | 2 | 3                           | Broken bones                     | 0                | 1 2 3 |
| Eye pain/strain          | 0 | 1                | 2 | 3                           | <b>BLOOD/PERIPHERAL VASCULAR</b> |                  |       |
| <b>EARS</b>              |   |                  |   | <b>Anemia</b>               |                                  |                  |       |
| Earaches                 | 0 | 1                | 2 | 3                           | Easy bleeding/bruising           | 0                | 1 2 3 |
| Impaired hearing         | 0 | 1                | 2 | 3                           |                                  |                  |       |
| <b>NOSE AND SINUSES</b>  |   |                  |   |                             |                                  |                  |       |

**Dr. Jacqui Fleury ND**

PH (306) 373-5209 | FAX (306) 373-5207  
#3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6  
truepotentialhealth@gmail.com | truepotentialhealth.com

## CONTEXT OF CARE REVIEW

What three 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 for your child from working with our clinic?

Is there anything that you feel is important that has not been covered?

*Thank you & welcome to our clinic. I look forward to working with you and your child.*



**Dr. Jacqui Fleury ND**

PH (306) 373-5209 | FAX (306) 373-5207

#3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6

truepotentialhealth@gmail.com | truepotentialhealth.com

## Informed Consent and Request for Naturopathic Medical Care

As a patient I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed so that I may make the decision to give, or withhold, my consent as to whether or not to undergo care with Dr. Jacqui Fleury, ND, having had the opportunity to discuss the potential benefits, risks and hazards involved.

I, \_\_\_\_\_, hereby request and consent to examination and treatment with naturopathic medicine by Dr. Jacqui Fleury, and/or other licensed doctors of naturopathic medicine or licensed acupuncturists serving as backup for her, hereafter called allied health care provider. I can request that students and preceptors not be included in my evaluation and treatment.

**I understand that I have the right to ask questions and discuss to my satisfaction with Dr. Jacqui Fleury, and/or with the allied health care provider, providing backup:**

- 1.) My suspected diagnosis(es) or condition(s)
- 2.) The nature, purpose, goals and potential benefits of the proposed care
- 3.) The inherent risks, complications, potential hazards or side effects of treatment or procedure
- 4.) The probability or likelihood of success
- 5.) Reasonable available alternatives to the proposed treatment procedure
- 6.) Potential consequences if treatment or advice is not followed and/ or nothing is done

**I understand that a naturopathic evaluation and treatment may include, but are not limited to:**

- Physical exam (including general, musculoskeletal, EENT, heart and lung, orthopedic and neurological assessments)
- Common diagnostic procedures (including venipuncture, laboratory evaluation of blood, urine, stool and saliva)
- Soft tissue and osseous manipulation (including naturopathic/osseous manipulation of the spine and extremities)
- Dietary advice and therapeutic nutrition (including use of foods, diet plans, nutritional supplements and intra-muscular vitamin injections)
- Botanical/ herbal medicines (prescribing of various therapeutic substances including plant, mineral, and animal materials). Substances may be given in the forms of teas, pills, creams, powders, tinctures which may contain alcohol, suppositories, tropical creams, pastes, plasters, washes or other forms
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Hydrotherapy (use of hot and cold water)
- Counseling (including but not limited to visualization for improved lifestyle strategies)

**Notice to pregnant women:** All female patients must alert the provider if they have confirmed or suspect pregnancy as some therapies prescribed could present a risk to the pregnancy.

**Notice to individuals with bleeding disorders, pace makers, and/or cancer:** For your safety it is vital to alert your provider, Dr. Jacqui Fleury, ND, of these conditions.

### Please Initial:

☐ I understand that Dr. Jacqui Fleury, ND, is currently not licensed to prescribe drugs or any controlled substances.

**Dr. Jacqui Fleury ND**

PH (306) 373-5209 | FAX (306) 373-5207

#3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6

truepotentialhealth@gmail.com | truepotentialhealth.com

☐ I understand that Dr. Jacqui Fleury, ND, is not a psychologist or psychiatrist. Counseling services are provided for the support of improved lifestyle strategies.

☐ I recognize that even the gentlest therapies may potentially have complications in certain conditions, in very young children, in the elderly, or in those on multiple medications. Hence, the information I have provided is complete and inclusive of all health concerns including the possibility of pregnancy, and all medications, including over the counter drugs (eg. Tylenol) and supplements.

I do not expect Dr. Jacqui Fleury and/or any allied health care provider to be able to anticipate and explain all of the risks and complications, and I wish to rely on the provider to exercise all judgment during the course of the procedure based on the known facts. I also understand that it is my responsibility to request that Dr. Jacqui Fleury explain therapies and procedures to my satisfaction. I further acknowledge that no guarantee of services have been made to me concerning the results intended from any treatment provided to me. By signing below I acknowledge that I have been provided ample opportunity to read this form or that it has been read to me. I understand all of the above and give my oral and written consent to the evaluation and treatment. I intend this as a consent form to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Printed Name of Guardian

\_\_\_\_\_  
Signature of Guardian

**Dr. Jacqui Fleury ND**

PH (306) 373-5209 | FAX (306) 373-5207

#3, 1810 – 8<sup>th</sup> Street East | Saskatoon, SK S7H 0T6

truepotentialhealth@gmail.com | truepotentialhealth.com

## Fee Schedule

Please reference the fee schedule on our website at [www.truepotentialhealth.com](http://www.truepotentialhealth.com)

Phone consultations are billed at the same rate as return visits.

Lab work and supplements prescribed by Dr. Fleury are an additional cost and not included in the visit fee.

Please note: Patient is responsible for payment at the time of service, unless previously arranged by Dr. Fleury. A portion of your visit may be claimed through your extended health coverage, please check with your provider. We are happy to provide physical exams at no extra charge. All other testing is done at additional charge, please ask Dr. Fleury for prices during your visit. You will be billed for phone consultations except those regarding problems or questions with prescribed treatments. ***Because fees are subject to change, please confirm at time of booking.***

**Cancellation policy: Any appointments cancelled with less than 24 hours notice will be subject to a charge for the full cost of the missed visit.**

I clearly understand that Dr. Fleury is not a medical doctor, but a naturopathic doctor who practices with natural therapeutics.

I understand that I am responsible for payment at the time of service, unless previously arranged by Dr. Fleury. I also understand that I will be billed for phone consultations, except those regarding questions about prescribed treatments.

I also understand that I will be charged the full visit fee for appointments cancelled without 24 hours notice, except in cases of emergency.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_