true potential
health services inc.

Dr. Kahlen Pihowich ND
PH (306) 373-5209 | FAX (306) 373-5207
#3, 1810 – 8th Street East | Saskatoon, SK S7H 0T6
contact@truepotentialhealth.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: _____

_____

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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
____ Measles
____ Mumps
____ Rubella
____ Scarlet fever
____ Pneumonia
____ Frequent colds
____ Rheumatic fever
____ Tonsillitis, approx no. of times: _____
____ Ear infections, approx no. of times: _____
____ Strep throat, approx no. of times: _____
____ 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: _____

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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

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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 & 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?

_____

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ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs?_____

Any foods? _____

Any environmentals?_____

Symptoms Experienced During Allergic Reaction:

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

_____

_____

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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): _____

_____

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REVIEW OF SYSTEMS

0 = never 1 = occassionally 2 = frequently 3 = all the time

MENTAL/ EMOTIONAL	
Mood Swings	0 1 2 3
Irritability	0 1 2 3
Hyperactivity	0 1 2 3
Introvert/extrovert	0 1 2 3
Motion/car sickness	0 1 2 3
Anxiety/nervousness	0 1 2 3
Cries easily	0 1 2 3
Unusual fears	0 1 2 3
Sleep problems	0 1 2 3
Nightmares	0 1 2 3
ENDOCRINE	
Heat/cold intolerance	0 1 2 3
Fatigue	0 1 2 3
Excessive thirst	0 1 2 3
Excessive hunger	0 1 2 3
Low blood sugar	0 1 2 3
High blood sugar	0 1 2 3
SKIN	
Rashes	0 1 2 3
Eczema, Hives	0 1 2 3
Acne, Boils	0 1 2 3
Itching	0 1 2 3
HEAD	
Headaches	0 1 2 3
Head Injury	0 1 2 3
Dizzy spells	0 1 2 3
High fevers	0 1 2 3
EYES	
Glasses or contacts	0 1 2 3
Tearing or dryness	0 1 2 3
Eye pain/strain	0 1 2 3
EARS	
Earaches	0 1 2 3
Impaired hearing	0 1 2 3
NOSE AND SINUSES	
Frequent colds	0 1 2 3
Nose Bleeds	0 1 2 3
Stuffiness	0 1 2 3
Hayfever	0 1 2 3
Sinus problems	0 1 2 3
Loss of smell	0 1 2 3
MOUTH AND THROAT	
Frequent sore throat	0 1 2 3
Canker sores	0 1 2 3
Breath odor	0 1 2 3
RESPIRATORY	
Cough	0 1 2 3
Wheezing	0 1 2 3
Asthma	0 1 2 3
Bronchitis	0 1 2 3
CARDIOVASCULAR	
Heart disease	0 1 2 3
Murmurs	0 1 2 3
URINARY	
Frequent urination	0 1 2 3
Bed wetting	0 1 2 3
GASTROINTESTINAL	
Belching/passing gas	0 1 2 3
Stomach aches	0 1 2 3
Constipation	0 1 2 3
Diarrhea	0 1 2 3
Bowel Movements How often?_____	
MUSCULOSKELETAL	
Joint pain/stiffness	0 1 2 3
Muscle spasms/cramps	0 1 2 3
Broken bones	0 1 2 3
BLOOD/PERIPHERAL VASCULAR	
Anemia	0 1 2 3
Easy bleeding/bruising	0 1 2 3

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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.

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Informed Consent and Request for Naturopathic Medical Care and Acupuncture

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. Kahlen Pihowich, 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 and acupuncture by Dr. Kahlen Pihowich, 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. Kahlen Pihowich, 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)
- Bowen therapy (gentle, non-forceful physical therapy)

The scope of practice of acupuncture is outlined below. I understand that traditional oriental medicine and acupuncture evaluation and treatment may include, but are not limited to:

- Acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface)
- Moxa (indirect or direct burning of herbal material in the form of a loosely compacted herb or stick
- Cupping (used to relieve symptoms of pain and chest congestion in which glass cups are placed on the skin with a vacuum created by heat)
- Dietary advice (based on traditional oriental medicine theory)
- Herbs (use of herbal formulas in the form of teas, powders, pastes, and plasters, which may be taken internally or used externally as a wash. Formulas may include shells, minerals, and animal materials)

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Potential risks: Pain, discomfort, blistering, minor bruising, discoloration, infections, burns, itching, loss of consciousness and deep tissue injury from needle insertions, topical procedures, heat, hydrotherapies; allergic reaction to prescribed herbs, supplements; soft tissue or bony injury from physical manipulation; aggravation of pre-existing symptoms.

Potential benefits: Restoration of the body's maximal and optimal functioning capacity, relief or pain and other symptoms of disease, assistance with injury and disease recovery, and prevention of disease or its progression.

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. Kahlen Pihowich, ND, of these conditions.

Please Initial:

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

☐ I understand that Dr. Kahlen Pihowich, 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. Kahlen Pihowich 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. Pihowich 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

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Fee Schedule

Please refer to the fee schedule on our website, www.truepotentialhealth.com

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

Lab work and supplements prescribed by Dr. Pihowich 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. Pihowich. 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. Pihowich 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. Pihowich is not a medical doctor, but a Naturopathic doctor who practices with natural therapeutics.

I have reviewed the above fees and understand that I am responsible for payment at the time of service, unless previously arranged by Dr. Pihowich. 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: _____