DR. LANI NYKILCHUK, ND
NATUROPATHIC DOCTOR

Timber Massage & Wellness
B, 6935 Harvie Avenue
604-344-0605
info@drlani.ca

PEDIATRIC INTAKE FORM (BIRTH TO 5 YEARS)

Please note that all the information that you provide will be held absolutely confidential.
If you have any questions, feel free to ask.

Today's Date: ____________________________
Patients Full Name: ____ Preferred Name:__________________________

Care Card Number (PHN):____
Age: ______ Date of Birth (M/D/Y): ______________________ Gender: M ❒ F ❒

Parent/Guardian's Name: ____
Address: ____
City: ____ Province: ________________ Postal Code: ______________________
Telephone (home): _______________________________________ (Parent's work):____________________________________
Parent's email address: ____

How did you hear about this clinic? ____
If you were referred, please indicate whom we may thank: ____

Name of doctor's office/hospital/clinic where your child's health records are kept:____________________________________
____
Other types of health care: (ie. Chiropractor, massage therapy, physiotherapist)______________________________________
____

Do you have extended coverage Y ❒ N ❒ Do you receive MSP premium assistance Y ❒ N ❒

Reason for referral or presenting problems: ____
____

HEALTH HISTORY QUESTIONNAIRE

Birth city & state: __________________________________ Birth time: ________________ Birth weight:___________________

What are your child's most important health problems? List as many as you can in order of importance:
1) ____
When did this start?_________________________________

2) ____
When did this start?_________________________________

3) ____
When did this start?_________________________________

4) ____
When did this start?_________________________________

Does your child have a contagious disease at this time? Y / N
If yes, what? ____

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MEDICATIONS / SUPPLEMENTS

NOW	PAST		NOW	PAST	
____	____	Aspirin	____	____	Decongestants
____	____	Tylenol	____	____	Anti-histamine
____	____	Antibiotics	____	____	Other____
____	____	Ibuprofen			

Allergies to medicines: ____

Nutritional supplements your child is taking: ____

____

MEDICAL HISTORY

❐ 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? How long ago? What were the results?

Electroencephalogram (EEG): ____

Psychological evaluations:____

Hearing test: ____

Speech/language tests: ____

Injuries/surgeries/hospitalizations (please list): ____

____

IMMUNIZATIONS

❐ MMR ❐ DPT ❐ Chicken pox ❐Others:_________________________
❐ Measles ❐ Diphtheria ❐ Small pox Adverse reactions: Y ❐ N ❐
❐ Mumps ❐ Tetanus ❐H. influenza If so, what? ______________________
❐ Rubella ❐ Polio ❐The flu ________________________________

FAMILY HISTORY

❐ Heart disease ❐ Diabetes ❐ Birth defects ❐ Hypertension
❐ Arthritis ❐ Tuberculosis ❐ Cancer ❐ Allergies
❐ Asthma ❐ Mental illness ❐ Osteoporosis ❐ Other significant:___________________

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? ______________________________

____

Mother's age at child's birth: ________

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

Mother's health during pregnancy:

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

BIRTH HISTORY

Term: ❐ Full ❐ Premature ❐ Late Length of labor?________________

Type of birth (home, hospital, C-section) ____

Complications:____

Birth city & province: ________________________________

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

❐ Rashes	❐ Birth injuries	❐ Blue baby	❐ Jaundice
❐ Seizures	❐ Cerebral palsy	❐ Colic	❐ Fever
❐ Birth defects	❐Other:______________________________		

Child's sleep patterns (1st year): ____

Breast fed: Y ❐ N ❐ How long: ___________ Formula: Y ❐ N ❐ Type? (milk,soy):____________________

Age began solids: _____________ Which foods:____

Age began: Sitting ___________ Crawling ___________ Walking ___________ Talking _______________

ALLERGIES

Is your child hypersensitive or allergic to:

Any drugs?____

Any foods? ____

Any environmentals?____

SYMPTOMS

❐ Hives	❐ Burning urine	❐ Bloody urine	❐ 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

DIET

Please describe your child's typical daily diet:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

Thank you & Welcome! It is an honor to work with you and your child!

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INFORMED CONSENT AND REQUEST FOR NATUROPATHIC MEDICAL CARE & ACUPUNCTURE

I, ________________________________, hereby request and consent to examination and treatment by Lani Nykilchuk, ND, 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. Nykilchuk, and/or with the allied health care provider, providing backup:

- My suspected diagnosis(es) or condition(s)
- The nature, purpose, goals and potential benefits of the proposed care
- The inherent risks, complications, potential hazards or side effects of treatment or procedure
- The probability or likelihood of success
- Reasonable available alternatives to the proposed treatment procedure
- 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 pap smears, 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 food, nutritional supplements, or intravenous injection of nutrients)
- Traditional Oriental medicine- including acupuncture (insertion of specialized disposable stainless steel sterilized needles through the skin into underlying tissues at specific points on the bodies surface), moxa and cupping.
- Botanical/ herbal medicines
- Homeopathic remedies (highly diluted quantities of naturally occurring substances)
- Lifestyle counseling (including but not limited to visualization for improved lifestyle strategies)
- Bowen therapy (gentle physical therapy)
- Prescribed medication (which are within the naturopathic scope of practice in BC)

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 and medications; 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, Lani Nykilchuk, ND, of these conditions.

☐ 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 and supplements.

I do not expect Lani Nykilchuk, ND 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. Nykilchuk 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 & Guardian	Signature of Patient/Guardian	Date