DR. NATALIE RAHR
NATUROPATHIC DOCTOR

NeuroKids
NEURODEVELOPMENT SUPPORT

info@drnatalierahr.com
www.drnatalierahr.com

Pediatric Intake Form

Please complete and email back to info@drnatalierahr.com
Please be as complete as possible with your answers. Feel free to include reports or test results. This allows for the best possible care for your child's individual needs.
All information is kept completely confidential.

First Name: _____ Last Name:_____

Gender:_____ Age:_____ Birthdate (dd/mm/yy):_____

Care Card Number: _____

Address:_____ City:_____

Province:_____ Postal Code:_____

Parent/Guardian Names:_____

Phone:_____ Work:_____

Email Address:_____

Are we allowed to contact you by email? Y N

Is your child currently receiving healthcare? Y N

If so from whom and where?

Names of other healthcare providers/therapists (including naturopathic doctors, medical doctors, chiropractors, etc)

Please list you child's main health concerns in order of importance:

Please list any know allergies including to medications, environmental and food:

Please list any hospitalizations, serious injuries, and/or surgeries (date and type):

Family Medical History:
Please check off if there is a family history of any and indicate Maternal (M) or Paternal (P) for which side of the family

Asthma_____
Allergies_____
Arthritis_____
Seizures_____
Deafness_____
Cancer_____
Mental Illness_____
Depression_____
Diabetes_____
Kidney Disease_____

High Blood Pressure_____
Gastrointestinal Disease_____
Birth Defects_____
High Cholesterol_____
Heart Disease_____
TB/Cystic Fibrosis_____
Autoimmune Disease_____
Anxiety_____
Developmental Delay_____
Alzheimers/Dementia_____

Others:

Birth History

Mode of Delivery: Vaginal delivery_____ C-Section_____

If C-Section please elaborate:

If vaginal, was labour induced or augmented with pitocin or other medications? Y N

Forceps or vacuum used? Y N

Gestation: Premature_____ Full Term_____

Birth Weight:_____

APGAR scores (if known):_____

Please describe any other complications during or after delivery:

Postpartum History

Was your child breastfed? Y N If yes, for how long?_____

Did your child have jaundice? If yes please describe treatments undertaken
_____

Did you or your child receive antibiotics or any other antibiotics after delivery? _____

Did your child receive vaccinations after deliver? Which ones? Please describe any reactions they may have had.
_____
_____

Did mom suffer form postpartum blues/depression? If yes please describe any medications or other treatments received
_____
_____

Please describe your child's current diet (check all that apply):

No restriction_____ Gluten Free_____ Casein Free_____ Yeast Free_____

Salicylate Free_____ Low Phenolics_____ Organic_____

High Protein/Low Carb_____ IgG Reactive Foods Avoidance_____

Specific Carbohydrate Diet_____ Grain Free/Paleo_____ Ketogenic_____

Other (please describe):_____

Please describe your child's typical breakfast:

_____

Please describe you child's typical lunch:

_____

Please describe your child's typical dinner:

_____

Please describe you child's typical snacks:

_____

What does your child drink throughout the day? _____

Does your child eat refined sugar, fast food, artificial colours/flavouring, sweeteners, preservatives or drink soda? If so, what kind and how often?

_____

Medications

List all prescriptions, over-the-counter drugs, vitamins, herbs, supplements and any non-medical drugs.

Please check if the following symptoms are a current or recurring:

General
Poor appetite
Night sweats
Weight gain
Poor sleep
Sweat easily
Weight loss
Fatigue
Chills
Cravings
Bleed or bruise easily
Fevers
Strong thirst
Sudden energy drop

Skin and Hair
Rashes
Change in hair or skin texture
Recent moles
Itching
Loss of hair
Ulcerations
Eczema
Dandruff
Pimples

Head, Eyes, Ears Nose, Throat
Headaches
Night blindness
Sinus problems
Neck pain
Colour blindness
Nose bleeds
Concussions
Cataracts
Jaw clicks or pain
Eye pain
Earaches
Tooth pain
Eye strain
Poor hearing
Mercury tooth fillings
Blurry vision
Ringing in the ears
Recurrent sore throats
Using glasses
Facial pain
Sores on lips or tongue

Respiratory
Difficulty breathing
Asthma
Coughing blood
Cough
Pain with a deep breath
Pneumonia
Bronchitis
Phlegm production (colour?)

Gastrointestinal
Indigestion
Abdominal pain or cramps
Rectal pain
Gas
Nausea
Hemorrhoids
Bad breath
Vomiting
Leaning abdomen over furniture
Blood in stool
Constipation
Chronic laxative use
Diarrhea

Urinary
Frequent urination
Unable to hold urine
Wetting the bed
Pain with urination
Blood in urine

Neuro-Psychological
Loss of balance
Depression
Quick temper/irritable
Susceptible to stress
Sensory issues
Seizures
Poor memory
Dizziness
Areas of numbness
Anxiety
Lack of coordination

Musculoskeletal
Muscle pain
Joint pain
Muscle weakness

Has your child ever been treated for emotional concerns?

_____

_____

Any other neurological or psychological concerns?

_____

_____

What are your goals of treatment?

Please describe anything else you would like to discuss.

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NATUROPATHIC DOCTOR

Informed Consent to Treatment

1. I understand that Dr. Natalie Rahr, ND is a BC licensed Naturopathic Doctor and that she will provide therapies that are within her scope of practice.
2. I understand that any advice given to me as a patient of Dr. Natalie Rahr is not mutually exclusive from any treatment or advice I may now, or in the future, be given from another health care provider.
3. I understand that I am accepting or rejecting the advice given during my consultation by my own free will.
4. I understand that I am at liberty to seek or to continue medical care from other health care providers.
5. I understand that Dr. Natalie Rahr, ND is not suggesting or recommending that I refrain from seeking advice or continuing care from other health care providers.
6. I understand that Naturopathic Physicians reserve the right to determine which cases fall outside of their scope of practice, and an appropriate referral will be recommended.
7. I understand that the services are not covered by MSP or other provincial health plans and that fees are payable at the time of appointment, including fees for services, laboratory tests and any prescriptions provided.
8. I understand that 48 hours notice is required to cancel otherwise I will be responsible for a cancellation fee of $75-200 depending on length of appointment.
9. I understand that all therapies, services and supplements/prescriptions provided are non-refundable and that prices may change without notice.
10. I understand that any therapies recommended will be explained to me in full by my physician and I will give consent to treatment based on informed consent.
11. I understand that COVID 19 precautions are being taken for in person visits, and that Dr. Natalie Rahr, ND is not liable if I should contract COVID 19 or other illnesses while visiting the office or surroundings.
12. During Telehealth visits (phone or online) I understand that all information is kept as secure and confidential as possible and that these visits do not replace in person primary care. For individuals outside BC, I understand that, depending where I reside, appointments are for information purposes only and treatment must be accessed locally.

I _____ have read, understood and agree to the above statements.

Signature: _____ Date: _____