Dr. Sandra Miranda, N.D.
Naturopathic Doctor

Dear Patient:

Thank you for choosing the Miranda Naturopathic Clinic for your health care needs. By choosing our clinic, we assure you that your child will receive the highest quality of health care. In order to best help your child (under 12 years old), we will need to know about his/her medical history. Please take a few moments to fill in the following questionnaire and a 3 day diet diary before your next appointment.

Your child's first appointment will take approximately 75 minutes long, the second visit will be approximately 60 minutes long and subsequent appointments (progress checks) will take approximately 20 to 30 minutes. During the first visit, an in-depth health history is taken in order to understand all factors that may be affecting your child. The visit also includes a health concern oriented physical exam and depending on your child's age, it will also include some diagnostic tests for example, urinalysis, Vitamin C urine test, Bowel toxicity Urine test, and zinc status (for older children). Further laboratory testing may be discussed and performed if indicated. All this information will assist us in making a thorough assessment of your child's condition. All information will remain completely confidential. A personalized treatment plan is then proposed.

If possible, please arrange to bring, mail or fax all medical test (blood, urine, ultrasound, MRI's and surgery results) pertaining to your health from your physician's office.

As a courtesy to our patients with allergies and for your possible homeopathic treatment, we ask that you do not wear perfume of any kind in the clinic.

Please remember that it takes time to feel better when using naturopathic medicine. Your child may have spent many years with a chronic medical problem unsolved by conventional medicine; or you may just want to make adjustments in order to improve his/her general health. No matter what your reasons are for bringing your child in, remember that some patients need to be patient! The more you and your child are able to participate in his/her care, the easier it will be to address all health concerns.

1. This is to acknowledge that I have read the above information and understood its contents.
2. I agree to pay my full account at the time of each visit or treatment, including fees for services, laboratory tests or any supplement or remedies I may wish to purchase.
3. I authorize and consent to the treatments I may receive from Sandra Miranda ND on my own free will and choice.
4. I understand that I am at liberty to seek or continue medical care from a physician or health care provider.
5. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating my intentions first.

_____ _____

Signature (Legal Guardian) Date

Thank you for taking the time and patience to complete this form. We know it is very detailed but it is very important to collect all the details to know "the whole person" and in finding the root cause of your child's problem. We look forward to working with you and your family in your Naturopathic care.

CHILD INTAKE FORM

Date: _____ How did you hear about our clinic? _____

CHILD'S PERSONAL INFORMATION

Last Name: _____ First Name: _____ Age: _____ Sex: M F
Address: _____ Date of birth: _____
_____ Phone: (____) _____

Parent / Guardian:

Last Name: _____ First Name: _____ Relationship to child: _____
Address: _____ Phone: H (___) _____
_____ W (___) _____

Name of the person filling out this form? _____ Relationship to child: _____

Other Health Care Providers:

Name			
Address			
Phone #	( )	( )	( )
Specialty			

CHIEF HEALTH CONCERNS

	Health Concern (list in order of importance)	When did it start?	How has it been treated so far?
1.-			
2.-			
3.-			
4.-			
5.-			
6.-			

MEDICAL HISTORY

Child's general state of health *(circle):* poor fair good excellent unknown
How many times treated with antibiotics? _____
Any allergies or sensitivites? (medications, foods, environmental) _____
_____

How many hours does your child sleep? At night:_____ During the day: _____

Vaccinations	Age	Adverse Reaction	***Vaccination***	Age	Adverse Reaction
Diptheria			Polio		
Pertussis/whooping cough			Haemophilus influenza B		
Tetanus			Hepatits A		
Measles			Hepatitis B		
Mumps			"flu"		
Rubella			Other:_____		

Medication	Age	Reason for Administration	Adverse Reaction
Current Medications (prescription, non-prescription, vitamin/mineral, supplements, herbs, homeopathics, other)			
Past Medications (prescription, non-prescription, vitamin/mineral, supplements, herbs, homeopathics, other)			

Any accidents or hospitalizations? _____
_____

BIRTH HISTORY

Prenatal: (before birth) Age of mother at conception: _____

Health of parents at conception: Mother: poor fair good excellent unknown
Father: poor fair good excellent unknown

Health of mother during pregnancy: poor fair good excellent unknown

Mother's diet during pregnancy: poor fair good excellent unknown

Any complications/illnesses during pregnancy? _____
_____

Any supplements/medications taken during pregnancy? _____
_____

Mother's use during pregnancy: medications recreational drugs alcohol coffee smoke

Term length: full premature _____wks late _____wks

Natal: (at birth) Length of labour _____ Weight at birth: _____ Length at birth: _____

Nature of delivery: vaginal c-section induced analgesia forceps Other: _____

Any complications encountered? _____

Baby's APGAR score: _____ Did the baby breastfeed immediately after birth? Y N

Any complications of mom or baby at birth? _____
_____

FEEDING HISTORY

For how long was the baby breastfed? _____ If not, what kind of formula/liquid was given? _____

What solid foods were introduced to the child during the first year?

Type of food	*When was it introduced?*		*Type of food`*	*When was it introduced?*

Indicate the child's typical diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks / Fluids _____

LIVING CONDITIONS

Who does the child live with? _____ Any siblings? How old are they? _____

Does anyone in the house smoke? Y N Emotional climate at home (*circle*): Stable Stressful Very stressful

Where does the child spend most of his time during the day? _____

Are there any pets living in the child's house? If so, what are they? _____

REVIEW OF SYSTEMS – Please indicate if the child has had any of the following (P- past) (C- current)
Current Weight _____ Maximum weight _____ When? _____ Height _____

GENERAL			
Anemia	Yes	(P / C)	No
Tremor	Yes	(P / C)	No
Fainting	Yes	(P / C)	No
Dizziness	Yes	(P / C)	No
Fatigue	Yes	(P / C)	No
Headache	Yes	(P / C)	No
Insomnia/sleeping problems	Yes	(P / C)	No
Convulsions	Yes	(P / C)	No
Hyperactivity	Yes	(P / C)	No
Cannot loose weight	Yes	(P / C)	No
Sudden weight loss	Yes	(P / C)	No
RESPIRATORY			
Chest pain/tightness	Yes	(P / C)	No
Chronic cough	Yes	(P / C)	No
Difficulty breathing	Yes	(P / C)	No
Spitting blood	Yes	(P / C)	No
Spitting phlegm	Yes	(P / C)	No
Asthmatic symptoms	Yes	(P / C)	No
Wheezing	Yes	(P / C)	No
Whooping cough	Yes	(P / C)	No
Bronchitis	Yes	(P / C)	No
Tuberculosis	Yes	(P / C)	No
Influenza	Yes	(P / C)	No
Pneumonia	Yes	(P / C)	No
SKIN			
Acne / Boils	Yes	(P / C)	No
Roseola	Yes	(P / C)	No
Warts	Yes	(P / C)	No
Measles	Yes	(P / C)	No
Dryness	Yes	(P / C)	No
Eczema	Yes	(P / C)	No
Chicken Pox	Yes	(P / C)	No
Bruise easily	Yes	(P / C)	No
Rubella	Yes	(P / C)	No
Hives	Yes	(P / C)	No
CARDIOVASCULAR			
Septal defect	Yes	(P / C)	No
Heart Murmur	Yes	(P / C)	No
Slow heart beat	Yes	(P / C)	No
Rapid heart beat	Yes	(P / C)	No
Low blood pressure	Yes	(P / C)	No
Leg cramps at night	Yes	(P / C)	No
Shortness of breath	Yes	(P / C)	No
SCALP AND HAIR			
Dandruff	Yes	(P / C)	No
Psoriasis	Yes	(P / C)	No
Hair loss	Yes	(P / C)	No
Dry hair	Yes	(P / C)	No
Oily hair	Yes	(P / C)	No
Itchy scalp	Yes	(P / C)	No
Baldness batches	Yes	(P / C)	No
Head lice	Yes	(P / C)	No
Hair implants	Yes	(P / C)	No

GASTROINTESTINAL			
Gas	Yes	(P / C)	No
Jaundice	Yes	(P / C)	No
Nausea	Yes	(P / C)	No
Fissures	Yes	(P / C)	No
Diarrhea	Yes	(P / C)	No
Constipation	Yes	(P / C)	No
Poor appetite	Yes	(P / C)	No
Hemorroids	Yes	(P / C)	No
Liver / Gall bladder trouble	Yes	(P / C)	No
Colon trouble	Yes	(P / C)	No
Burping after meals	Yes	(P / C)	No
Intestinal worms	Yes	(P / C)	No
Excessive hunger	Yes	(P / C)	No
Pain over stomach	Yes	(P / C)	No
Abdominal distension	Yes	(P / C)	No
Halitosis / bad breath	Yes	(P / C)	No
Rectal bleeding	Yes	(P / C)	No
Bloated after meals	Yes	(P / C)	No
Vomitting blood	Yes	(P / C)	No
Induced vomitting	Yes	(P / C)	No
Rectal itch or redness	Yes	(P / C)	No
Grey/Black/Bloody stools	Yes	(P / C)	No
Bulimia / Anorexia nervosa	Yes	(P / C)	No
Diverticulitis	Yes	(P / C)	No
Polyps in colon	Yes	(P / C)	No
Stomach ulcers	Yes	(P / C)	No
Sleepy after meals	Yes	(P / C)	No
Painful to swallow	Yes	(P / C)	No
Food particles in stool	Yes	(P / C)	No
MUSCLE, BONE AND JOINTS			
TMJ	Yes	(P / C)	No
Gout	Yes	(P / C)	No
Hernia	Yes	(P / C)	No
Arthritis	Yes	(P / C)	No
Bursitis	Yes	(P / C)	No
Neck stiffness	Yes	(P / C)	No
Joint stiffness	Yes	(P / C)	No
Fibromyalgia	Yes	(P / C)	No
Upper back pain	Yes	(P / C)	No
Middle back pain	Yes	(P / C)	No
Lower back pain	Yes	(P / C)	No
Rheumatoid arthritis	Yes	(P / C)	No
Numbness in a body part	Yes	(P / C)	No
Growing Pain	Yes	(P / C)	No
Pain in tail bone	Yes	(P / C)	No
Sciatica pain	Yes	(P / C)	No
Poor posture	Yes	(P / C)	No
Swollen joints	Yes	(P / C)	No
Pain between ribs	Yes	(P / C)	No
Scoliosis	Yes	(P / C)	No
Muscle twitches	Yes	(P / C)	No
Fractures	Yes	(P / C)	No
Weakness	Yes	(P / C)	No

MOUTH

Mumps	Yes	(P / C)	No
Snore	Yes	(P / C)	No
Teeth trouble eg cavities	Yes	(P / C)	No
Gums bleeding	Yes	(P / C)	No
Teeth sensitive to cold/heat	Yes	(P / C)	No
Taste changes	Yes	(P / C)	No
Drooling at night	Yes	(P / C)	No

NOSE

Nose tip itch	Yes	(P / C)	No
Nose bleeds	Yes	(P / C)	No
Nasal obstruction	Yes	(P / C)	No
Nasal congestion	Yes	(P / C)	No
Sneezing spells	Yes	(P / C)	No
Sinus problems	Yes	(P / C)	No
Hay fever	Yes	(P / C)	No

THROAT

Tonsilitis	Yes	(P / C)	No
Frequent sore throats	Yes	(P / C)	No
Cold sores	Yes	(P / C)	No
Throat itch	Yes	(P / C)	No
Enlarged glands	Yes	(P / C)	No
Throat irritation	Yes	(P / C)	No
Voice changes / hoarseness	Yes	(P / C)	No
Thrush	Yes	(P / C)	No

EARS

Ringing of ears	Yes	(P / C)	No
Ear aches	Yes	(P / C)	No
Ear redness	Yes	(P / C)	No
Ear cannal itch	Yes	(P / C)	No
Ear discharge	Yes	(P / C)	No
Pulling of ear	Yes	(P / C)	No
Excessive ear wax	Yes	(P / C)	No
Impaired hearing	Yes	(P / C)	No

EYES

Eyes itch	Yes	(P / C)	No
Eyes redness	Yes	(P / C)	No
Eye discharge	Yes	(P / C)	No
Sties on eye lids	Yes	(P / C)	No
Failing vision	Yes	(P / C)	No
Glaucoma	Yes	(P / C)	No
Bags under eyes	Yes	(P / C)	No

ENDOCRINE GLANDS

Goiter	Yes	(P / C)	No
Diabetes	Yes	(P / C)	No
Puffy face	Yes	(P / C)	No
Protruded eyes	Yes	(P / C)	No
Hypoglycemia	Yes	(P / C)	No
Thyroid disease	Yes	(P / C)	No
Intolerance to cold/heat	Yes	(P / C)	No

NERVOUS SYSTEM

Nervous	Yes	(P / C)	No
Unusual fears	Yes	(P / C)	No
Depressed	Yes	(P / C)	No
Annoyed easily	Yes	(P / C)	No
Hopeless outlook	Yes	(P / C)	No
Frightening dreams / thoughts	Yes	(P / C)	No
Thoughts of suicide	Yes	(P / C)	No
Multiple sclerosis	Yes	(P / C)	No
Speech problems	Yes	(P / C)	No
Paralysis	Yes	(P / C)	No
Loss of memory	Yes	(P / C)	No

GENITO-URINARY

Bed wetting	Yes	(P / C)	No
Blood in urine	Yes	(P / C)	No
Frequent urination	Yes	(P / C)	No
Cannot control urine	Yes	(P / C)	No
Kidney infections	Yes	(P / C)	No
Kidney stones	Yes	(P / C)	No
Burning during urination	Yes	(P / C)	No
Slow urination	Yes	(P / C)	No
Itchy genitals	Yes	(P / C)	No
Swollen testicles	Yes	(P / C)	No
Difficulty starting urine	Yes	(P / C)	No

Age breasts started enlarging? _____
Age voice began to deepen? _____
Blood type _____
Number of times child brushes teeth? _____
How often does child have a bowel movement? _____

Age menses started? _____
Age facial hair first appeared? _____
Date of last blood test? _____
Last visit to the dentist? _____
How often does child urinate? _____

What else would you like me know about your child's health?

_____

_____

THANK YOU FOR TAKING THE TIME TO FILL UP THIS INTAKE FORM