Suite 305, 3425 – 22nd ST SW, Calgary, AB – T2T 6S8
Phone: (403) 383-3228 | Email: info@essencewellness.ca

PEDIATRIC INTAKE

Patient Information:

Name: ____ Date: _________________
Address: ____
City: ____________________ Province: ______________ Postal Code: ______________
Phone: (H) ____________________________(Cell) _____________________________
Date of Birth: _______________(YYYY/MM/DD) Age: ____ Sex: M / F / ◻ ___________
Occupation: _______________________ Email: ____________________________________
By providing my email, I agree to receiving clinic email reminders, health updates, promotions, etc.
In case of emergency, who should we contact: _________________________________
How did you find out about our services? ______________________________________

Patient Health History:

Please list your child's health concerns (from major to minor):
1. ____
2. ____
3. ____
4. ____
5. ____

Please list all accidents, surgeries or hospitalizations and the year they occurred:
____ __________
____ __________
____ __________

Please list any medications and supplements your child is currently taking:
____
____

Is your child currently seeing any other alternative health care professionals?
____

Please list all allergies:
____

When was your child's last physical exam? _____________________________________

When was your child's last blood test? ____
Family Doctor's name: ____
Address: __________________________ Phone number: ___________________________

Family Medical History:

Please list all family members who have any major health conditions:
____
____
____

Which of the following has your child had? (N=never, M=mild, A=average, S=severe)

___ Rubella (German Measles) ___ Chicken Pox ___ Impetigo ___ Mumps
___ Ear Infections ___ Scarlet Fever ___ Strept Throat ___ Measles
___ Mononucleosis ___ Roseola ___ Whooping Cough

Please indicate what immunizations your child has had:

___ DPT (diptheria, pertussis, tetanus) ___ Hepatitis A ___ Hepatitis B
___ Tetanus booster, when? __________ ___ Flu vaccine ___ Polio
___ MMR (measles, mumps, rubella) ___ Haemophilus influenza B

How many times has your child been treated with antibiotics? ________

Was your Child breast fed, How long? ________ Formula/Milk/Soy/Other:___________

Consent for Treatment with Essence Wellness Clinic

I am hereby requesting ☐ **Acupuncture** ☐ **Massage** ☐ **Naturopathic** treatments from Essence Wellness Clinic. New complications and concerns, if they do arise, will be discussed with my practitioner/therapist, and appropriate action will be taken. I understand that although these are natural and alternative treatments I am seeking, there may be risks of bruising, pain in treated area, and worsening of symptoms during the healing process. I also understand that there are no guarantees for cure for any of my ailments or improvements of my symptoms. I hereby release Essence Wellness and all practitioners/therapists treating me from all liabilities.

I am also aware of the clinic's late cancellation policy of a charge of **50% of the visit cost** if I fail to give **less than 24 hours notice for cancellations**. **I will be responsible to pay that charge before I can re-book.**

Signature of parent/guardian ____________________________________

Name of parent/guardian____

Date________________________