NATUROPATHIC PEDIATRIC INTAKE FORM

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GENERAL

Name:			Date of 1st Visit:	
Date of Birth: dd /mm /yyyy	Age:	Gender:	Height:	Weight:
Address:				
City:		Prov:	Postal Code:	
Phone (home):		Phone (work):		
Phone (cell):		Email:		
Person completing this form:				
Name of Guardian:			Relationship:	
Name of Guardian:			Relationship:	
With whom does this child live?				
Was this child adopted?	If yes, at what age?			

EMERGENCY CONTACT

Name:	Relationship:
Phone (home):	(work/cell):

OTHER HEALTH CARE PROVIDERS

1.	2.
Phone:	Phone:
Fax:	Fax:
3.	4.
Phone:	Phone:
Fax:	Fax:

Please indicate any regular screening tests your child has done: ____________________

Date of last screening test or physical exam: ____________________

How did you hear about our clinic? ____________________

HEALTH HISTORY

Reason for visit (list in order of importance):

How long has the child had this condition:

What type of therapies have you tried in the past for these concern(s)?

❑ Diet Modification ❑ Vitamins/minerals ❑ Herbs ❑ Homeopathy ❑ Chiropractic ❑ Pharmaceuticals
❑ Other ______

What was the outcome? ______

Please list all prescriptions, over the counter medications, supplements, vitamins or natural health products the child is **currently** taking, the reason why, and for how long they have been taking them:

Medication/Natural Health Product	Reason Taking	How long

How many times has the child been treated with antibiotics? ______

Major Hospitalizations, Surgeries, and Injuries: please indicate dates and complications (if any)

Year Illness, Surgery, Injury, Major Medical Diagnosis

Please list all allergies: (food, environmental, medications, etc)

Please list any food sensitivities:

Please list any other foods that are excluded from the child's diet and why:

Please check all of the following conditions that your child is currently experiencing (C) or has experienced in the past (P)

Condition	C	P	Condition	C	P	Condition	C	P
Measles	❑	❑	Mononucleosis	❑	❑	Bed Wetting	❑	❑
Chicken Pox	❑	❑	Strep Throat	❑	❑	Anxiety	❑	❑
Headaches	❑	❑	Rubella	❑	❑	Asthma	❑	❑
Mumps	❑	❑	Chronic Runny Nose	❑	❑	ADD/ADHD	❑	❑
Ear Infections	❑	❑	Hives/Rashes/Eczema	❑	❑	Cold Sores	❑	❑
Pneumonia	❑	❑	Temper tantrums	❑	❑	Sinus Problems	❑	❑
Constipation	❑	❑	Coughing/wheezing	❑	❑	Seizures	❑	❑
Scarlet Fever	❑	❑	Colic/gas/cramping	❑	❑	Diarrhea	❑	❑
Tonsillitis	❑	❑	Digestive Difficulties	❑	❑	Frequent Colds	❑	❑

VACCINATION HISTORY

Please indicate which vaccinations the child has received and the dates received

- ❑ Diptheria dates ______________
- ❑ Pertussis dates ______________
- ❑ Tetanus dates ______________
- ❑ Polio dates ______________
- ❑ HiB dates ______________
- ❑ Measles dates ______________
- ❑ Other dates ______________
- ❑ Mumps dates ______________
- ❑ Rubella dates ______________
- ❑ Hepatitis A dates ______________
- ❑ Hepatitis B dates ______________
- ❑ Chicken Pox dates ______________
- ❑ Flu dates ______________

Please indicate if your child experienced any reaction or illnesses following a vaccination. Please indicate what the reaction was and to which vaccination(s) ____

____

____

FAMILY HISTORY

Please check any the following that a family member has experienced:

- ❑ Arthritis
- ❑ Asthma
- ❑ Alzheimer's Disease
- ❑ Autoimmune (MS, Lupus, etc)
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Eczema
- ❑ Drug Addiction/Alcoholism
- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ Migraine headaches
- ❑ Psoriasis
- ❑ Kidney Disease
- ❑ Stroke
- ❑ Thyroid Issues
- ❑ Mental Illness
- ❑ Other ____________________

PRENATAL HISTORY

Maternal age for the pregnancy: Paternal age for the pregnancy:

Number of previous pregnancies: Miscarriages: Abortions:

Please describe any problems with conception or infertility treatment received for this child:

____

____

____

Please check any of the following that applied to the pregnancy:

- ❑ Diabetes
- ❑ Nausea/vomiting
- ❑ Cigarette smoking
- ❑ Alcohol/tobacco/drug use ______________________________
- ❑ Bleeding ______________________________
- ❑ Infections ______________________________
- ❑ Prescription medication ______________________________
- ❑ Supplements ______________________________
- ❑ Over the Counter medications ______________________________
- ❑ Prenatal testing ______________________________
- ❑ Physical/Emotional trauma ______________________________
- ❑ Workplace chemicals ______________________________
- ❑ Exposure to disease or other harmful substances ______________________________
- ❑ Other ______________________________
- ❑ High Blood Pressure
- ❑ Thyroid conditions
- ❑ Strep B positive

Please indicate the general health/well-being of the parents during the pregnancy:

Mother:	❑ excellent	❑ good	❑fair	❑poor	❑unknown
Father:	❑ excellent	❑ good	❑fair	❑poor	❑ unknown

Please indicate the general emotional well being of the parents during the pregnancy:

Mother:	❑ excellent	❑ good	❑fair	❑poor	❑unknown
Father:	❑ excellent	❑ good	❑fair	❑poor	❑ unknown

How was the mother's diet during pregnancy?

❑ excellent ❑ good ❑fair ❑poor ❑unknown

EARLY CHILDHOOD HISTORY

Where was the birth? ______________________________

Name of obstetrician/midwife/health care providers: ______________________________

Gestational Age at Birth:

Preterm (< 37 wks) ____wks Term (38-42 wks) ____wks Post term (> 42 wks) ___wks

Birth Weight: _______ Length: _______ Head Circumference: ___________

Please indicate if any of the following interventions were applied:

❑Induction ❑ Forceps ❑ Vacuum extraction ❑ C-section
❑Episiotomy ❑ Pitocin ❑ Pain medication ❑ Epidural
❑Antibiotics ❑Other ______________________________

Were there any birth complications? (ie breech) ______________________________

How long was the labour? _________ APGAR Score (0-10) 1min: ___ 5min ____

Please indicate if any of the following were present shortly after birth:

- ❑ Infections/Fever ❑ Respiratory Distress ❑ Jaundice ❑ Poor feeding ❑ Anemia
- ❑ Congenital Defects ❑ Colic ❑ Rashes ❑ Seizures ❑ Birth Trauma/Injuries
- ❑ Other: ____________________

DEVELOPMENTAL AND SOCIAL HISTORY

At what age did your child first:

Sit up ______ Crawl ______ Walk ______ Talk ______

At what age did your child begin teething? ______

Were there any difficulties associated with teething? ____

Is your child in: ❑school ❑daycare ❑homecare ❑other What grade level? ______

General school/daycare behaviour/performance:____

____

How is the child's behaviour at home? ____

Does your child have any habits? ________________________ Any fears? ________________________

Has the child been diagnosed with any learning disabilities? ____

Does your child make friends easily? ____

Child's interests and favourite activities: ____

According to your child, do they enjoy these activities? ____

How many hours/week does your child: Play on the computer or video games? ________ Exercise? ______

Watch television? ______ Read?(not for school) ______

Please write a little about your child's personality? ____

____

LIFESTYLE HABITS

What time does your child usually go to bed? _______ Wake up? _____________

Does your child nap during the day? Y / N What time(s): ______________________

Does your child have nightmares? Y / N How often? ________________________

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc)

____

Was the child breastfed? ______________________ For how long? ________________

Was the child formula fed? _____________________ Which formula? _______________

Please note any problems with or reactions to feeding: ____

____

____

When was solid food introduced? ____

Order of food introduction: ____

____

Please describe your child's eating behaviours (eg. Good appetite, picky eater, etc.)

____

Does your child have any strong food cravings or aversions? ______________________________

Is the child exposed to any of the following on a regular basis?

❑tobacco smoke ❑ pets ❑ old building ❑ renovations ❑chemical fumes ❑new building

Please describe: ____

What is the source of your child's drinking water?

❑ tap ❑ filtered ❑ distilled ❑ bottled ❑ other ____________________

Marital status of the child's parents: ❑ Married ❑ Divorced ❑ Separated

How would you describe the emotional climate of the child's home? _______________________

____

Thank you for taking the time to fill out these forms.

I look forward to working with you on your journey to health and wellbeing.