

NATUROPATHIC PEDIATRIC INTAKE FORM

225 MILITARY RD, PO BOX 516, LANCASTER, QC K0C 1N0
 PHONE 514.674.1674 EMAIL ND@INTEGRATIVEHEALTHCENTRE.CA
WWW.INTEGRATIVEHEALTHCENTRE.CA

GENERAL

Name:		Date of 1 st 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	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Bed Wetting	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Strep Throat	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Rubella	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Hives/Rashes/Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Temper tantrums	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Coughing/wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Colic/gas/cramping	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>

VACCINATION HISTORY

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

- | | | | |
|-------------------------------------|-------------|--------------------------------------|-------------|
| <input type="checkbox"/> Diphtheria | dates _____ | <input type="checkbox"/> Mumps | dates _____ |
| <input type="checkbox"/> Pertussis | dates _____ | <input type="checkbox"/> Rubella | dates _____ |
| <input type="checkbox"/> Tetanus | dates _____ | <input type="checkbox"/> Hepatitis A | dates _____ |
| <input type="checkbox"/> Polio | dates _____ | <input type="checkbox"/> Hepatitis B | dates _____ |
| <input type="checkbox"/> HiB | dates _____ | <input type="checkbox"/> Chicken Pox | dates _____ |
| <input type="checkbox"/> Measles | dates _____ | <input type="checkbox"/> Flu | dates _____ |
| <input type="checkbox"/> Other | 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:

- | | | |
|------------------------------------------------------|----------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Autoimmune (MS, Lupus, etc) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Other _____ |

PRENATAL HISTORY

Maternal age for the pregnancy:
Number of previous pregnancies:

Paternal age for the pregnancy:
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:

- | | |
|--------------------------------------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Thyroid conditions |
| <input type="checkbox"/> Cigarette smoking | <input type="checkbox"/> Strep B positive |
| <input type="checkbox"/> Alcohol/tobacco/drug use _____ | |
| <input type="checkbox"/> Bleeding _____ | |
| <input type="checkbox"/> Infections _____ | |
| <input type="checkbox"/> Prescription medication _____ | |
| <input type="checkbox"/> Supplements _____ | |
| <input type="checkbox"/> Over the Counter medications _____ | |
| <input type="checkbox"/> Prenatal testing _____ | |
| <input type="checkbox"/> Physical/Emotional trauma _____ | |
| <input type="checkbox"/> Workplace chemicals _____ | |
| <input type="checkbox"/> Exposure to disease or other harmful substances _____ | |
| <input type="checkbox"/> Other _____ | |

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

- | | | | | | |
|---------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|----------------------------------|
| Mother: | <input type="checkbox"/> excellent | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input type="checkbox"/> poor | <input type="checkbox"/> unknown |
| Father: | <input type="checkbox"/> excellent | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input type="checkbox"/> poor | <input type="checkbox"/> unknown |

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

- | | | | | | |
|---------|------------------------------------|-------------------------------|-------------------------------|-------------------------------|----------------------------------|
| Mother: | <input type="checkbox"/> excellent | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input type="checkbox"/> poor | <input type="checkbox"/> unknown |
| Father: | <input type="checkbox"/> excellent | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input type="checkbox"/> poor | <input type="checkbox"/> unknown |

How was the mother's diet during pregnancy?

- | | | | | |
|------------------------------------|-------------------------------|-------------------------------|-------------------------------|----------------------------------|
| <input type="checkbox"/> excellent | <input type="checkbox"/> good | <input type="checkbox"/> fair | <input type="checkbox"/> poor | <input type="checkbox"/> 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:

- | | | | |
|--------------------------------------|--------------------------------------|--------------------------------------------|------------------------------------|
| <input type="checkbox"/> Induction | <input type="checkbox"/> Forceps | <input type="checkbox"/> Vacuum extraction | <input type="checkbox"/> C-section |
| <input type="checkbox"/> Episiotomy | <input type="checkbox"/> Pitocin | <input type="checkbox"/> Pain medication | <input type="checkbox"/> Epidural |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> 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.