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PEDIATRIC INTAKE FORM

As your child's Naturopathic Doctor, it is important that I am aware of your child's current health status, his/her complete medical history, as well as what areas of his/ her health you would like to see change in the future. Please complete this form as thoroughly as possible, as your responses will greatly assist in the development of a personalized treatment plan.

*Please bring all of the completed forms in this package with you to your first visit.

Identifying Information

Who is filling out this form? (name, relation): ____________________

Child's Name: ____________________ Age:______ Sex: ______ Date of Birth:______________

Height: _________ Weight: _________ Grade level: _________

AHC# ____________________

Parents Names: ____________________ Occupation: ____________________

____________________ ____________________

Contact Information for child's primary caregiver(s) (Who the child lives with):

Name: ____________________ Relation:____________________

Address: ____________________

Postal Code: ____________________

Phone Numbers: (H): ____________________(W): ____________________

Email: ____________________

Contact Information for child's secondary caregiver(s):

Name: ____________________ Relation: ____________________

Address: ____________________

Phone Numbers: (H): ____________________ (W): ____________________

Emergency Contact:

Name: ______________________________ Relation: ____________________

Phone Numbers: (H): ______________ (W): ______________ (C): ______________

Family Doctor/ Pediatrician: ______________________________

Phone Number: ________________ (Fax): ________________

Chief Concern #1 (Please Explain):

____

____

Chief Concern #2 (Please Explain):

____

____

Chief Concern #3 (Please Explain):

____

____

List of Current Medications/ Natural Health Products:

____

____

Prenatal Information

Adopted: Y / N Previous History of Infertility: Y / N

How was pregnancy achieved? (e.g. intercourse, IVF, AI, sperm donation, other): ______________

Was the pregnancy planned?: Y / N

Birth Order: ____________ Siblings Names & Age: ____________________________

Age of Mother at Conception: __________ Age of Father at Conception: _________

Number of Previous Pregnancies: ________ Number of Previous Deliveries: ________

Conditions Mom experienced during pregnancy: (e.g. elevated blood pressure, gestational diabetes, bleeding, infections, thyroid problems, nausea, vomiting, bed rest, edema(swelling), fainting, anemia, weight gain/ loss, physical trauma): ____

____

Did the Mother use any of the following during pregnancy?:

Substance:	Yes / No	Please List (specific type, how much, how often):
Tobacco		
Alcohol		
Recreational Drugs		
Caffeine		
Medications (prescribed or over the counter)		
Supplements		
Other		

Tests performed during pregnancy: (ultrasound, amniocentesis, chorionic villi sample, triple screen, maternal serum screening, other)

___

Please indicate any physical or emotional traumas Mom experienced during pregnancy:

___

Does the Mother work outside of the home?: Y / N

If Yes, please indicate at what point in the pregnancy did the mother take maternity leave: ____________

How would you describe the pregnancy?: ____

Birth History

Term Length: Preterm (37wks or less) Full-term (38-42wks) Post-term (42+wks)

Location of delivery (e.g. home, hospital, birthing centre, other): ______________________________

Length of labour: __________________________

Was the labour spontaneous?: Y / N If No, How was it induced?: __________________________

Type of Delivery: Vaginal / Cesarean Section / Breech / Emergency C-Section (Please Circle)

Interventions of Birth (e.g. anesthesia, epidural, episiotomy, forceps, vacuum, other):

___

Birth injuries: Y / N, If Yes please describe: ____

Congenital defects: Y / N, If Yes please describe: ____

Caregivers involved in the birth (e.g. Obstetrician, Midwife, Doula, Family Doctor):

___

Birth Weight: ____________ Length: ____________ APGAR Score (if known): _______________

Early complications (e.g. failure to thrive, illness, jaundice, hypoglycemia, respiratory difficulty, meningitis, rashes, seizures, difficulty feeding): ____

Interventions following birth: (e.g. medications, respirator, surgery, phototherapy, other)

___

Nutritional History

Breastfed: Y / N I   If No, Why?: ______________________

Substitute Formula used: ______________________

If Yes, Duration:______________________

Mother's diet while breastfeeding: (e.g. foods typically enjoyed, food cravings, foods avoided, child's reactions): ______________________

____

Did the child experience colic? Y / NIf yes, for how long? ______________________

Weaning History (e.g. when, child's response, etc.): ______________________

First Food(s) Introduced:

Food	When (e.g. 6, 9, 12 months)?	Reactions (if any)?
______	______	______
______	______	______
______	______	______
______	______	______

Does the child have any dietary restrictions? (e.g. religious, vegetarian, vegan, etc):

____

Food Allergies / Intolerances: ______________________

How would you describe the child's eating habits?:______________________

Describe a typical day's diet:

Breakfast: ______________________

Lunch: ______________________

Dinner: ______________________

Snacks: ______________________

Water Intake (total quantity): ______________________

Other Fluids (total quantity): ______________________

Child's food cravings: ______________________

Medical History

How would you describe the child's general state of health?: ________________________________

Please indicate any serious conditions, surgeries, illnesses or injuries, and any hospitalizations; along with approximate dates: ________________________________

____

Please list past prescription medications:

____

____

How many times has the child been treated with antibiotics?: ________________________________

Does the child have any allergies? (e.g. food, medicines, environmental, etc.):

____

What screening tests has the child had to date? (e.g. blood, hearing, vision, etc. including approx. date):

____

Immunization History

Vaccination	**Approximate Date(s)**	**Child's Reaction**, if any (e.g. fever, rash, pain, insomnia, vomiting, swelling,mood changes, or other)
DPT (diphtheria, pertussis, tetanus)		
Polio (IPV)		
Hib (Haemophilus Influenzae type b)		
MMR (measles, mumps, rubella)		
Hepatitis B		
Influenza, "Flu"		
Varicella "chicken pox"		
HPV		
Meningococcal Conjugate		
Pneumococcal Conjugate		
Hepatitis A		
Tetanus Booster (Td, Tdap or Td-IPV)		
Other:		

Please circle any that apply to the child N = Never, P = In the Past, C = Currently

Skin:		**Ears:**		**Gastrointestinal:**	
Rashes	N P C	Infection	N P C	Trouble swallowing	N P C
Eczema	N P C	Hearing Loss	N P C	Nausea & vomiting	N P C
Psoriasis	N P C	Ringing in ears	N P C	Bloating	N P C
Vitiligo	N P C	Nose & Sinuses:		Abdominal Pain	N P C
Dryness	N P C	Nasal Stuffiness	N P C	Diabetes	N P C
Hives	N P C	Nose Bleeds	N P C	Excessive Gas	N P C
Boils	N P C	Infections	N P C	Constipation	N P C
Warts	N P C	Mouth & Throat:		Blood in Stool	N P C
Fungal Infections	N P C	Thrush	N P C	Weight loss/gain	N P C
Impetigo	N P C	Bad breath/odour	N P C	Diarrhea	N P C
Mind:		Tonsillitis	N P C	**Childhood Illnesses:**	
Nervousness/anxiety	N P C	Sore Throat	N P C	Stomach Flu	N P C
Head:		**Cardiovascular:**		Chicken Pox	N P C
Cradle Cap	N P C	Heart Murmurs	N P C	Croup	N P C
Hair loss	N P C	Rheumatic fever	N P C	Measles	N P C
Headaches	N P C	Respiratory:		Mumps	N P C
Dizziness	N P C	Cough	N P C	Meningitis	N P C
Dandruff	N P C	Wheezing	N P C	Pneumonia	N P C
Lice	N P C	Colds	N P C	Mononucleosis	N P C
Head Injury	N P C	Asthma	N P C	Rubella	N P C
Eyes:		Bronchitis	N P C	Strep Throat	N P C
Redness	N P C	Infection	N P C	Scarlet Fever	N P C
Discharge/Infection	N P C	**Genitorurinary:**		Whooping Cough	N P C
Vision problems	N P C	Frequent urination	N P C	**Other:**	
Double vision	N P C	Bladder infection	N P C	Fevers	N P C
Blurred vision	N P C	**Haematological:**		Growing pains	N P C
Neurological:		Easy bleeding	N P C	Fracture	N P C
Seizures	N P C	Blood Transfusions	N P C	Allergies	N P C
Tingling/numbness	N P C	Anemia	N P C	Fatigue	N P C
		East Bruising	N P C	Hernia	N P C

Developmental History

Did the child experience any developmental delays? Y/N If so, describe:

____

Developmental Milestone:	Age of Child:		
Rolling over	____________	Crawling	____________
Sitting on own	____________	Walking	____________
Talking	____________	Eruption of Teeth	____________

Family Medical History

Relation	Significant Health Concerns	If deceased, list cause & age of death
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings		

Sleep History

Where does the child sleep? (e.g. own bed, parent's bed, crib, with siblings): ________________________

Age when child first began to sleep through the night: __________________

Describe the child's sleep pattern (e.g. bed time, avg. length of sleep, naps):

____

Does the child have any difficulty falling asleep or waking up? ____________________________________

Does the child experience nightmares?: Y / N or night terrors?: Y / N

Frequency:____

Describe repetitive dreams/ nightmares/ night terrors:

____

Occurrence of sleepwalking: Y / N If Yes, Frequency: _______________________

Occurrence of Bedwetting: Y / N If Yes, Frequency: _______________________

How it is dealt with?: ____

Environmental Exposures

Occurrence of moving/ painting/ renovations during pregnancy: Y / N ______________________________

How long has the child lived in this location?: ____

Age of Home: ____

What is the flooring in the house? (e.g. carpet, hardwood flooring): _________________________________

How is the child's home heated?: ____

Does anyone in the child's household smoke?: Y / N

Indicate if there are any pets in the child's home: ____

Water source (e.g. well water/ city water/ bottled/ filtered – what kind, other):

____

Do you know of any toxins or other hazards the child is regularly exposed to (e.g. home, other's work, hobbies, etc)? Please describe. ____

____

Travel history (please include destinations and date of travel):

____

____

Lifestyle

Where does the child spend his/ her time during the day? (e.g. home, daycare, school, babysitter):

____

How would you describe the child's temperament?: ______________________________

How does the child interact with other people?: ______________________________

Have you ever noticed any behavioural problems at home/ school/ daycare/ sitters?:

____

How is the child's performance at school?: ______________________________

Has the child experienced any emotional trauma(s)?: ______________________________

How does the child handle stress?: ______________________________

What type of physical activity does the child engage in? how often?:

____

Child's favorite activities/ hobbies: ______________________________

How many hours per day of TV does the child watch? ______________________________

How often (outside of school) does the child read or is read to by someone?

____

Additional comments/ Anything you would like to share that hasn't already been covered:

____

____

How did you hear about our clinic? ______________________________

SIGNATURE

I, ______________________ attest that the information provided is true and accurate to the best of my knowledge.

Signature: ______________________________ Date: ______________