

Pediatric Intake Form

Full Name: _____ Date: _____
(First) (Middle) (Last) (dd/mm/yy)

Age: _____ Birth date: _____ Sex: _____ Gender: _____
(dd/mm/yy)

Contact Information

Address: _____ City: _____ Postal: _____
(Street No.) (Street Name) (Apt. No.)

Home Phone: _____ Work Phone: _____ Other: _____

E-mail Address: _____ Relationship to child: _____

May we leave messages relating to your visits? Y N. Which Phone Number: _____

Emergency Contact Information

Emergency Contact Name: _____

Phone: _____ Relationship to child: _____

Other Health-care Providers

Names and types of other Healthcare providers:

1. _____ Phone: _____

2. _____ Phone: _____

3. _____ Phone: _____

Date of last medical visit: _____ Date of last physical exam: _____
(dd/mm/yy) (dd/mm/yy)

How did you hear about this clinic? _____

If referred, please state by whom? _____

Have you been treated by Naturopathic Doctor before? Y N

If yes, by whom? _____ Date of last ND visit? _____
(dd/mm/yy)

Health Assessment Questionnaire

Chief Concerns (please list in order of importance):

1. _____
2. _____
3. _____
4. _____
5. _____

Medications/Supplements/ Drugs

Please list all the current prescription medications:

Name	Dose	Frequency	Duration	Side effects (any)

List all past medications: _____

Please list all the current supplements, vitamins, herbs, homeopathic, over-the-counter, non-prescription medications:

Name	Dose	Frequency	Duration	Side effects (any)

Medical History

How would you describe your child's general state of health? Excellent Good Fair Poor

Please list any major trauma, accident, illness, injuries, surgeries, and hospitalizations:

Incident/Procedure	Date	Long term effect/results

Please indicate what immunizations the child has had:

- DPT (diphtheria, pertussis, tetanus)
- Tetanus booster; when?
- MMR (measles, mumps, rubella)
- Other: _____
- Haemophilus Influenza B
- "Flu"
- Polio
- Hepatitis A
- Hepatitis B
- Smallpox

Please indicate if any caused adverse reactions: _____

Current Weight: _____ Height: _____ Weight 1 year ago: _____

Date of last dental check up: _____ Any mercury fillings? Y N If yes, how many? _____

Does the child have any known allergies? Y N If yes, please list the allergies: _____

Does the child have any food allergies or sensitivities? Please list: _____

Is the child on a restricted diet? Y N Has the child ever been on a restricted diet? Y N

Please describe: _____

Describe the child's typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluid intake: _____

Childhood Illnesses

Please check all that apply and indicate child's age at time of infection:

- Chicken Pox _____
- Pneumonia _____
- Rheumatic Fever _____
- Polio _____
- Frequent colds _____
- Scarlet Fever _____
- Strep Throat _____
- Rubella _____
- Hand, foot & mouth _____
- Fifth's Disease _____
- Ear infections _____
- Measles _____

Please check any of the following that your child has experienced in the PAST (P) or CURRENT (C)

General

	P	C		P	C		P	C
Chills			Poor sleep			Fatigue		
Night sweats			Weight gain/loss			Sweat easily		

Head, Eyes, Ears, Nose and Throat (HEENT)

	P	C		P	C		P	C
Headaches			Eyes bothered by sun			Stiffness		
Head injury			Itching in eyes			Hay fever		
Dizziness			Redness in eyes			Sinus problems		
Impaired vision			Discharge from eyes			Frequent sore throat		
Glasses/contacts			Tearing/dryness in eyes			Sore tongue/mouth		
Eye pain			Impaired hearing			Gum problems		
Blind spot			Earache			Hoarseness		
Double vision			Discharge from ears			Dental cavities		
Glaucoma			Ear infections			Loss of taste		
Cataracts			Frequent colds			Other		
Blurring			Nose bleeds					

Neck

	P	C		P	C		P	C
Lumps			Swollen glands			Goiter		
Pain			Stiffness			Other		

Respiratory

	P	C		P	C		P	C
Difficulty breathing			Pain with a deep breath			Pneumonia		
Cough			Production of mucus			Asthma		
Bronchitis			Coughing blood			Pleurisy		
Emphysema			Shortness of breath			Last chest x-ray		
Tuberculosis			Shortness of breath at night			Other		
Tuberculin test			Shortness of breath lying down					

Blood/lymphatic

	P	C		P	C		P	C
Anemia			Past transfusions			Lymph node swelling		
Easy bleeding			Easy bruising					

Skin and Hair

	P	C		P	C		P	C
Rashes			Eczema, hives			Itching		
Acne, boils			Loss of hair			Dandruff		
Dryness			Ulcerations			Skin cancer		
Recent moles			Change in hair/skin texture			Color change		
Lumps			Dryness/moistness			Temperature		
Nail changes			Other					

Cardiovascular

	P	C		P	C		P	C
Fainting			High blood pressure			Cold hands or feet		
Chest pain			Low blood pressure			Irregular heartbeat		
Angina			Swelling of ankles/feet/hands			Varicose veins		
Murmurs			Blood clots			Heart disease		
Rheumatic fever			Palpitations, fluttering			Cyanosis		

Gastrointestinal

	P	C		P	C		P	C
Trouble swallowing			Change in bowel movements			Indigestion		
Heartburn			Blood in stool			Diarrhea		
Change in thirst			Belching/passing gas			Rectal bleeding		
Change in appetite			Jaundice			Hemorrhoids		
Nausea			Liver disease			Black, tarry stool		
Vomiting			Gall bladder disease			Abdominal pain		
Vomiting blood			Hernia			Food allergy		

Urinary

	P	C		P	C		P	C
Frequent urination			Unable to hold urine			Blood in urine		
Kidney stones			Frequency at night			Frequent UTIs		
Decrease in flow			Urgency to urinate			Hesitancy		
Pain on urination			Increased frequency			Other		

Musculoskeletal

	P	C		P	C		P	C
Joint pain/stiffness			Weakness			Broken bones		
Backache			Muscle spasms/cramps			Joint swelling		

Neurologic

	P	C		P	C		P	C
Fainting			Seizures/convulsions			Paralysis		
Muscle weakness			Numbness/tingling			Loss of memory		
Loss of balance			Involuntary movement			Speech problems		

Endocrine

	P	C		P	C		P	C
Thyroid trouble			Heat/cold tolerance			Excessive thirst		
Excessive hunger			Excessive urination			Excessive sweating		
Diabetes			Hypoglycemia					

Family Medical History

Indicate which close relative (parent, sibling, grandparent) has any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Thyroid Disease _____ |
| <input type="checkbox"/> Seizures _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Alcoholism _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Other _____ |

Please list all family members the child lives with: _____

Prenatal History

Was the child conceived naturally? Y N

Any fertility interventions? Y N

Please describe: _____

Any illness or difficulties during pregnancy? Check all that apply.

- | | | | | |
|-----------------------------------|---|---|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Physical trauma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Illness |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Emotional trauma | <input type="checkbox"/> Nausea | <input type="checkbox"/> Other: _____ |

Please list any drugs, alcohol, cigarette smoking or medications taken during pregnancy: _____

Please list any vitamins or other supplements taken during pregnancy: _____

<u>Mother</u>	<u>Father</u>
Health at conception _____	Health at conception _____
Age at birth _____	Age at conception _____
Pregnancy weight gain _____	

Birth History

How long was the pregnancy? Full term Late Premature # of weeks: _____
 Was the labour? Spontaneous Induced Duration: _____
 Were there any difficulties or complications? _____
 What type of delivery? C-section Vaginal Hospital Home birth
 Were any interventions used? Epidural Episiotomy Forceps Suction
 Was mom Strep B positive? Y N Were antibiotics given during birth? Y N
 Baby's Birth Weight: ____ Length: ____ APGAR Score 1 min ____ 5 min ____

Neonatal History

Any difficulties or complications soon after birth? Check all that apply:

Anemia Convulsions Poor feeding Birth defects
 Infections Rashes Colic Jaundice
 Respiratory distress Other _____

Age began: Sitting: _____ Crawling: _____ Talking: _____ Walking: _____
 Any problems with teeth? Y N _____ Age of 1st tooth: _____
 How would you characterize your child's development?
 Physically Slow Average Fast Mentally Slow Average Fast
 Has your child started puberty? Y N If yes, when? _____

Nutrition

Breast Fed? Y N How long? _____
 Formula Fed? Y N Age started? _____ Type? _____
 Solids? Y N Age started? _____
 First foods introduced: _____
 Please describe eating habits: _____

Sleep Patterns

Please describe your child's sleep patterns during the first year: _____

 Usual bed time: _____ Usual wake time: _____
 Any napping during the day? Y N Describe: _____
 Any difficulties falling asleep or staying awake? Y N Describe: _____

Environment

Is your child exposed to significant tobacco smoke (work, home, etc.)? Y N

Is your child frequently exposed to animals (work, pets, etc.) Y N

How is your home heated? _____

Is your child regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? _____

How would you describe the emotional climate of your home? _____

Personality & Behaviour

Please describe your child's daycare or school (if applicable) experience in terms of enjoyment, performance and socialization: _____

What are your child's interests? _____

How many days per week does your child participate in out-of-school programs? _____

How many hours per day does your child use:

Television: _____ Computer: _____ Video games: _____ Tablets/other: _____

Does your child use a cell phone? Y N

Is your child particularly sensitive to any of the following? Check all that apply.

- | | | | | |
|---|---------------------------------|----------------------------------|-----------------------------------|-------------------------------|
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> Drafts | <input type="checkbox"/> Heights | <input type="checkbox"/> Smells | <input type="checkbox"/> Wind |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Heat | <input type="checkbox"/> Music | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Wool |

Briefly describe your child's personality, including both positive and negative characteristics:

Is there anything that you feel is important that has not been covered? _____
