

NATUROPATHIC PEDIATRIC INTAKE FORM

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Child's name: _____ Child's Age: _____
Date of birth: _____ Child's grade level: _____ Sex: M F
Who is filling out this form? (name and relationship): _____
How did you learn about our clinic? _____
Who does the child live with? _____

**** Naturopathic and preventative health care is only possible when the doctor has a complete picture for the client physically, mentally and emotionally. Therefore, please take the time to thoroughly complete this health questionnaire.****

CONTACT INFORMATION

Name and relation to child: _____
Address: _____
Phone number: (home) _____ (work) _____
(cell) _____ (email) _____

Name and relation to child: _____
Address: _____
Phone number: (home) _____ (work) _____
(cell) _____

Please list any additional health care providers with their designation (pediatrician, family physician etc.) and contact information:

PRIMARY HEALTH CONCERNS

In your opinion, what are your child's most important health concerns?

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

How did these conditions develop? Include date of onset, development and duration of symptoms, treatment and response to treatment, and changes in condition. Can you identify any traumatic events (life trauma, surgery, drug reactions) as having caused or aggravated your child's health concerns?

MEDICAL HISTORY

How would you describe your child's general state of health (excellent, good, fair or poor)?

Please indicate any surgeries, hospitalizations, injuries or serious conditions your child has experienced with approximate dates.

Current medications or supplements:

Past medications or supplements:

How many times has your child had antibiotics? _____

Does your child have any allergies (medications, environmental)?

Has your child been to see the dentist? [] yes [] no

Describe any dental work done: _____

Describe your child's daily oral hygiene practice: _____

Has your child had their vision checked? [] yes [] no

Describe any vision problems: _____

Bowel/Urinary Habits:

Frequency of stool _____ times per day, _____ times per week

Does your child experience any pain when passing stool? _____

Do any of your child's bowel habits concern you? _____

Are there any urinary symptoms you are concerned about? _____

Has your child ever experienced any of the following conditions? If you are unsure of any of the terminology please put a question mark beside the word.

- | | | | |
|--------------------------|--|--------------------------|--|
| Allergies- seasonal | <input type="checkbox"/> yes <input type="checkbox"/> no | Measles | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Diarrhea | <input type="checkbox"/> yes <input type="checkbox"/> no | Cold sores | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Allergies-environmental | <input type="checkbox"/> yes <input type="checkbox"/> no | Meningitis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Difficulty concentrating | <input type="checkbox"/> yes <input type="checkbox"/> no | Colic | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Appendicitis | <input type="checkbox"/> yes <input type="checkbox"/> no | Mumps | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Difficulty sleeping | <input type="checkbox"/> yes <input type="checkbox"/> no | Conjunctivitis(pink eye) | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Atopic Dermatitis | <input type="checkbox"/> yes <input type="checkbox"/> no | Pneumonia | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Ear infection | <input type="checkbox"/> yes <input type="checkbox"/> no | Constipation | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Asthma | <input type="checkbox"/> yes <input type="checkbox"/> no | Sinusitis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Eczema | <input type="checkbox"/> yes <input type="checkbox"/> no | Convulsions | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Bronchitis | <input type="checkbox"/> yes <input type="checkbox"/> no | Skin rash | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Frequent colds | <input type="checkbox"/> yes <input type="checkbox"/> no | Cradle Cap | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Cancer | <input type="checkbox"/> yes <input type="checkbox"/> no | Strep throat | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Hay fever | <input type="checkbox"/> yes <input type="checkbox"/> no | Croup | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chicken pox | <input type="checkbox"/> yes <input type="checkbox"/> no | Thrush | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Head lice | <input type="checkbox"/> yes <input type="checkbox"/> no | Diabetes | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chronic Bedwetting | <input type="checkbox"/> yes <input type="checkbox"/> no | Tonsilitis | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Hyperactivity | <input type="checkbox"/> yes <input type="checkbox"/> no | Diaper rash | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chronic Bleeding noses | <input type="checkbox"/> yes <input type="checkbox"/> no | Urinary tract infection | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Impetigo | <input type="checkbox"/> yes <input type="checkbox"/> no | Seizures | <input type="checkbox"/> yes <input type="checkbox"/> no |
| Chronic Bruising | <input type="checkbox"/> yes <input type="checkbox"/> no | Headaches | <input type="checkbox"/> yes <input type="checkbox"/> no |

VACCINATION HISTORY

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Hemophilus B | <input type="checkbox"/> Chicken pox |
| <input type="checkbox"/> DPT or DT –
(Diphtheria, Pertussis, Tetanus) | <input type="checkbox"/> MMR – (Measles, Mumps,
Rubella) | <input type="checkbox"/> Flu |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Other: _____ |

Please indicate if your child experienced any adverse reactions to any vaccination: _____

FAMILY HISTORY

Have any close relatives had any of the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Juvenile Arthritis | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay fever |

Do either of the parents have any history of chronic illness?

LIFESTYLE

What time does your child go to bed? _____ Wake up? _____
Does your child take naps? _____ When? _____
Do they have any trouble falling asleep? _____
Do they sleep straight through the night? _____
Do they wake up looking/acting refreshed? _____
Do they have any recurring dreams or nightmares? _____

Please write a short description of your child as he/she is currently. Include strengths, weaknesses and major personality traits:

Is your child currently in school, daycare, at home? _____

How would you describe your child's behaviour in school/ daycare? _____

Does this differ greatly from behaviour at home? _____

What makes your child angry? _____

Do they have any difficulties expressing anger? _____

Do they experience uncontrollable rage? _____

What makes your child sad? _____

Does he/she cry when sad? _____

List major experiences of grief or loss in your child's life? _____

What fears does your child have? _____

How does your child react when afraid? _____

What is the emotional climate in the child's home? _____

Does anyone in the household smoke? _____

Does the child exercise regularly? How much and what form of activity? _____

How many hours of television does your child watch each day? _____

PRE-NATAL HEALTH AND BIRTH HISTORY

How old was the mother at the time of the child's birth? _____

Number of previous pregnancies the mother carried to term? _____

Number of previous pregnancies not carried to term? _____

	Excellent	Fair	Good	Poor	Unknown
How was the health of the mother at time of conception?					
How was the health of the father at time of conception?					
How was the health of the mother during the pregnancy?					
How was the emotional state of the mother during pregnancy?					
How was the mother's diet during pregnancy?					

Did the mother receive medical care during pregnancy? _____

Did the mother use any of the following during her pregnancy?

- alcohol, cigarettes or recreational drugs _____
- prescription drugs or over the counter medications (eg. Tylenol) _____
- supplements or vitamins ? _____

Were there any interventions used during the pregnancy? (eg. ultrasound or amniocentesis) _____

Were there any interventions used or complications during the delivery? (eg. Epidural, forceps, c-section, induction) _____

Weight of infant at birth: _____

Term length of pregnancy:

[] pre-term (37 weeks or less): _____ weeks

[] full-term (38-42 weeks): _____ weeks

[] post-term (42 weeks or more): _____ weeks

Did the infant experience any of the following conditions during or following the birth?

[] injuries during the birth: _____

[] birth defects: _____

[] jaundice: _____

[] infections: _____

DIET HISTORY

Breast fed? _____ How long? _____

Approximate feeding schedule? _____

Formula? _____ How long? _____ Combined with breast milk? _____
What type of formula was used? (milk, soy, other) _____

At what age was solid food first introduced? _____

What types of food were introduced and in what order? _____

Did your child have any reaction to the food being introduced? _____

Does your child have any current food allergies? _____

Does your child have any dietary restrictions? (eg. Religious, vegetarian, vegan) _____

What is a typical day's diet for your child?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

List any foods that your child seems to crave, regardless of their nutritional value(includes sweets, chocolate, salty, sour, bread, rich/fatty foods etc.)

Is your child thirsty? [] yes [] no Amount of liquid child drinks each day? _____

Amount of plain water: _____

What temperature of liquid does your child prefer to drink? [] hot [] cold [] room temp

Are you satisfied with your child's diet the way that it is now? Why or why not?

What is the approximate weight of your child? _____

Has there been any recent weight gain or weight loss? _____