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

VACCINATION HISTORY

[ ]Hepatitis B	[ ] Hemophilus B	[ ] Chicken pox
[ ] DPT or DT – (Diptheria,Pertussis, Tetanus)	[ ] MMR – (Measles, Mumps, Rubella)	[ ] Flu
[ ] Polio	[ ]Tetanus	[ ] 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:

[ ] Allergies	[ ] Seizures
[ ] Anemia	[ ] Stroke
[ ] Asthma	[ ] Kidney disease
[ ] Birth defects	[ ] Psoriasis
[ ] Bleeding disorder	[ ] Depression
[ ] Cancer	[ ] Mental illness
[ ] Diabetes	[ ] High blood pressure
[ ] Juvenile Arthritis	[ ] Eczema
[ ] Glaucoma	[ ] 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: _____

<u>DIET HISTORY</u>

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?_____