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.

Condition		Condition	
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
[ ] DPT or DT – (Diptheria,Pertussis, Tetanus)
[ ] Polio
[ ] Hemophilus B
[ ] MMR – (Measles, Mumps, Rubella)
[ ]Tetanus
[ ] Chicken pox
[ ] Flu
[ ] 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
[ ] Anemia
[ ] Asthma
[ ] Birth defects
[ ] Bleeding disorder
[ ] Cancer
[ ] Diabetes
[ ] Juvenile Arthritis
[ ] Glaucoma
[ ] Seizures
[ ] Stroke
[ ] Kidney disease
[ ] Psoriasis
[ ] Depression
[ ] Mental illness
[ ] High blood pressure
[ ] Eczema
[ ] 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?____________________________________