

Pediatric Intake Form, for children ages 0 - 12 years

Date:

Name:	Age:	Date of Birth:
Circle: Male or Female	Height:	Weight:
Names of Parents/ Guardians:		
Address:	City or town:	Province:
Postal code:	Home phone:	Parent's work phone:
Email address of parent:		
Name of person completing intake form:		
Relationship to patient:		

Medical History:

How did you find out about the naturopathic services at this clinic?												
Last physician or practitioner seen? When?												
Have you ever sought help from another Naturopathic practitioner?												
What is the <u>main</u> reason for coming today?												
How long has your child experienced this?												
Is it getting better or worse over time?												
List in order of importance other health concerns & length of time:												
<table border="1"> <thead> <tr> <th>Concern</th> <th>How long has this lasted?</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> </tr> </tbody> </table>	Concern	How long has this lasted?										
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Which of the following has your child experienced? And indicate "C" (current) or "P" (past) or "F" (frequent):

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Eczema/ Skin problems | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Growing pains / Scoliosis |
| <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Allergies | <input type="checkbox"/> Colic | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Constipation/ Diarrhea | <input type="checkbox"/> Attention Problems - ADD/ADHD |
| <input type="checkbox"/> Sinus troubles | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nausea/ Vomiting | <input type="checkbox"/> Bed Wetting |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Roseola | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Bronchitis/ Upper Respiratory Infections | <input type="checkbox"/> Other (please specify): | | |

Has your child ever been hospitalized (other than at birth)?

Date	Reason

Are you content with your child's present level of health? Please explain:

Is your child currently taking any medication? Yes No

Please list present and past medications, along with reason:

Medication	When?	Reason?

Approximate number of doses of antibiotics your child has taken:

Does your child take any herbal or vitamin supplementation? Yes No

If yes, please list:

Has your child received vaccinations? Yes No

If yes, which ones?

Were there any reactions observed? Please explain:

Prenatal History:

Was your child premature?	Yes, # weeks:	No
Ultrasounds during pregnancy?	Yes, number:	No
Medications during pregnancy?		
Medications during labour/ delivery?		
Where you induced?		
Was your child ever in any of the following positions?		
<input type="checkbox"/> Breech	<input type="checkbox"/> Side lying	<input type="checkbox"/> Face/ brow presentation
What type of delivery did you have?		
Any complications during delivery?		
Location of birth:		
<input type="checkbox"/> Hospital	<input type="checkbox"/> Birth centre	<input type="checkbox"/> Home
Child's weight at birth:		
Child's height at birth:		
Was your child breastfed?	Yes, _____ months.	No
Or formula fed?	Yes; Type: _____.	
Introduced to solid foods at _____ months.		
Cow's milk at _____ months.		

Family History:

Relative	Living (age)	Health problems	Died (age)	Cause
Mother				
Father				
Siblings (List):				
Grandmother (Mom's mom)				
Grandfather (Mom's dad)				
Grandmother (Dad's mom)				
Grandfather (Dad's dad)				
Other - specify (aunts, uncles, etc)				

Home life:

Please describe the child's home environment:

Has the child ever been under the care of a professional counselor, psychologist, social worker or other therapist? Please explain.

Please give a brief description of your child's personality:

Does your child exercise?

Yes

No

What type of exercise?

Environment:

Is your child exposed to toxins or other hazards? (For example: cigarette or drug smoke, paint fumes, factories, pesticides, tar, exhaust, etc.) Please explain:

Do they seem to react easily to chemicals?

Do you have any pets in the home?

Yes

No

List any known allergies: (Include foods, medications, environmental, animals, etc.)

Has your child ever traveled abroad?

Yes

No

Location	Age at time of travel

School Age Children:

Is your child home-schooled?	Yes	No
At what age did your child start school?		
Has your child ever been held back a grade?	Yes	No
What grade is your child currently in?		
Does your child enjoy school?	Yes	No
Has your child ever been diagnosed with a learning disability? If yes, please explain:	Yes	No
Describe your child's ability to interact socially with other children at school:		

Additional comments:

Thank you! It's time for your child's healing journey to begin...