

NATUROPATHIC PERSPECTIVES

Redefining Your Health



Pediatric Intake

Child's Name _____ Today's Date _____

Child's Age _____ Date of birth _____ Sex M / F

Address: _____

E-mail Address: _____

Telephone number: Home: _____

Who is filling out this form? _____

With whom does the child live? _____

May we leave messages relating to your child's visits? Yes / No

Emergency contact:

Name: _____ Relation: _____

Address: _____

Home phone: _____ Work Phone: _____

How did you hear about our Clinic: _____

Referred by: _____

Other health care providers (i.e. Medical Doctor, Pediatrician, Chiropractor) the child is seeing:

1. _____ 2. _____

(_____) _____ (_____) _____

Please list your child's health concerns in order of importance:

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

Medical history

Was this child adopted? Y / N *If yes, at what age?* _____

Please complete as much of the following information as you know.

Child's Height: _____ Weight: _____ Blood Type: _____

Has your child ever experienced any of the following illnesses?

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Polio | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Ear infections: |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Strep throat | How many and |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Diaper rash | <input type="checkbox"/> Frequent colds | how often? |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> Cradle cap | <input type="checkbox"/> Stomachaches | _____ |
| <input type="checkbox"/> Whooping
Cough | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Headaches | _____ |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Constipation | <input type="checkbox"/> Heat or cold
intolerance | _____ |
| <input type="checkbox"/> High fevers | | | _____ |

Has your child received any of the following vaccinations (date it was received)?

- | | | |
|--------------------------------------|---|---|
| <input type="checkbox"/> DPT _____ | <input type="checkbox"/> Flu _____ | Did your child have any adverse reactions or
chronic illness following vaccination?

_____ |
| <input type="checkbox"/> MMR _____ | <input type="checkbox"/> Smallpox _____ | |
| <input type="checkbox"/> HiB _____ | <input type="checkbox"/> Pneumovax _____ | |
| <input type="checkbox"/> Polio _____ | <input type="checkbox"/> Chickenpox _____ | |
| <input type="checkbox"/> TB _____ | <input type="checkbox"/> Other: _____ | |
| | | |

Does your child get regular screening tests done by another doctor? Yes/No

Has your child had any serious conditions, illnesses or injuries, and any hospitalizations.

Please list along with approximate dates. _____

Does your child have any known allergies (medicines, environmental, etc.)?

Is your child **currently** taking any medications or supplements (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)? Please list.

Prenatal Health and History

Parental History	Blood type	Health at conception (please circle)	Health throughout pregnancy (circle)	Age at time of child's birth	# of previous pregnancies
Mother		Poor Fair Good Excellent Unknown	Poor Fair Good Excellent Unknown		
Father		Poor Fair Good Excellent Unknown	Poor Fair Good Excellent Unknown		*****

Did the mother experience any food cravings/aversions during pregnancy? Y / N
 If yes, please list? _____

Did mother receive medical care during pregnancy? Y / N / Unknown

Did mother experience any of the following during pregnancy?

- Bleeding High blood pressure Nausea Physical/emotional trauma
- Vomiting Thyroid problems Diabetes Other _____

Were any of the following interventions used during pregnancy?

- Ultrasound Amniocentesis Chorionic villi sampling Triple Screen
- Maternal serum screening Other: _____

Did mother use any of the following during pregnancy?

- Tobacco Alcohol Recreational drugs: _____
- Prescription medications: _____
- Over-the-counter medications: _____
- Vitamins and/or supplements: _____

Birth History

Term length:

- Pre-term (less than 37 wks): _____ wks
- Full-term (38-42 wks): _____ wks
- Post-term (more than 42 wks): _____ wks

Type of birth: Vaginal C-section

Interventions:

- Induction Use of forceps Epidural/anesthesia Episiotomy Other: _____

Were there any complications during delivery (e.g., breech)? _____

Length of labour: _____ hrs Weight of infant at birth: _____ kg / lbs

Family history

Indicate if a close relative (parent, grandparent, sibling) *of the child* has any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Kidney disease	
Heart disease		Drug abuse or Alcoholism	
High blood pressure		Other mental illness	
Cancer		Other	
Diabetes			

I don't know my child's family medical history

Sleep Patterns

What time does your child usually go to bed? _____

Wake in the morning? _____

Does your child nap during the day? Y / N What time(s): _____

Does your child have nightmares? Y / N How often? _____

Does your child have any problems associated with sleeping (e.g. trouble falling asleep, grinding teeth, sleep walking, etc.)? _____

Social Patterns

Is your child in: school / daycare / homecare / other: _____ What grade level: _____

How would you describe your child's behaviour at school? _____

How about behaviour at home? _____

Does your child make friends easily? _____

What are your child's interests & favourite activities? _____

According to your child, does he/she enjoy these activities? _____

Is your child physically active regularly? Y / N How much & how often? _____

Does your child have any habits (i.e. thumb sucking)? _____

Does your child have any fears? _____

How much television does your child watch? _____ hours/day.

Does your child play on the computer or video games? Y / N *If yes,* _____hrs/wk

How often does your child read (not for school), or How often does someone read to your child? Daily Several times a week Weekly Less than weekly

Environment

Are there any pets in the home? Y / N What type and how many? _____

Does anyone in the child's household smoke? Y / N

How is the child's home heated _____

Are there humidifiers used in your home? _____

How would you describe the emotional climate of the child's home? _____

Has your child ever had any significant physical or emotional traumas?

Please write a little about your child's personality, both positive and negative? Is there anything you would want to change? _____

To the best of my knowledge, the information contained in this document is accurate.

Printed Name _____ Date _____

Signature of the Guardian _____