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 for naturopathic correspondence: _____
May we email you appointment reminders? Yes / No

Signature:_____ Time:_____ Date:_____ Witness:_____

Telephone numbers: Home: _____

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

Who is filling out this form? _____
With whom does the child live? _____

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._____
_____ _____
_____ _____

(_____)_____ (_____)_____

Naturopathic Perspectives
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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?

☐ Rubella	☐ Polio	☐ Bedwetting	☐ Ear infections: How many and how often?
☐ Mumps	☐ Rheumatic fever	☐ Strep throat	_____
☐ Measles	☐ Diaper rash	☐ Frequent colds	_____
☐ Chickenpox	☐ Cradle cap	☐ Stomachaches	_____
☐ Whooping Cough	☐ Diarrhea	☐ Headaches	_____
☐ Scarlet Fever	☐ Constipation	☐ Heat or cold intolerance	
	☐ High fevers		

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

☐ DPT _____	☐ Flu _____	Did your child have any adverse reactions or chronic illness following vaccination?
☐ MMR _____	☐ Smallpox _____	_____
☐ HiB _____	☐ Pneumovax ____	_____
☐ Polio _____	☐ Chickenpox ____	_____
☐ TB _____	☐ 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

APGAR score, if known (0 to 10): 1 minute _____ 5 minutes _____ 10 minutes _____

Did the child experience any of the following at or shortly after birth?

☐ Jaundice ☐ Rashes ☐ Seizures ☐ Birth injuries: _____
☐ Infections: _____
☐ Difficulties with feeding: _____
☐ Birth defects: _____

Health and Development

At what age did your child first:
Sit up _____ Crawl _____ Walk _____ Talk _____

At what age did your child begin teething? _____
Were there any difficulties associated with teething? _____

If the child has started their menses, at what age did it begin? _____
Has your child experienced any pubertal changes? _____

Nutritional History

How was your infant fed? ☐ Breast fed ☐ Formula
How long? _____ Milk/Soy/Other: _____

Did your infant experience any reactions to the breast milk or formula? _____
_____

What foods were introduced **before 6 months**? Please list the approximate month.
Any reactions? _____
_____

What foods were introduced **between 6 and 12 months**? Were there any reactions to these foods? _____
_____

Did your child ever experience colic? Y/N *If yes*, how severely? Mild / Moderate / Severe

Does your child have any food allergies or intolerances? Please list.
_____
_____
_____

Does your child have any dietary restrictions (vegetarian/vegan, religious, etc.)? _____
Please describe your child's eating habits (e.g., good appetite, picky eater, etc.).
_____

Does the child have strong aversions to any foods? _____

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 _____