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## **PEDIATRIC INTAKE FORM**

*\*Please bring copies of your child's recent blood work and test results to the first appointment*

*\*Please bring all prescription medications OR a print out from the pharmacist with all of your child's prescription medications to the first appointment*

*\*Please bring all supplements and other remedies to the first appointment*

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

MSP (Care Card) Number: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's Cell Phone: \_\_\_\_\_

Mother's Mailing Address: \_\_\_\_\_

Location Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ (can we leave a message at this number?) Y/N

Email: \_\_\_\_\_ (can we add you to our newsletter list?) Y/N

Father's Name: \_\_\_\_\_ Father's Cell Phone: \_\_\_\_\_

Father's Mailing Address (if different): \_\_\_\_\_

Location Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home phone: \_\_\_\_\_ (can we leave a message at this number?) Y/N

Email: \_\_\_\_\_ (can we add you to our newsletter list?) Y/N

Who does this child usually live with? (Include all family members): \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

Has any other family member been a patient at this clinic? \_\_\_\_\_

Who is your family doctor (MD?) \_\_\_\_\_

When, where and from who did your child last receive medical/health care? \_\_\_\_\_

Is your child currently under the care of any medical specialists? If so, please list below.

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Is your child currently seeing any other health care provider? I.e. another naturopathic physician, chiropractor, acupuncturist, massage therapist, counselor, etc. If so, please list below.

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## HEALTH HISTORY QUESTIONNAIRE

What are your child's most important health problems? List as many as you can in order of importance.

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In general, how is your child's health? \_\_\_\_\_

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Does your child have a contagious disease at this time? Y/N

If so, what? \_\_\_\_\_

### **Context of Care**

What does your child LOVE to do? \_\_\_\_\_

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What does your child spend the most time doing? \_\_\_\_\_

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How much time does your child spend outside every day? \_\_\_\_\_

How would you describe your child's personality? \_\_\_\_\_

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How does your child interact with others? \_\_\_\_\_

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What do you believe are potential obstacles to your child's optimal health? \_\_\_\_\_

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How committed are you to helping your child meet their health goals?

(Rate from zero to 100% commitment)

0%   10   20   30   40   50   60   70   80   90   100%

Will *ALL* other family members support your child to meet their health goals?      Y/N

If not, please explain:

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## Prenatal

In general, how was this child's mother's health during pregnancy? Did she have any major illnesses, accidents, traumas or stress? If so, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was this child delivered full-term ( $\geq 37$ wks)? Y/N \_\_\_\_\_ If not, when? \_\_\_\_\_  
Vaginal or C-Section birth? \_\_\_\_\_ Birth Weight: \_\_\_\_\_  
Any problems or complications during birth? Y/N \_\_\_\_\_ If so, please explain: \_\_\_\_\_

Has this child had any developmental problems? Y/N \_\_\_\_\_ If so, please explain: \_\_\_\_\_  
\_\_\_\_\_

## Previous Illness

Rheumatic Fever	Y N	Mumps	Y N
Chicken Pox	Y N	Measles	Y N
Tonsillitis	Y N	Whooping Cough	Y N
Ear Infections	Y N	Strep Throat	Y N
Bronchitis	Y N		
Other	Y N	List _____	

Has your child had any of the following tests? If so, when & where:

Electroencephalogram (EEG) \_\_\_\_\_

Psychological evaluation \_\_\_\_\_

Hearing tests \_\_\_\_\_

Speech/Language test \_\_\_\_\_

Has this child experienced any major accidents, illness, trauma or stress? If so, please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Hospitalizations/Surgeries/Injuries

Has this child ever been to the hospital? Why? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Immunizations

Has this child received the standard vaccinations according to the current recommendations? Y/N  
If not, have they received any of the following vaccines?

Polio	Y N	Pertussis	Y N
Tetanus	Y N	Diphtheria	Y N
Measles/Mumps/Rubella	Y N	Influenza	Y N
Hepatitis	Y N	Meningitis	Y N
Chicken Pox	Y N	Others? (I.e. for travel) _____	

Has this child ever had an adverse reaction to any vaccine? Y/N \_\_\_\_\_

Has this child ever had a covid vaccine? If so, how many and at what age? \_\_\_\_\_

### Allergies

Is this child hypersensitive or allergic to any of the following?

Drugs? \_\_\_\_\_

Foods? \_\_\_\_\_

Environmental Allergens? \_\_\_\_\_

Breast fed? \_\_\_\_\_ How long? \_\_\_\_\_ Formula? \_\_\_\_\_ What type? \_\_\_\_\_

At what age was solid food introduced? \_\_\_\_\_ First foods? \_\_\_\_\_

### Typical Food Intake

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Drinks: \_\_\_\_\_

### Medications/Supplements

*\*\* Please bring all of your child's medications and supplements to their first appointment*

Please list **any** prescription medications, over the counter medications, vitamins or other supplements your child is taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## REVIEW OF SYSTEMS

**Y** = a condition now      **P** = a condition in the past      **N** = never had

### Mental/Emotional

Mood Swings	Y	P	N	Anxiety/nervousness	Y	P	N
Irritability	Y	P	N	Cries easily	Y	P	N
Hyperactivity	Y	P	N	Unusual fears	Y	P	N
Introvert/extrovert	Y	P	N	Sleep problems	Y	P	N
Motion/car sickness	Y	P	N	Nightmares	Y	P	N
Attention Deficit	Y	P	N	Problems at school	Y	P	N
Dyslexia	Y	P	N				

### Endocrine

Heat/cold intolerance	Y	P	N	Fatigue	Y	P	N
Excessive thirst	Y	P	N	Excessive hunger	Y	P	N
Low blood sugar	Y	P	N	High blood sugar	Y	P	N

**Y** = a condition now    **P** = a condition in the past    **N** = never had

**Skin**

Rashes	Y	P	N	Eczema	Y	P	N
Acne, Boils	Y	P	N	Itching	Y	P	N
Hives	Y	P	N	Psoriasis	Y	P	N

**Head**

Headaches	Y	P	N	Head Injury	Y	P	N
Dizzy spells	Y	P	N	High fevers	Y	P	N

**Eyes**

Glasses	Y	P	N	Tearing or dryness	Y	P	N
Eye pain/strain	Y	P	N	Date of last eye exam: _____			

**Ears**

Earaches	Y	P	N	Impaired hearing	Y	P	N
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**Nose and Sinuses**

Frequent colds	Y	P	N	Nose bleeds	Y	P	N
Stuffiness	Y	P	N	Hay fever	Y	P	N
Sinus problems	Y	P	N	Loss of smell	Y	P	N

**Mouth and Throat**

Frequent sore throat	Y	P	N	Canker sores	Y	P	N
Breath odor	Y	P	N	Snoring	Y	P	N

**Respiratory**

Cough	Y	P	N	Wheezing	Y	P	N
Asthma	Y	P	N	Bronchitis	Y	P	N

**Cardiovascular**

Heart Disease	Y	P	N	Murmurs	Y	P	N
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**Urinary**

Frequent urination	Y	P	N	Bed wetting	Y	P	N
Bladder infection	Y	P	N				

**Gastrointestinal**

Belching/passing gas	Y	P	N	Stomachaches	Y	P	N
Constipation	Y	P	N	Diarrhea	Y	P	N
Bowel Movements	How often _____						

**Musculoskeletal**

Joint pain/stiffness	Y	P	N	Muscle spasms/cramps	Y	P	N
Broken bones	Y	P	N	Poor co-ordination	Y	P	N

**Blood/Peripheral Vascular**

Anemia	Y	P	N	Easy bleeding/bruising	Y	P	N
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