Dr. Loreen Dawson, BSc, ND and Dr. Baili Clarke, BSc, ND
Naturopathic Physicians
info@hummingbirdclinic.ca | 604.740.8838
www.hummingbirdclinic.ca
PO Box 770, 5684 Mermaid Street, Sechelt, BC V0N 3A0

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.
_____
_____
_____

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.
_____
_____
_____
_____

HEALTH HISTORY QUESTIONNAIRE

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

In general, how is your child's health?

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?

What does your child spend the most time doing?

How much time does your child spend outside every day?

How would you describe your child's personality?

How does your child interact with others?

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

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:

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 (≥ 37wks)? 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 _____

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

****** P*lease 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
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
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