

PEDIATRIC INTAKE FORM

PERSONAL INFORMATION

Patient's Full Name: _____ F: M:

Date of Birth (day/month/year): _____ Age: _____ Height: _____ Weight: _____

Address: _____

Home Phone Number: (____) _____ Contact email: _____

Parents Work Numbers: (____) _____ (____) _____

Emergency Contact Number:

Name: _____ Relationship: _____ Phone Number: (____) _____

How did you hear about our Clinic?: _____

Referred by: _____

Other health care providers you are seeing:

1. _____ 2. _____ 3. _____

(____) _____ (____) _____ (____) _____

RELATIONSHIPS OF PATIENT

Parent #1:

Name: _____ Biological? Y: N:

Relation: _____ Occupation: _____

Parent #2:

Name: _____ Biological? Y: N:

Relation: _____ Occupation: _____

Siblings: None: 1: 2: 3: 4+:

Status of Parents (circle): Married Separated Divorced Common Law

Who does the child live with: _____

HISTORY OF PRESENT CONCERNS

What are your child's health concerns, in order of importance to you:

1. _____

2. _____

3. _____

4. _____

ALLERGIES AND SENSITIVITIES

Known Sensitivities/Allergies of Child (Food, Material, Chemicals, Environment, Animals):

Do you have pets in the house (circle): Y N if Yes, list: _____

MEDICATIONS/SUPPLEMENTS

Current Medications/Supplements: _____

Past Medications/Supplements: _____

Antibiotic Use: Y: N: if Yes, How many times: ____

Hospitalizations: Y: N:

VACCINATION HISTORY

Has Your Child Received Immunizations? Y: N:

Please indicate what immunizations have been given

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Tetanus booster; when? _____ | <input type="checkbox"/> "Flu" | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> MMR (measles, mumps, rubella) | <input type="checkbox"/> Polio | <input type="checkbox"/> Smallpox |

Other _____

Please indicate if any caused adverse reactions: _____

MENTAL/EMOTIONAL OF CHILD

Describe Your Child's Disposition (you may check more than one): Happy: Depressed:

Calm: Excitable: Obedient: Difficult: Quiet: Noisy: Aggressive:

Helpful: Thoughtful: Patient: Artistic: Athletic: Expressive:

Reserved: Social: Enjoy Solitude: Other: _____

When your child is angry: Cries: Sulks: Screams: Tantrums:

Becomes Destructive: Other: _____

When scared: Cries: Screams: Becomes quiet: Calls for you: Other: _____

Common Fears: _____

Common Anxieties: School: Adults: Crowds: Other: _____

Does your child enjoy other children: Y: N:

Does your child seem to enjoy time with adults: Y: N:

PRENATAL HISTORY

Age of Mother at Time of Pregnancy: ____ Age of Father at Time of Pregnancy: ____

Natural or Infertility Problems: Y: N:

Duration of Work During Pregnancy and Occupation: _____

Risk Factors/Complications During Time of Pregnancy:

Smoking: Quantity- _____

Medications: List- _____

Supplements: List- _____

Alcohol: Quantity- _____

Illegal Drugs: List- _____

Depression: Nausea: Vomiting: Toxemia: Gestational Diabetes:

Illnesses, Hospitalizations, Accidents or Traumas During Pregnancy: (Please List)

Prenatal Testing: Ultrasounds: # ____ Amniocentesis: # ____ Other: _____

Number of Previous Pregnancies: ____ Number of Deliveries: ____

Previous Miscarriages? Y: N: If yes, how many? ____

Previous Abortions? Y: N: If yes, how many? ____

BIRTH

Labour Duration: ____ Pregnancy Length: <37 Weeks: 37-42 Weeks: >42 Weeks:

Induced Labour: Y: N: , if Yes, why? _____

Medications Taken: Y: N: if Yes, what? _____

Mode of Delivery: Vaginal (unassisted): Vaginal (forceps): Vaginal (suction):

Caesarean Delivery: Breach: Complications: _____

Birth Weight of Child (lbs/kg): ____ Length (in/cm): ____

Birth Place: Hospital: Home: Other Location: City, Country: _____

Delivery Performed by: Medical Doctor: Midwife: Other: _____

FEEDING HISTORY/FOOD INTRODUCTIONS

Was Your Child Breast Fed: Y: N: Duration: _____

Any associated problems with Weaning: _____

Was Your Child Fed Formula: Y: N: Type of Formula: _____

Feeding Frequency: _____

Any Supplements (please list): _____

Age of Introduction of Solid Foods: ____

Difficulties involved: Y: N: , Colicky: Regurgitation: Vomiting:

Any Negative Reactions Associated with the Introduction of a Specific Food: Y: N:

(Please describe) _____

FAMILY MEDICAL HISTORY OF CHILD

Relation to Child	Age	Health Issues (past/current)/Age at Death & Cause
Mother		
Father		
Brother(s)		
Sister(s)		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

Child is adopted medical history is unknown

CONSENT TO TREATMENT OF A MINOR

PATIENT INFO:

First Name: _____

Last Name: _____

Age: _____

Male: or Female:

I AUTHORIZE the treating Doctor of Naturopathic Medicine, who has been engaged by me to examine and administer Naturopathic care and treatment to _____ whose relationship to me is as a _____.

I have been given an explanation of and understand the nature of the naturopathic medical care and treatment. I authorize the treating Naturopathic Doctor, to take whatever measures he/she considers necessary or desirable in connection with such Naturopathic care and treatment.

This consent is modified as follows: _____

My name, address and telephone number, or that of another contact person for the patient (whichever is appropriate) is as follows:

DATED at Collingwood, in the Province of Ontario, this _____ day of _____, _____
(month) (year)

Parent or Guardian of Minor – print name

Signature

Naturopathic Doctor

Signature