



NATUROPATHIC PEDIATRIC INTAKE FORM

Child's name: _____

Gender: _____ Date of birth: _____ Age: _____

Parent's Name, Age and Occupation:

1. _____

2. _____

Parents are (circle one): Married Separated Divorced Common law Other: _____

Parent contact information:

Address City, Province Postal code

Phone number Alternate phone number

Reason for office visit	How long has this been going on?
1.	
2.	
3.	

Pediatrician/Family Doctor information:

Name: _____ Phone number: _____

List any surgeries or major illnesses (with dates):

List any current medications and/or supplements (please bring with you to first appointment):

List any past medications and/or supplements (include dates):

If your child has taken antibiotics, how many times? _____

Any known allergies to foods, medication, supplements, animals or environment?

FAMILY MEDICAL HISTORY

	Age/Age at death	General health (excellent, good, poor)	Health conditions
Mother/Father			
Mother/Father			
Sibling 1			
Sibling 2			
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Other			

* Parents of same sex families, please indicate the name of each parent listed.

Was your child adopted? Yes No If yes, at what age: _____

HEALTH HISTORY Please check all that apply (circle c=current or p=past):

<input type="checkbox"/> Cradle cap	c	p	<input type="checkbox"/> Eczema	c	p
<input type="checkbox"/> Diarrhea	c	p	<input type="checkbox"/> Constipation	c	p
<input type="checkbox"/> Asthma	c	p	<input type="checkbox"/> Anemia	c	p
<input type="checkbox"/> Chronic sniffles/stuffiness	c	p	<input type="checkbox"/> Diaper rash	c	p
<input type="checkbox"/> Nightmares	c	p	<input type="checkbox"/> Bedwetting	c	p
<input type="checkbox"/> Allergies	c	p	<input type="checkbox"/> Fears/phobias	c	p
<input type="checkbox"/> Colds	c	p	<input type="checkbox"/> Ear infection	c	p
<input type="checkbox"/> Lice	c	p	<input type="checkbox"/> Conjunctivitis (Pink eye)	c	p
<input type="checkbox"/> Poor teeth	c	p	<input type="checkbox"/> High fever	c	p
<input type="checkbox"/> Hyperactivity	c	p	<input type="checkbox"/> Extreme shyness	c	p
<input type="checkbox"/> Chicken pox	c	p	<input type="checkbox"/> Measles	c	p
<input type="checkbox"/> Fifth's disease	c	p	<input type="checkbox"/> Erythema Infectiosum	c	p
<input type="checkbox"/> Warts	c	p	<input type="checkbox"/> Strep throat	c	p

<input type="checkbox"/> Colic	c	p	<input type="checkbox"/> Impetigo	c	p
<input type="checkbox"/> Finicky eater/ Poor appetite	c	p	<input type="checkbox"/> Hearing/vision problems	c	p
<input type="checkbox"/> Thrush	c	p	<input type="checkbox"/> Early puberty (before 11)	c	p
<input type="checkbox"/> Tantrums	c	p	<input type="checkbox"/> Mumps	c	p
<input type="checkbox"/> Stomach aches	c	p	<input type="checkbox"/> Other:		

VACCINATION HISTORY

Check all vaccinations that have been administered (or attach copy of vaccination card)	Date Received	Reactions (ie. Fever, seizure, mood change, infections, etc)
<input type="checkbox"/> MMR		
<input type="checkbox"/> DTPP (Diphtheria, Tetnus, Pertussis, Polio)		
<input type="checkbox"/> Haemophilus influenza type B		
<input type="checkbox"/> Pneumococcal		
<input type="checkbox"/> Meningitis		
<input type="checkbox"/> Chicken pox		
<input type="checkbox"/> Influenza		
<input type="checkbox"/> Hepatitis A		
<input type="checkbox"/> Hepatitis B		
<input type="checkbox"/> Small Pox		
<input type="checkbox"/> Other		
<input type="checkbox"/> Check here if you have chosen not to vaccinate your child		

PRENATAL HISTORY

Was there any difficulty conceiving this child? Yes No

of pregnancies carried to term? _____ # of pregnancies not carried to term? _____

What age was mother at child's conception? _____ Father's age at conception? _____

Parents health at conception (G=good, P= poor) Mother: _____ Father: _____

Was your child conceived naturally? Yes No

Any fertility interventions? Yes No If yes, explain:

Mother's pregnancy weight gain _____ lbs.

Any illness or difficulties during pregnancy? Please circle

Nausea	Vomiting	Diabetes	Illness	Thyroid Issues
Hypertension	Bleeding	Physical trauma	Emotional trauma	Other:

Was the mother exposed to any of the following during pregnancy? Please circle

Recreational drugs	Alcohol	Smoke/second hand smoke	Cigarettes
Environmental toxins	Medications	Caffeine, how much?:	Other:

List any medications taken during pregnancy:

List any vitamins or other supplements taken during pregnancy:

Did mother travel during pregnancy? Yes No Describe:

Did mother work during pregnancy? Yes No Describe, until when?

What was mother's emotional state during the pregnancy? Describe significant relationships.

EARLY CHILDHOOD HISTORY

Child's gestational age at birth:

Pre-term (<37 wks):	wks	Full-term (38-42):	wks
Post-term (>42):	wks		

Were any of the following used during the birth? Please circle

Induced labour	Forceps	Vacuum extraction	Epidural/anesthesia
Episiotomy	Oxytocin/Pitocin	Pain Medication	C-section
Other:			

Length of labour: _____

Birth Weight: _____ Length: _____ Head Circumference: _____

Did your child experience any of the following shortly after birth? Please circle

Colic	Jaundice	Infection / fever	Trauma
Rashes	Respiratory distress	Birth defects	Seizures
Difficulties feeding	Anemia	Birth trauma / injuries	
Other:			

Does your child have any unusual habits?

Does your child have any fears?

How is your child's behaviour at home?

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

General school/daycare behaviour and performance:

Has your child been diagnosed with any learning disabilities?

Does your child make friends easily?

Child's interests and favourite activities?

How many hours/week does your child:

Play on the computer or video games _____ Watch TV _____

Read (not for school) _____ Exercise _____

Please describe your child's personality:

NUTRITION

Was the child breast-fed? Yes No If "yes", until what age? _____

If "no", what type of formula or other liquid was used? _____

At what age were solid foods introduced? _____

Were you selective in which foods were introduced first? Yes No

Describe the sequence in which foods were introduced:

Describe any noticeable reactions to foods introduced (rashes, changes in sleeping habits)

Describe any dietary restrictions (food intolerances/ allergies, religious, vegetarian, vegan, etc.)

Describe any food cravings:

Describe any food aversions:

Describe the child's present eating habits:

Describe your child's thirst:

List your child's dietary intake for the last 24 hours.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

What is the source of your household's drinking water?

Well Tap Filtered Distilled Bottled spring Reverse osmosis

ENVIRONMENT

Who does your child live with?

Describe the emotional climate of your child's home?

Is your child sensitive to any of the following? Please circle

Cold	Heat	Wind	Draft	Smell
Height	Sunlight	Music	Wool	Small spaces
Other:				

SLEEP

Describe any issues your child has regarding bedtime, naps, falling asleep, etc: