DR. SCARLETT COOPER
naturopathic doctor

DATE _____

CONFIDENTIAL CHILD/PEDIATRIC INTAKE FORM

_____ SEX _____ BIRTHDATE _____/_____/_____
First Name Middle Name Last Name D M Y

PARENTS' NAMES _____

HOME ADDRESS _____
Street City/Province Postal Code

HOME PHONE_____ WORK _____ CELL _____

CARECARD NUMBER: _____ FAMILY M.D. _____

REFERRED BY: _____

PERSON LEGALLY RESPONSIBLE FOR CHILD:_____
Name Relationship Signature

PREVIOUS NATUROPATHIC TREATMENT? ___YES___NO DOCTOR'S NAME _____

IF YES, FOR:_____

PURPOSE OF THIS APPOINTMENT: _____

_____

CHILDHOOD ILLNESSES (Check all that apply)

____ Chicken Pox	____ Scarlet Fever	____ Respiratory Allergies	____ Hepatitis
____ Measles	____ Bronchitis	____ Food Allergies	____ Tonsillitis
____ Mumps	____ Pneumonia	____ Eczema	____ Ear infections
____ Rubella	____ Rheumatic Fever	____ Asthma	____ Frequent Colds

____ Other; please list _____

INJURIES

____ Sprains, strains ____ Fractures ____ Blows to Head ____ TMJ or orthodontic problems

Other injuries _____

Surgeries/Hospitalizations/Scars (tonsils, wisdom teeth, tattoos, stitches, mole removals) _____

_____

MEDICATIONS	Now	# times previously used		Now	# times
Aspirin	____	____	Antibiotics	____	____
Tylenol	____	____	Anti-histamine	____	____
Decongestant	____	____	Allergies to medicines?	____	____
Ibuprofen	____	____	Other	____	____

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VACCINATIONS

___ Measles ___ Polio ___ MMR ___ Smallpox ___ HPV

___ Diphtheria ___ Mumps ___ DPT ___ Tetanus ___ Influenza

___ Other, please list_____

FAMILY HISTORY

___ Heart Disease ___ Diabetes ___ Birth defects ___Tuberculosis ___ Allergies

___ Hypertension ___ Arthritis ___ Cancer ___ Mental Illness

SYMPTOMS (mark "√" if current, "x" for past symptoms)

_____ Hives
_____ Eczema
_____ Bleeding gums
_____ Nose bleeds
_____ Acne
_____ High fevers
_____ Chronic rash
_____ Hearing loss
_____ Diarrhea
_____ Sore throats
_____ Gas
_____ Frequent colds
_____ Wheezing
_____ Asthma
_____ Cough

_____ Burning of urine
_____ Frequent urination
_____ Heart murmur
_____ Vomiting spells
_____ Anemia
_____ Stomach aches
_____ Jaundice
_____ Easy bruising
_____ Flat feet
_____ Constipation
_____ Frequent headaches
_____ Bleeding tendencies
_____ Joint pains
_____ Dizzy spells
_____ Earaches

___ Bloody urine
_____ Cries easily
_____ Nervous
_____ Sleep problems
_____ Night sweats
_____ Sensitive to light
_____ Body/breath odour
_____ Motion/ car sickness
_____ No appetite
_____ Nightmares
_____ Canker sores
_____ Unusual fears
_____ Excessive fatigue
_____ Hair loss
_____ Other; please list_____

Please describe your child's typical daily diet: _____

_____

Please list supplements currently taking: _____

Please list supplements taken in past: _____

Please list medications currently taking: _____

Please list medications taken in past: _____

Please describe child's personality briefly: _____

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Previous pregnancies by natural mother, miscarriages or complications? _____

_____

Mother's age at child's birth? _____

Mother's health during pregnancy?

____ Bleeding ____ Nausea ____ Physical or emotional trauma

____ Medications ____ Hypertension ____ Cigarettes, alcohol, drug consumption

____ Diabetes ____ Thyroid problems ____ Illnesses

____ Other, please explain: _____

BIRTH HISTORY

Term: _____ Full _____ Premature _____ Late

Length of Labour _____ Complications? _____

Has your child had any of the following problems?

____ Jaundice ____ Diarrhea ____ Birth Defects ____Rashes

____ Colic ____ Fever ____ Cerebral Palsy ____ Seizures

____ Blue Baby ____ Birth Injuries ____ Allergies

____ Other, please explain: _____

Weight at birth _____ Present weight _____ Length at Birth _____ Present length/height _____

Child's sleep patterns (first year) _____

Food Intolerances (of any) _____

Feeding: Breastfed? _____ How long? _____ Formula and type? _____

Age child began solid foods _____

Age when the following foods were introduced:

Fruit _____ Vegetables _____ Grains _____ Protein _____ Types of protein? _____

Age when child began:

Sitting _____ Crawling _____ Walking _____ First words _____

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