



DATE _____

CONFIDENTIAL CHILD/PEDIATRIC INTAKE FORM

First Name Middle Name Last Name SEX _____ BIRTHDATE ____/____/____
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)

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Respiratory Allergies | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> 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	___	___

VACCINATIONS

- | | | | | |
|---|--------------------------------|------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Polio | <input type="checkbox"/> MMR | <input type="checkbox"/> Smallpox | <input type="checkbox"/> HPV |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Mumps | <input type="checkbox"/> DPT | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Other, please list _____ | | | | |

FAMILY HISTORY

- | | | | | |
|--|------------------------------------|--|---|------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Birth defects | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Mental Illness | |

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Burning of urine | <input type="checkbox"/> Bloody urine |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Cries easily |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Vomiting spells | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Anemia | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> High fevers | <input type="checkbox"/> Stomach aches | <input type="checkbox"/> Sensitive to light |
| <input type="checkbox"/> Chronic rash | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Body/breath odour |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Motion/ car sickness |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Flat feet | <input type="checkbox"/> No appetite |
| <input type="checkbox"/> Sore throats | <input type="checkbox"/> Constipation | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Gas | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Canker sores |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendencies | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Excessive fatigue |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Earaches | <input type="checkbox"/> 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: _____

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 _____