**Pediatric Patient Intake Form**

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| Last Name: | | | First Name: | | | | | | Middle Name: | |
| Date of Birth  (MM/DD/YYYY): | | | Age: | | | Sex:  F / M | | | Who is filling out this form? (name, relationship) | |
| **Contact Information** | | | | | | | | | | |
| Full Address: | | | | | | | City, Province: | | | |
| Postal Code: | Daytime phone #: | | | Evening phone #: | | | | | | May we leave messages regarding your visit? Yes / No |
| Email: | | | | | | | | | | |
| **Emergency Contact Information** | | | | | | | | | | |
| 1) Last Name: | | First Name: | | | | | | Relationship: | | |
| Daytime phone #: | | | | | | Evening phone #: | | | | |
| 2) Last Name: | | First Name: | | | | | | Relationship: | | |
| Daytime phone #: | | | | | | Evening phone #: | | | | |
| **Other Healthcare Providers** | | | | | | | | | | |
| 1) Name:  Specialty/Focus:  Phone #: | | 2) Name:  Specialty/Focus:  Phone #: | | | | | | 3) Name:  Specialty/Focus:  Phone #: | | |
| Date of last doctor visit: | | | | | Date of last physical exam: | | | | | |
| Please list regular screening tests performed by other physicians: | | | | | | | | | | |

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| How did you hear about this clinic? | |
| If referred, please state by whom: | |
| Have you been treated by a Naturopathic Doctor before: Yes / No | |
| If yes, by whom? | Date of last visit to ND: |

**Pediatric Health Assessment Questionnaire**

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| **In your opinion, what are your most important health concerns:** |
| 1) |
| 2) |
| 3) |
| 4) |
| 5) |

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| **Medical History** | | | | | | |
| Was the child adopted? Yes / No | | Does the child receive regular age-specific screening exams? (hearing, vision, height, weight, etc.) Yes / No | | | | |
| Current Height: | | Current Weight: | | | | |
| **Vaccination / Immunization Record:** Check all that apply  Please note vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule   |  |  |  | | --- | --- | --- | | □ DPT (Diptheria, Pertussis, Tetanus) | □ BCG (Tuberculosis) | □ Pneumococcal Conjugate  (Meningitis/Pneumonia) | | □ MMR (Measles, Mumps, Rubella) | □ Hepatitis A | □ Meningococcal C Conjugate  (Meningitis) | | □ Gardasil/Cervarix (HPV Vaccine) | □ Polio | □ Varivax/Varilrix (Chicken Pox) | | □ Haemophilus Influenza B | □ Flu Vaccine | □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |   Did any of your vaccines cause adverse reactions? If yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **Which of the following childhood illnesses have the child had:** Check all that apply   |  |  |  | | --- | --- | --- | | □ Asthma | □ Polio | □ Mumps | | □ Rheumatic fever | □ Scarlet fever | □ Roseola | | □ Rubella (German measles) | □ Whooping cough | □ Measles | | □ Chicken Pox | □ Mononucleosis | □ Skin concerns | | □ Sinus concerns | □ Ear infections | □ Epilepsy | | □ Frequent colds | □ Tonsillitis | □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ Strep throat |  |  | | | | | | | |
| **List previously diagnosed medical conditions:** | | | **Treatment Received** | | | **Year** |
| 1) | | |  | | |  |
| 2) | | |  | | |  |
| 3) | | |  | | |  |
| 4) | | |  | | |  |
| **List all allergies (medications, foods, supplements, environmental, etc.)** | | | | **Reaction Type** | | |
| 1) | | | |  | | |
| 2) | | | |  | | |
| 3) | | | |  | | |
| 4) | | | |  | | |
| **List all prescription drugs** (oral contraceptive, etc.), **over-the-counter medications** (pain killers, antacid, etc.), **herbs and natural supplements** (vitamins, homeopathics, etc.) that you are taking | | | | | | |
| **Medication** | **Dosage** | | | | **Start Date** | |
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| **Family Medical History** | | | | | |
| Please include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information. | | | | | |
|  | **Age** | **Health History** |  | **Age** | **Health History** |
| **Father** |  |  | **Mother** |  |  |
| **Grandmother (Paternal)** |  |  | **Grandmother**  **(Maternal)** |  |  |
| **Grandfather**  **(Paternal)** |  |  | **Grandfather**  **(Maternal)** |  |  |
| **Siblings** |  | F/M | **Siblings** |  | F/M |
|  | F/M |  | F/M |

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| **Prenatal History** | | | |
| Pregnancy weight gain: | | Was the child conceived naturally? | |
| If fertility intervention were used, please indicate: | | | |
| Mother’s age at conception: | | Father’s age at conception: | |
| Did the mother experience any of the following during pregnancy? Check all that apply.   |  |  |  | | --- | --- | --- | | □ Excessive bleeding | □ Nausea | □ High blood pressure | | □ Diabetes | □ Vomiting | □ Thyroid concerns | | □ Emotional trauma | □ Physical trauma |  | | □ Other illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| **List of all prescription drugs and over-the-counter medications taking during pregnancy:** | | | |
| **Medication** | **Dosage** | | **Start Date** |
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| **List all herbs and natural supplements taken during pregnancy:** | | | |
| **Medication** | **Dosage** | | **Start Date** |
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| **Natal (Birth) History** | | |
| What type of delivery? Vaginal birth / C-section  Hospital / Home-birth | | Duration of labour: |
| Was the labour: Spontaneous or Induced | | If there were difficulties, please describe: |
| Were any delivery interventions used? Yes / No  **If yes, which ones?** Epidural Episiotomy  Forceps Suction | | **Was mom Strep B positive?**  **If yes, were antibiotics used during birth?**  Yes / No |
| **Term length:** Full / Premature: wks / Overdue: wks | | |
| **Birth Weight:** | **Birth Length:** | **Apgar score: 1 min: 5 min:** |
| **Did the baby experience any of the following at or after birth?** Check all that apply.   |  |  | | --- | --- | | □ Jaundice | □ Birth injuries | | □ Seizures | □ Congenital conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | □ Rash | □ Colic | | □ Infections | □ Poor feeding | | □ Respiratory distress | □ Other illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Were any of the following interventions used:** Silver nitrate drops / Vitamin K drops / other | | |

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| **Dietary and Lifestyle Habits** | | | | |
| **Nutrition and Feeding** | Was the child breast-fed? Yes / No | If yes, for how long? | | |
| Was the child formula fed? Yes / No | If yes, when did he/she start? | | |
| When was solid food 1st introduced? | Please list the 1st foods introduced? | | |
| Does the child follow a specific diet regime? Vegetarian / Vegan / Other | | | |
| On average, how many meals does the child have in a day? 1 2 3 4 5 >5 | | | |
| **Sleeping and Resting** | How many hours of sleep does the child get? | | | Does the child nap? Yes / No |
| Does the child have trouble falling asleep? Yes / No | | | What keeps him/her up? |
| Does the child sleep through the night? Yes / No | | | If no, how often does he/she wake up? |
| Child’s usual sleep time: | Child’s usual wake-up time: | | |
| Does the child: wet the bed / snore / have nightmares / sleep walk / talk in their sleep | | | |
| **Development and Social History** | Describe how the child interacts with siblings / friends? | | | |
| Does the child exercise regularly? Yes / No | | If yes, what type? | |
| In a typical day, how long does the child:  Watch TV: Play games: Use computer: | | | |
| At what age did the child first:  Sit up: Crawl: Walk: Talk: Teeth: Toilet Training: | | | |

**Is there any other important information that you would like me to know?**

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