**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 applyPlease note vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule

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| □ 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

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| □ 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 |  |  |

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| **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.

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| □ Excessive bleeding | □ Nausea | □ High blood pressure |
| □ Diabetes | □ Vomiting | □ Thyroid concerns |
| □ Emotional trauma | □ Physical trauma |  |
| □ Other illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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.

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| □ Jaundice | □ Birth injuries |
| □ Seizures | □ Congenital conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| □ Rash | □ Colic |
| □ Infections | □ Poor feeding |
| □ Respiratory distress | □ Other illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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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