

**PEDIATRIC INTAKE FORM** (under 16 years of age)

**PLEASE NOTE: WE ARE A FRAGRANCE FREE BUILDING**

DATE: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Child's Sex: (M/F)      Weight: \_\_\_\_\_ Height \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ Postal Code: \_\_\_\_\_ Referred by: \_\_\_\_\_

Parent/Guardian's Names: \_\_\_\_\_

Address (if not the same as above): \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_

Are you currently under the care of another physician(s)? Please list the **Physicians name, for what conditions, and the treatment.**

Do you have extended healthcare benefits? \_\_\_\_\_

**What are the main health concerns? Please list in order of importance.**

	complaint	since	cause
1.			
2.			
3.			
4.			

**What medications is the child currently taking?**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Past Medical History** (surgeries, hospitalizations, accidents, injuries, traumatic events)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What was the date of the child's last full medical examination? \_\_\_\_\_ The date(s) of any blood test(s) the child has had done \_\_\_\_\_

**Immunizations** (Please **circle** the ones your child has had)

Measles, Mumps, Rubella  
Diphtheria, Pertussis, Tetanus  
Other: \_\_\_\_\_

Smallpox  
Hepatitis

Polio  
Influenza

Oral Polio

Has your child had any adverse effects from any of them? \_\_\_\_\_

### DENTAL HISTORY

Name of Dentist \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number \_\_\_\_\_

Date of last dental check-up \_\_\_\_\_ for what? \_\_\_\_\_

Does your child have: Root Canals \_\_\_\_\_ how many? \_\_\_\_\_

Cavities \_\_\_\_\_ how many? \_\_\_\_\_

Gum Disease \_\_\_\_\_

Age of child for first tooth \_\_\_\_\_ Age of child for permanent teeth \_\_\_\_\_

### INFANT CARE

Please list brand names used for:

Diapers \_\_\_\_\_

Formula \_\_\_\_\_

Shampoo \_\_\_\_\_

Baby Wash \_\_\_\_\_

Diaper Rash \_\_\_\_\_

Baby Wipes \_\_\_\_\_

Anything else \_\_\_\_\_

### PERSONAL HYGIENE (for older children)

Shampoo \_\_\_\_\_

Hair products \_\_\_\_\_

Mouthwash \_\_\_\_\_

Toothpaste \_\_\_\_\_

Soap \_\_\_\_\_

Deodorant/ anti perspirant \_\_\_\_\_

**Childhood Illnesses (Please circle the ones your child has had)**

Measles	Mumps	Pneumonia	Chickenpox
Scarlet Fever	Rubella	Rheumatic Fever	frequent Colds
Tonsillitis	Ear Infection	Diphtheria	Pertussis
Other: _____			

**Allergies?**

**Symptoms (Please circle and use a **P** for past symptoms)**

Eczema	Nosebleeds	Easy Bruising	Diarrhea
Constipation	Body/Breath Odour	Change in Appetite	Frequent Vomiting
Stomach Aches	Blood in Stools	Burning/Painful Urination	Frequent Urination
Bed Wetting	Blood in Urine	Sore Throats	Wheezing
Cough	Hearing Loss	Ringing in Ears	Ear Infection
Grinding Teeth	Cries Easily	Sleep Problems	Night Sweats
Hair Loss	Dizzy Spells/Dizziness	Tendency to Bleed	Seizures
Skin Condition (warts, eczema, abscess, cold sores, rash, etc.)			Fatigue
Other: _____			

**Birth History**

Term (please circle)	Full	Premature	Late
Weight at Birth: _____	Length of Labour: _____ hrs.	Complications: _____	
(Please circle) Was the delivery by:	C-Section	Vaginal Birth	

Did your infant experience any of the following at birth or soon after? (please circle)

Jaundice	Birth Defect	Colic
Seizures	Birth Injury	Rashes

Other: \_\_\_\_\_

**General Information**

Child's sleep patterns (first year): \_\_\_\_\_

Age began:      Sitting: \_\_\_\_\_      Crawling: \_\_\_\_\_      Walking: \_\_\_\_\_      Talking: \_\_\_\_\_

Food intolerance/allergies: \_\_\_\_\_

(please circle) Feeding:    Breast                      How long? \_\_\_\_\_

                                    Formula

                                    Milk: (cow, goat, soy, nut/seed, other)

Age at which solid foods were introduced: \_\_\_\_\_

Which foods were introduced first? \_\_\_\_\_

Diet in a typical day:

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

**What are your goals and/or expectations of visiting a Naturopathic Doctor?**

\_\_\_\_\_

**What changes have been made to improve your child's quality of life?**

\_\_\_\_\_

*\* Please be advised that a cancellation fee of \$40 applies to appointments missed without 24 hours notice. (Weather permissible)*