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PEDIATRIC INTAKE FORM (under 16 years of age)

PLEASE NOTE: WE ARE A FRAGRANCE FREE BUILDING

TODAY'S 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? _____ Email Contact for parent:____

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	Smallpox	Polio	Oral Polio
Diphtheria, Pertussis, Tetanus	Hepatitis	Influenza	

Other:
____

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 ________________________

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 $50 applies to appointments missed without 24 hours notice. (Weather permissible)***