Dr. Stephen Maltais ND, MSc.

88 Dover Mills Road
Port Dover, ON. N0A 1N1
Office: 519-583-1234
Fax 519=583-1018
www.dovernaturopath.com

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: ( ) _____

Email address:_____

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.			
1.			
2.			
3.			

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 Immunizations_____

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 $90 applies to appointments missed without 24 hours notice. (Weather permissible)***