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**Doctor of Naturopathic Medicine**

# PEDIATRIC INTAKE FORM

Please print clearly and fill out this form to the best of your ability. It will help to assess the child's present health and will assist in facilitating the healing process.

Who is filling the form (name & relation): ______________________________ Date: ____________________
Referred by: ________________________________________________________________________
Name: __________________________________ Age: ___________________________________
Gender: Male/Female Present weight: __________________________________
Ethnicity: _______________________________ Present height: __________________________________
Name of mother: _________________________ Name of father: __________________________________

Emergency Contact Information:
Name: _____________________________________ Relation: ___________________________________
Address: ___________________________________ Home phone #: _____________________________
____________________________________ Work phone #: _____________________________
____________________________________ Cell phone #: _______________________________

Names of other health care practitioners (pediatrician/medical doctor, specialists, etc.) the child is seeing:

Name: ________________________ Name: _______________________ Name: ________________________
Practitioner: ___________________ Practitioner: __________________ Practitioner: ___________________
Address: ______________________ Address: _____________________ Address: ______________________
______________________________ _____________________________ ______________________________
Phone: (_____)_________________ Phone: (_____)________________ Phone: (_____)_________________

**CHIEF HEALTH CONCERNS:**
List the child's health concerns (in order of importance):
1. ________________________________________________________________________________
2. ________________________________________________________________________________
3. ________________________________________________________________________________

**MEDICAL HISTORY:**
Describe the child's general state of health: __________________________________________________

Indicate any serious conditions, illnesses or injuries, and any surgeries or hospitalizations (provide approximate dates):
1. ____________________________________________________________________________________
2. ____________________________________________________________________________________
3. ____________________________________________________________________________________

List any allergies (food intolerances/allergies, medicines, environmental, etc.) the child has: ____________
________________________________________________________________________________________

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List all vitamins, minerals, botanical (herbal) medicines, Asian medicines (Chinese Patent drugs), or homeopathic remedies that the child is currently taking. Indicate daily dosage:

1. ______________________________
2. ______________________________

List all names of *prescribed medication* currently being taken. Include dosage, frequency, how long the child has been taking it, and any adverse reactions/allergies to medications:

| Medication | Dose (i.e. mg) | Frequency (#times/day) | Since How Long | Adverse Reactions Allergies (Describe) |
|---|---|---|---|---|
| | | | | |
| | | | | |

List all *over the counter medication* that the child takes (e.g.: Aspirin, cough syrup, etc.). Include dosage and frequency and any adverse reactions/allergies to medications:

| Medication | Dose (i.e. mg) | Frequency (#times/day) | Since How Long | Adverse Reactions Allergies (Describe) |
|---|---|---|---|---|
| | | | | |
| | | | | |

How many times has the child been treated with antibiotics? ______________________

Which of the following has the child had in the past? (n-never, m-mild, a-average, s-severe)

- o Rubella (German measles) n m a s
- o Measles n m a s
- o Chicken pox n m a s
- o Whooping cough n m a s
- o Mononucleosis n m a s
- o Ear infections n m a s
- o Roseola n m a s
- o Scarlet Fever n m a s
- o Mumps n m a s
- o Strep throat n m a s
- o Impetigo n m a s
- o Other: ____________ n m a s

What screening test(s) has the child had (blood, hearing, vision, etc.)? ______________________

______________________________

**PRENATAL AND BIRTH INFORMATION:**

What was the health of the parents at conception?

Mother: Poor Fair Good Excellent Unknown
Father: Poor Fair Good Excellent Unknown

**During the pregnancy:**

How was the health of the mother during the pregnancy? Poor Fair Good Excellent Unknown
How was the mother's diet during pregnancy? Poor Fair Good Excellent Unknown
Did the mother receive prenatal medical care? Y/N/Unknown

Please check (✓) any of the following that applied to the pregnancy.

- o Diabetes
- o Bleeding
- o Thyroid problems
- o Nausea
- o Vomiting
- o Infections
- o Alcohol/drug use
- o High blood pressure
- o Other: ____________

Did the mother use any of the following during the pregnancy?

- Tobacco
- Alcohol
- Recreational Drugs
- Over-the-counter/Prescription medications: ______________________
- Supplements: ______________________
- Other: ______________________

Was there any physical or emotional trauma (accidents, abuse, death in the family, etc.)? Y/N
What? ______________________
Any exposure to diseases? Y / N Which one(s)? ______________________
Any traveling? Y / N Where? ______________________
Occupation (type and location): ______________________

**BIRTH HISTORY:**
What was the mother's age at child's birth? ______________________
Length of pregnancy term: □ Full □ Premature: ___________weeks □ Late: ____________weeks

Please check (✓) any of the following that applied to the birth:

- Induced
- Pitocin
- Pain medication
- Epidural
- Vaginal
- C-section
- Episiotomy
- Forceps
- Vacuum extraction
- Birth injuries
- Other: ____________________

How long was the labour (hours)? _____________ Any complications? ______________________
Infant weight: _______________ Length: ________________ Head circumference: _______________
APGAR score (if known): Birth: __________ 1 minute: ___________ 5 minutes: ____________

**NEONATAL HISTORY:**
Please check (✓) any of the following that apply:

- Anemia
- Jaundice
- Seizures
- Infections
- Poor feeding
- Rashes
- Respiratory distress
- Colic
- Congenital/birth defects: ______________________
- Other: ______________________

Was the infant breastfed? Y / N How long? ______________________
Was the infant formula fed? Y / N Which one was/is used? ______________________
Is the child fed cow's milk? Y / N Since when? ______________________
At what age was solid food introduced? ____________________ Which foods? ______________________

Please check (✓) any of the following vaccinations that have been given:

- ❑ Chicken pox (Varicella)
- ❑ Cholera
- ❑ DTP (Diphtheria/Tetanus/Pertussis)
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Influenza (flu shot)
- ❑ MMR (Measles/Mumps/Rubella)
- ❑ Meningococcal (meningitis)
- ❑ Pneumococcal
- ❑ Polio
- ❑ Travel Vaccinations
- ❑ Rabies
- ❑ Typhoid
- ❑ BCG (Tuberculosis)
- ❑ Yellow Fever
- ❑ Don't know

Were there any reactions (within one week) to any of the above? Y / N (if yes, please describe):
______________________________________________


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**DEVELOPMENTAL MILESTONES:**
Indicate the age at which each of the following was reached:

| | | | | | |
|---|---|---|---|---|---|
| Rolling over | | Running | | Asking questions | |
| Crawling | | Toilet training | | 1st tooth | |
| Spoken words | | Counting to 10 | | All teeth | |
| Walking alone | | Dressing self | | | |

**FAMILY HEALTH HISTORY:**

| Family member | Age | Illnesses |
|---|---|---|
| Mother | | |
| Father | | |
| Maternal grandmother | | |
| Maternal grandfather | | |
| Paternal grandmother | | |
| Paternal grandfather | | |
| Sibling: | | |
| Sibling: | | |

□ I don't know the family medical history

**LIFESTYLE:**
Does your child have any dietary restrictions (religious, vegetarian/vegan, allergens, etc.)? Y/N
If yes, describe: ______________________________
Describe a typical day's diet:
Breakfast: ______________________________
Lunch: ______________________________
Dinner: ______________________________
Snacks: ______________________________
Beverages (and total quantity): ______________________________
List foods most frequently eaten and how often: ______________________________
______________________________

How would you describe the child's temperament? ______________________________

Is the child in: (circle one) school daycare home care other: ______________
Describe the child's general school/daycare performance: ______________
Has the child been diagnosed as having any learning disabilities? Y / N
If yes, what disability? ______________________________

List any interests: ______________________________
Favourite activity: ______________________________
How much television does your child watch? ______________ hours a day/week

Does the child exercise regularly? Y/N
If yes, describe what type, how long & how often: ______________________________

Number of hours of sleep: _______________ Naps (hours): _______________

Does anyone in the child's household smoke? Y/N

Are there animals in the home? Y/N If yes, what: ____________________________________________

Do you know of any toxins or other hazards the child is regularly exposed to (home, other's work, hobbies, etc.)? Please describe: ____________________________________________________________________

Please check (✓) any of the following that applies to the present living conditions:

| | | | |
|---|---|---|---|
| o Rental apartment | o Old house (> 20 years) | o City living | o Pets: ___________ |
| o Basement dwelling | o Condominium | o Suburb living | o Smoking adults |
| o New house (< 5 years) | o Recent renovations | o Carpets | |

How would you describe the emotional climate of the child's home? _________________________________
______________________________________________________________________________________________

Is there anything that you feel is important that has not been covered? _______________________________
______________________________________________________________________________________________

**REVIEW OF SYSTEMS:**
Please circle the condition if the child has it now or has had it in the past:

- **Skin** – rashes, eczema, psoriasis, acne, itching, lumps, colour change, dry, moist, easy bruising
- **Nails** – colour changes, fungal infections, brittle/shear, vertical/horizontal lines, hangnails
- **Head** – headaches, dizziness
- **Eyes** – corrected vision, pain, tearing, dryness, blurring, redness, discharge, itching
- **Ears** – impaired hearing, earache, discharge, infections
- **Nose & Sinus** – frequent colds, nose bleeds, stuffiness, hay fever, sinus problems
- **Mouth & Throat** – frequent sore throat, gum problems, hoarseness, dental cavities, loss of taste
- **Neck** – lumps, swollen glands, pain/stiffness, enlarged thyroid
- **Lungs** – cough, phlegm, spitting up blood, wheezing, difficulty breathing or shortness of breath, pain on breathing, asthma, bronchitis, tuberculosis, pneumonia
- **Cardiovascular** – heart disease, murmurs, palpitations, chest pain
- **Peripheral vascular** – deep leg pain, cold extremities, swollen arms/legs, ulcers
- **Gastrointestinal** – heartburn, indigestion, nausea, vomiting, belching, passing gas, stomach pain
- **Gastrointestinal** – constipation, diarrhea, blood in stool, mucous in stool, hemorrhoids, black stool
- **Urinary** – pain, frequent urination, inability to hold urine, blood in urine, urgency, infections
- **Musculoskeletal** – joint pain/stiffness/swelling, muscle pain/stiffness/weakness/cramps, broken bones
- **Neurologic** – fainting, seizures, paralysis, numbness/tingling
- **Neurologic** – loss of balance, involuntary movement, speech problems, memory loss
- **Endocrine** – fatigue, heat/cold intolerance, thyroid problems, excess thirst/hunger/sweating
- **Female health** – nipple discharge, vaginal discharge, vaginal itching, hernias
- **Male health -** testicular masses/pain, discharge from penis, hernias
- **Emotional** – mood swings, anxiety/nervousness, insomnia
- **Exposure** to pest, tobacco smoke, toxins/chemicals at home
- **Date of last physical exam:** ____________________________________________________________