
Pediatric Intake

Date: _____

Name: _____

Gender: F M

Age: _____

D.O.B.: _____

Address: _____

City: _____

Postal Code: _____

Telephone: (home) _____

E-mail: _____

Mother's full name: _____

Telephone: (work) _____

(mobile) _____

Father's full name: _____

Telephone: (work) _____

(mobile) _____

Other emergency contact: _____

Name: _____

Telephone: _____

Relation: _____

Is your child currently under the care of a medical doctor? Y N

Name: _____ Telephone: _____

How would you prefer to be addressed at the Clinic? _____

How did you hear about us? _____

Would you like to be added to our e-mail list to be informed of free lectures or other events presented by Toronto-Centre Naturopathic Medicine? Y N

CURRENT HEALTH CONCERNS

What are your child's health concerns (in order of importance to you)?

1. _____

2. _____

3. _____

4. _____

5. _____

Have any of these conditions recently changed or become worse? _____

What effect has this had on your child's life? _____

What is your child's general state of health? _____

Do you have any major concerns regarding your child's health? _____

What is your child's greatest health concern (in their opinion)? _____

Known allergies: _____

MEDICATIONS AND SUPPLEMENTS

Please list all prescription and non-prescription medications, including dosage, efficacy and adverse reactions.

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all supplements, homeopathic remedies, etc. including dosage, efficacy and adverse reactions.

1. _____

2. _____

3. _____

Previous treatments: (Include treatment, date and efficacy of treatment)

1. _____

2. _____

3. _____

4. _____

5. _____

CURRENT HEALTH PROFILE

Height: _____ Weight: _____ Max. weight: _____ Date of max. weight: _____

Foods avoided: _____

Why: _____

Food cravings: _____

Dairy consumption: Y N _____ servings daily

Soft drink consumption: Y N _____ 8 oz. servings/day

What is the source of your household's drinking water?

tap filtered distilled bottled spring

If you have not completed in a "Weekly Diet Journal" for your child, list their dietary intake for the last 24 hours.

B: _____

L: _____

D: _____

How many bowel movements does your child have daily? _____

If your child is presently breastfed, list your/your partner's (i.e., your child's mother) dietary intake for the last 24 hours.

B: _____

L: _____

D: _____

Regular exercise: Y N Type: _____ Duration: _____ Frequency: _____

How much time does your child spend watching television/using a computer on a typical day?

How much time does your child spend outdoors daily? _____

Does your child enjoy school? If "no", why not? _____

Has your child ever experienced an emotional trauma? If "yes", describe. _____

Does your child (experience):

Sleep problems: Y N Date/duration: _____

Nightmares: Y N Date/duration: _____

Bedwetting: Y N Date/duration: _____

Sleep excessively: Y N Date/duration: _____

Other sleep problems: _____

Is your child exposed to any of the following (at home or at school)?

tobacco smoke pets old building renovations chemical fumes

Elaborate: _____

GENERAL INFORMATION

Describe your child's personality/disposition. _____

What are your child's interests/hobbies? _____

Please describe any limitations to care that I should be aware of (e.g., time restraints, dietary restrictions).

PAST HEALTH HISTORY

Has your child ever been diagnosed with a medical condition? Elaborate: _____

Vaccinations/Immunizations: (Complete appropriate boxes)

Vaccine	Age(s)	Adverse reactions
Hep. B		
DPT		
Hib		
Polio		
Influenza		
MMR		
Varicella		

Has your child ever used antibiotics? Y N Date/dosage/duration: _____

For what condition? _____

CHILDHOOD ILLNESS

- chicken pox polio rubella tuberculosis
- measles rheumatic fever scarlet fever whooping cough
- mumps

Hospitalizations, surgeries, serious injuries: (Include date and reason for hospitalization)

OBSTETRIC HEALTH HISTORY

BIRTH HISTORY

At what age did you/your partner (i.e., your child's mother) give birth to your child? _____

Was this child your/your partner's (i.e., your child's mother) first pregnancy? Y N

If "no", where is this child in the birth order? _____

Did you and your partner have any difficulty conceiving? Y N

On a scale of 1-10 (10 = highest), what was the health of you and your partner at your child's conception:

Mother_____ Father_____

Describe any health problems you/your partner (i.e., your child's mother) experienced during the pregnancy.

What was your/your partner's (i.e., the child's mother) emotional state during the pregnancy?

Did you/your partner (i.e., your child's mother) use any of the following during the pregnancy:

Medications: Y N If "yes", which/dosage/duration:_____

Tobacco: Y N If "yes", pack(s)/day:_____

Alcohol: Y N If "yes", serving(s)*/day:_____

Recreational drugs: Y N If "yes", which/how often:_____

Were you/your partner (i.e., your child's mother) exposed to any workplace chemicals during pregnancy?

Y N If "yes", which ones?_____

*1 serving of alcohol = 1.5 oz. spirits, 4 oz. wine, 12 oz. beer (i.e., 1 "standard" serving)

Where did the birth happen (e.g., other country, home, etc.)?_____

How long was the labour?_____

Were there any complications at childbirth (e.g., breech)? Y N If "yes", describe.

Were any interventions employed during the labour or delivery (e.g., forceps)? Y N If "yes", describe.

Birth weight:_____ Birth length:_____

APGAR score (1 min.):_____ APGAR score (5 min.):_____

Age at first: sitting_____ crawling_____ teething_____ walking_____ talking_____

What was your child's general appearance at birth?_____

At/in the first few weeks following birth, did your child experience any of the following:

congenital birth defect fever feeding difficulties

skin conditions infection jaundice

FEEDING HISTORY

Was your child breastfed? Y N If "yes", until what age?____; if "no", what type of formula was used (e.g., commercial brand, homemade, etc.)?_____

At what age were solid foods introduced?_____

Were you selective in which foods were introduced first? Y N If "yes", describe._____

Were there any allergy-type reactions to any foods introduced? If "yes", describe._____

Describe your child's present eating habits._____

FAMILY HEALTH HISTORY

Please check appropriate boxes for immediate family (i.e., grandparents, parents, siblings).

- | | | |
|---|---|---|
| <input type="radio"/> allergies/hay fever | <input type="radio"/> eating disorders | <input type="radio"/> psychiatric illness |
| <input type="radio"/> asthma | <input type="radio"/> epilepsy | <input type="radio"/> obesity |
| <input type="radio"/> arthritis | <input type="radio"/> gout | <input type="radio"/> stroke |
| <input type="radio"/> bleeding problems | <input type="radio"/> heart problems | <input type="radio"/> substance abuse |
| <input type="radio"/> cancer | <input type="radio"/> high blood pressure | <input type="radio"/> thyroid problems |
| <input type="radio"/> diabetes | <input type="radio"/> kidney problems | <input type="radio"/> tuberculosis |

Age and health status of immediate family:

Mother: _____

Father: _____

Maternal grandmother: _____

Maternal grandfather: _____

Paternal grandmother: _____

Paternal grandfather: _____

Sister/brother: _____

Sister/brother: _____

Sister/brother: _____

Sister/brother: _____

Is there anything else I should be aware of? _____

REVIEW OF SYSTEMS

Please circle "Y" if your child is presently experiencing a symptom/condition and "P" if they have experienced it in the past.

GENERAL

fatigue/weakness Y P
fever/chills Y P

HAIR/SKIN/NAILS

cradle cap Y P
skin dryness Y P
yellowing Y P
itching Y P
rash/hives Y P
boils Y P
acne Y P
eczema Y P
psoriasis Y P
warts Y P
diaper rash Y P
nail ridging/spots Y P
Other: _____

HEAD

headaches Y P
injury Y P
Other: _____

EYES

impaired vision Y P
pain Y P
itching Y P
dryness Y P
tearing Y P
redness Y P
discharge Y P
Latest eye exam: _____
Other: _____

EARS

impaired
hearing Y P
earache Y P
itching Y P
discharge Y P
excessive wax Y P
infection Y P
dizziness Y P
Other: _____

NOSE/SINUSES

bleeding Y P
congestion Y P

obstruction Y P
hay fever/
allergies Y P
sinus problems Y P
injury Y P
Other: _____

MOUTH/THROAT

dental caries Y P
gum problems Y P
chancre sores Y P
frequent sore
throat Y P
tonsillitis Y P
thrush Y P
Latest dental exam :

Other: _____

RESPIRATORY

cough Y P
bloody sputum Y P
wheezing Y P
difficulty
breathing Y P
asthma Y P
bronchitis Y P
pneumonia Y P
Other: _____

CARDIOVASCULAR

cold hands/feet Y P
heart murmur/
palpitation Y P
rheumatic fever Y P
Other: _____

BLOOD

fatigue/weakness Y P
skin paleness Y P
easy bleeding/
bruising Y P
clotting problems Y P
blood transfusion Y P
anemia Y P
Other : _____

GASTROINTESTINAL

abdominal pain Y P

indigestion Y P
belching/flatulence Y P
nausea Y P
vomiting Y P
constipation Y P
diarrhea Y P
hemorrhoids Y P
Other: _____

URINARY

genital itching Y P
discoloured urine Y P
bedwetting Y P
Other: _____

MUSCULOSKELETAL

pain Y P
fractures Y P
Other: _____

NEUROLOGICAL

numbness/
tingling Y P
muscle weakness Y P
involuntary
movements Y P
paralysis Y P
fainting Y P
convulsions Y P
Other : _____

ENDOCRINE/METABOLIC

hypoglycemia Y P
diabetes Y P
Other: _____

PSYCHOSOCIAL

hyperactivity Y P
sleep problems Y P
phobias Y P
depression Y P
anxiety Y P
Other: _____