Benna Lun BSc(Hons) ND
Naturopathic Doctor

Pediatric (Age 0-10) Intake Form

Today's Date: _____

WHO IS FILLING OUT THIS FORM?

_____ _____
Name (Please print in block letters) Relationship to child

PATIENT INFORMATION

Full Legal Name: _____ _____ _____
First name Middle name Last name

By what name does the child prefer to be called? _____

Date of Birth (MM/DD/YYYY): _____ Age: _____ Sex: _____

Address: _____ _____
Street address Apartment #

_____ _____ _____
City Postal code Province

Please provide your contact information below and indicate whether or not we may leave messages relating to the child's appointments:

		Message?			Message?
(H) phone			(C) Phone		
(W) Phone			E-mail		

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone numbers: H: ( ) _____ OTHER: ( ) _____

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐ Yellowpages
☐ Walk-in
☐ Pamphlet/Flyer
☐ Referred by another patient
☐ Referred by staff member
☐ Referred by health care provider
☐ Other (please specify: _____ _____

HEALTH CARE PROVIDERS

Does the child have regular screening tests with a Doctor (e.g. yearly physicals)? (Please circle) Yes No

Please list the other health care providers from whom the child currently receives treatment:

Name: _____ Name: _____

Type of care: _____ Type of care: _____

Address: _____ Address: _____

_____ _____

Phone: ( )_____ Phone: ( )_____

Health care providers (continued)

Name: _____

Type of care: _____

Address: _____

_____

Phone: ( )_____

Name: _____

Type of care: _____

Address: _____

_____

Phone: ( )_____

CHIEF CONCERNS

Please list the top health care concerns for which you are seeking treatment in order of importance to you:

1. _____

2. _____

3. _____

4. _____

5. _____

MEDICAL HISTORY

How is the child's general state of health? Excellent Good Average Fair Poor

Please list any past health concerns, including major illnesses, hospitalizations, surgeries, etc., with approximate dates:

1. _____

2. _____

3. _____

4. _____

Does the child have any allergies (medication, seasonal, environmental, etc.)? _____

_____

_____

Please complete the following table regarding the child's medications and supplements:

CURRENT medications			
Drug name	Date started	Dose	What is this drug being taken for?
PAST medications			
Drug name	Date ended	Dose	What was this drug being taken for?
CURRENT supplements (including vitamins, minerals, herbs, homeopathics, etc.)			
Supplement name	Date started	Dose	What is this supplement being taken for?

Does the child use any over-the-counter (non-prescription) medications? Please list:

_____

_____

Please indicate which immunizations the child has received:

- ☐ DPT (Diptheria, pertussis, tetanus)
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Polio
- ☐ Smallpox
- ☐ Tetanus booster – when? _____
- ☐ Hemophilus influenza B
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ "Flu" shot
- ☐ Other: _____

Did any of the vaccines cause a negative reaction? Please describe: _____

_____

FAMILY MEDICAL HISTORY

Please indicate any health conditions occurring in the child's family. Include parents, siblings, grandparents, aunts, and uncles and specify maternal/paternal lineage.

Health condition	Family member(s)
Heart disease (heart attack, stroke, etc.)	
High blood pressure	
Diabetes	
Asthma	
Eczema or other skin condition	
Thyroid disease (Hypo or Hyper?)	
Arthritis/Rheumatism/other muscle or joint condition	
Cancer (Please indicate type)	
Mental illness (e.g. depression, anxiety, schizophrenia, etc)	
Environmental/seasonal allergies	
Other (please describe):	

☐ I don't know the child's family medical history

PRENATAL HEALTH HISTORY

What was the health of the child's mother during pregnancy? (Please circle)

Excellent Good Average Fair Poor Unknown

How old was the child's mother at the time of his/her birth? _____ years

Did the child's mother receive prenatal health care? (Please circle) Yes No Unknown

Did the child's mother experience any of the following during pregnancy?

- ☐ Nausea and/or vomiting
- ☐ High blood pressure
- ☐ Abnormal bleeding
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Physical trauma
- ☐ Emotional trauma
- ☐ Other: _____

Did the child's mother use any of the following during pregnancy:

- ☐ Alcohol
- ☐ Tobacco
- ☐ Caffeine
- ☐ Recreational Drugs: _____
- ☐ Prescription Medications: _____
- ☐ Over-the-counter Medications: _____
- ☐ Supplements: _____
- ☐ Herbs (Tinctures, teas, etc.): _____
- ☐ Other: _____

BIRTH HISTORY

Term length: _____ weeks Length of labour: _____ hours

Type of birth: ☐ Vaginal ☐ C-section ☐ Induced labour ☐ Forceps ☐ Use of anesthetics

Weight at birth: _____ kg / _____lbs _____ oz Length at birth: _____ cm / _____ in

Birth complications? (Please describe) _____

_____

_____

Did the child experience any of the following at or shortly after birth?

- ☐ Jaundice
- ☐ Rashes
- ☐ Seizures
- ☐ Birth defects: _____
- ☐ Birth injuries: _____
- ☐ Other: _____

HEALTH & DEVELOPMENT

How was the child's health in his/her first year? Excellent Good Average Fair Poor

How would you describe the child's:

- Sleeping pattern? _____
- _____
- Mood & Temperament? _____

  _____
- Behaviour at home? _____

  _____
- Behaviour and performance at school? _____

  _____

DIET

How was the child fed prior to 6 months of age? _____

What does the child eat on a typical day?

Breakfast: _____

Lunch: _____

Supper: _____

Snacks: _____

Beverages: _____

How are the child's meals usually prepared? (Please circle) At home Purchased

Does the child have any food allergies, sensitivities, or intolerances (that you know of)? _____

_____

Does the child have any dietary restrictions (religious, vegetarian/vegan, etc.)? _____

_____

ENVIRONMENTAL HISTORY

Is the child is currently in: ☐ Day care ☐ Home-school ☐ Other: _____

☐ Pre-school ☐ School: Grade _____ _____

What is the child's physical activity level? Very active Active Somewhat active Inactive

What are the child's favourite activities? _____

Is the child exposed to significant amounts of smoke (including tobacco smoke) or other forms of pollution through school, hobbies, home environment, etc.? _____

_____

Is the child frequently exposed to animals (including pets)? _____

How would you describe the emotional environment of the child's home? _____

_____

_____

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

_____

_____

Thank you for taking the time to complete this form