Pediatric Intake Form

Today's Date ______________________ Age ________ Grade Level _________

Name ____________________________________ Date of Birth ________________

Child's Height ___________________ Child's Weight _______________

Mother's Name ________________________ Father's Name _______________

Telephone (H) _______________________ (W) _______________________

Full Address ____

____

This record of your medical history is confidential. Information it contains will not be released to anyone unless you authorize the Oakville Naturopathic Clinic to do so.

Pediatrician/M.D. ______________________ M.D. Phone __________________

Other Practitioners ____

Please list the chief health concerns of your child:

1 ____

2 ____

3 ____

Please list current and past medications or supplements.

____
____
____

Please list *all* allergies (food, environmental, prescription drug)

____
____
____

Number of courses of antibiotics has your child had in lifetime? (approx). ______

Food allergies or intolerances? Please list. ________________________________

____

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty will greatly assist my understanding of your health care needs.

Prenatal Health

What was the health of the parents at the time of conception (please circle)?

Mother: Poor Fair Good Excellent Unknown

Father: Poor Fair Good Excellent Unknown

What was the health of the mother during pregnancy?

Poor Fair Good Excellent Unknown

What was the emotional state of the mother during pregnancy?

Poor Fair Good Excellent Unknown

How was the mother's diet during pregnancy?

Poor Fair Good Excellent Unknown

Did the mother experience any of the following during pregnancy?

□ Bleeding □ High blood pressure □ Nausea □ Vomiting

□ Diabetes □ Thyroid problems □ Physical or emotional trauma

□ Cigarettes/alcohol □ Other:

Birth History

Term length □ Pre-term (37 weeks or less): ___________ weeks

□ Full-term (38-42 weeks): ___________ weeks

□ Post-term (> 42 weeks): ___________ weeks

Mother's age at child's birth:________________________Type of birth: □ Vaginal □ C-section

Interventions during birth:

□ Induced labour □ Forceps □ Epidural/anesthesia □ Episiotomy

□ Other: ____

Length of labour: ___________ Weight of infant at birth: ________________________________

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

□ Jaundice □ Rashes □ Seizures □ Colic

□ Birth injuries: ____

□ Infections: ____

□ Difficulties with feeding: ____

□ Birth defects: ____

□ Other: ____

Dietary History

□ Breast fed? How long? ___________ □ Formula? How long? ___________

Does your child have any food allergies or intolerances? Please list.

____

____

Describe a typical day's diet for your child.

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Beverages (include total quantity) ____

Medical History

Has your child ever experienced any of the following illnesses?

□ Rubella □ Mumps □ Pneumonia □ Measles
□ Chickenpox □ Frequent colds □ Whooping Cough □ Asthma
□ Tonsillitis □ Scarlet Fever □ Polio □ Ear Infections
□ Rheumatic Fever □ Colic □ Other: ___________________________

Has your child received any of the following vaccinations?

□ DPT □ MMR □ Polio □ TB □ Flu
□ Smallpox □ Tetanus □ Chickenpox □ Other: ___________________________

Any adverse reactions or chronic illness following vaccination? ___________________________

Injuries/Surgeries/Hospitalizations (please list): ____
____

Any significant physical or emotional traumas? ____
____

Health and Development

How was your child's health in the first year? Poor Fair Good Excellent Unknown
How is your child's health now? Poor Fair Good Excellent Unknown
Age began: Sitting_________ Crawling _________ Walking _________ First words________

Sleep Patterns

How is your child's sleep? ____
Does your child have nightmares? Yes No How often? ________________________________

Family History

Please indicate if a close relative (parent, grandparent, sibling) has had any of the following:

Condition	Relative	Condition	Relative
□ Allergies		□ Seizures	
□ Anemia		□ Stroke	
□ Arthritis		□ Diabetes	
□ Asthma		□ Eczema	
□ Birth Defects		□ Glaucoma	
□ Bleeding Disorder		□ Kidney Disease	
□ Cancer		□ Psoriasis	
□ Hay Fever		□ Depression	
□ High Blood Pressure		□ Tuberculosis	
□ Juvenile Arthritis		□ Mental Illness	
□ Other		□ Unsure of history	

Environment

Are there any pets in the home? Yes No What type and how many?___________________

Does anyone in the child's household smoke? Yes No

Toxins that the child is regularly exposed to (home, hobbies, school, etc.)? ______________
____

How would you describe the emotional climate of the home? ____________________________
____

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

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