NATUROPATHIC PEDIATRIC INTAKE FORM

Child's name: ____

Gender:____________ Date of birth: _______________ Age: __________

______________________ ________________ ______________
Address City, Province Postal code

______________________ ____________________
Phone number - Day Phone number – Evening

Parent's Name, Age and Occupation:

1. ____

2. ____

Parents are (circle one):

Married Separated Divorced Common law Other: __________

Other health care providers your child is seeing (family doctor, specialist, chiropractor, etc…):

1. ____________________ 2. ____________________ 3. ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

( ) ________________ ( ) ________________ ( ) ________________

May I contact the above to discuss your child's health/treatment? ❑ Yes ❑ No

Chief concern	How long has it been going on?	Has this been previously diagnosed/treated? How?
1.		
2.		
3.		

Any known allergies to foods, medication, supplements, animals or environment?

____

____

List any surgeries or major illnesses (with dates):

____

____

List any current medications and/or supplements (please bring with you to first appointment):

____

____

List any past medications and/or supplements (include dates):

____

____

If your child has taken antibiotics, how many times? ____________________

FAMILY MEDICAL HISTORY

	Age/Age at death	General health (excellent, good, poor)	Health conditions
Mother/Father			
Mother/Father			
Sibling 1			
Sibling 2			

162 Metcalfe Street, Suite 100, 2nd floor, Ottawa, ON K2P1P2
(613) 598-0109 info@taraanchelnd.ca

FAMILY MEDICAL HISTORY CONT'D	Age/Age at Death	General health (excellent, good, poor)	Health conditions
Maternal Grandfather			
Maternal Grandmother			
Paternal Grandfather			
Paternal Grandmother			
Other			

* Parents of same sex families, please indicate the name of each parent listed.

Was your child adopted? ❑ Yes ❑ No If yes, at what age:____________________

HEALTH HISTORY Please check all that apply (circle c=current or p=past):

❑ Cradle cap	c	p	❑ Eczema/rash	c	p
❑ Diaper rash	c	p	❑ Thrush	c	p
❑ Impetigo	c	p	❑ Severe sun burn	c	p
❑ Warts	c	p	❑ Lice	c	p
❑ Chronic sniffles/stuffiness	c	p	❑ Asthma	c	p
❑ Allergies	c	p	❑ Colds	c	p
❑ Ear infection	c	p	❑ Conjunctivitis (Pink eye)	c	p
❑ Hearing problems	c	p	❑ Vision problems/glasses	c	p
❑ Late dentition	c	p	❑ Cavities	c	p
❑ Strep Throat	c	p	❑ Stomach aches	c	p
❑ Diarrhea	c	p	❑ Constipation	c	p
❑ Colic	c	p	❑ Nausea/vomitting	c	p
❑ High fevers	c	p	❑ Chicken Pox	c	p
❑ Mumps	c	p	❑ Measles	c	p
❑ Fifths disease	c	p	❑ Erythema Infectiosum	c	p
❑ Cold sore/HSV	c	p	❑ Tantrums	c	p
❑ Hyperactivity	c	p	❑ Extreme shyness	c	p
❑ Nightmares	c	p	❑ Bedwetting	c	p
❑ Picky eater/poor appetite	c	p	❑ Feas/phobias	c	p
❑ Seizures	c	p	❑ Delayed milestones	c	p
❑ Early puberty (before 11)	c	p	❑ Other:		

Notes:

VACCINATION HISTORY

Check all vaccinations that have been administered (or attach copy of vaccination card)	Date Received	Reactions, if any (i.e., fever, seizure, mood change, etc…)
❑ MMR		
❑ DTaP-IPV (Diptheria, Tetanus, Pertussis, Polio)		
❑ Haemophilus influenza type B		
❑ Pneumococcal		
❑ Meningitis		
❑ Rotavirus		
❑ Varicella (Chicken pox)		
❑ Influenza (Flu shot)		
❑ Hepatitis A		
❑ Hepatitis B		
❑ HPV (Gardacil/Cervarix)		
❑ Other		
❑ Check here if you have chosen not to vaccinate your child		

PRENATAL HISTORY

Were there difficulties conceiving? ❑ Yes ❑ No

pregnancies carried to term: _________ # pregnancies not carried to term: _________

Mother's age at conception: _________ Father's age at conception: _________

Were fertility interventions use? ❑ Yes ❑ No If yes, what type:

Mother's health at conception: _________ Father's health at conception: _________

Were any of the following complications during pregnancy?

❑ Bleeding ❑ Gestational diabetes ❑ High blood pressure ❑ Excessive weight gain

❑ Swelling ❑ Nausea/vomiting ❑ Accidents/Injuries ❑ High stress

❑ Herpes ❑ Infections (ie. Yeast) ❑ Thyroid problem ❑ Other:

Was the mother exposed to any of the following during pregnancy?

❑ Recreational drugs ❑ Alcohol ❑ Cigarette smoke ❑ Second hand smoke

❑ Environmental toxins ❑ Caffeine: How much _____________ ❑Other:

List any medications taken during pregnancy:

____

____

List any vitamins or other supplements taken during pregnancy:

____

____

What was mother's emotional state during the pregnancy? Describe significant relationships.

____

____

What is your overall impression of the pregnancy?

____

____

BIRTH HISTORY

Pregnancy length: ________________ weeks

Length of labour: __________________ hours/days

❑ Hospital birth ❑ Home birth ❑ Birthing centre

Were any of the following used during the birth?

❑ Induced labour ❑ Forceps ❑ Vacuum extraction ❑ Epidural/anesthesia

❑ Episiotomy ❑ Oxytocin/Pitocin ❑ Pain Medication ❑ C-section

Other:

Birth Weight:______________Length: ________________ Head Circumference:________________

162 Metcalfe Street, Suite 100, 2nd floor, Ottawa, ON K2P1P2
(613) 598-0109 info@taraanchelnd.ca

EARLY CHILDHOOD HISTORY

Did your child experience any of the following shortly after birth?

- ❑ Colic
- ❑ Jaundice
- ❑ Infection / fever
- ❑ Birth trauma/injuries
- ❑ Rashes
- ❑ Respiratory distress
- ❑ Birth defects
- ❑ Seizures
- ❑ Difficulties feeding
- ❑ Anemia
- ❑ Trauma
- ❑ Other:

At what age did the following occur?

- ❑ Smiling ____________
- ❑ Sitting ____________
- ❑ Crawling ____________
- ❑ Walking ____________
- ❑ Talking ____________

PERSONALITY

Describe your child:

____

____

____

Does your child have any unusual habits?

____

____

Does your child have any fears?

____

____

How is your child's behaviour at home?

____

____

____

162 Metcalfe Street, Suite 100, 2nd floor, Ottawa, ON K2P1P2
(613) 598-0109 info@taraanchelnd.ca

Is your child in: ❑ school ❑ daycare ❑ homecare ❑ other What grade level?

General school/daycare behaviour and performance:

____

____

Has your child been diagnosed with a learning disability? ❑ Yes ❑ No

____

____

What are your child's interests and favourite activities?

____

____

NUTRITION

Was the child breast-fed? ❑ Yes ❑ No If yes, until what age?_______

Was formula introduced? ❑ Yes ❑ No If yes, when: ________

What type of formula?________________________________

At what age were solid foods introduced?_______

In what order were foods were introduced?

____

____

Were there any noticeable reactions to foods introduced (rashes, changes in sleeping habits):

____

____

Describe any current dietary restrictions (food intolerances/ allergies, religious, vegetarian, vegan, etc.):

____

____

List your child's favourite foods:

____

____

Least favourite foods:

____

____

Describe the child's present eating habits:

____

____

List your child's dietary intake for the last 24 hours:

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Drinks: ____

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

❑ Well ❑ Tap ❑ Filtered ❑ Distilled ❑ Bottled spring ❑ Reverse osmosis

ENVIRONMENT

Who does your child live with?

____

Describe the emotional climate of your child's home?

____

____

How many hours per day does your child:

❑ Play on the computer or video games ____________________ ❑ Watch TV ____________________

❑ Read (not for school) ____________________________________ ❑ Exercise _____________________

Does anyone in the home smoke? ❑ Yes ❑ No Do you have pets?: ❑ Yes ❑ No

Flooring: ❑ Carpet ❑ Wood ❑ Laminate ❑ Other: ________________

SLEEP

How many hours does your child sleep at night? ________ Naps? ______

Describe bedtime:

____

____

Does your child wake during the night? ❑ Yes ❑ No If yes, how often?

Does your child have nightmares? ❑ Yes ❑ No If yes, how often?

Does your child wet the bed? ❑ Yes ❑ No If yes, how often? Is this a change?

Does your child snore? ❑ Yes ❑ No

What position does your child sleep in?

____

Is there anything else about your child that you would like me to know?

____

____