NATUROPATHIC PEDIATRIC PATIENT INTAKE FORM

Child's Name: _____ Date: _____

Guardian's Name(s)/Relation: _____

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

Sex at birth: □ Female □ Male Preferred Pronoun: _____

Gender Identity: _____ □ Prefer not to answer

Address: _____ Apt/unit #:_____

City: _____ Province: _____ Postal Code: _____

Guardian's Phone # (Home): _____ (Work): _____ (Cell): _____

Preferred form of contact for reminder/follow-up calls: ○Home ○Work ○Cell ○Email

Guardian's E-mail: _____

Emergency Contact Name: _____ Relation: _____

Phone Number(s): _____ or _____

How did you hear about us? _____

Name of the friend or professional who referred you_____

Extended Health Insurance Company Name: _____

Insured Member: _____ Birth Date (MM/DD/YYYY): _____

Policy # _____ Member ID#_____

Coverage per year: _____

Other Health Care Providers (including medical doctor) your child is seeing:

Name: _____ Name_: _____ Name: : _____

Specialty: _____ Specialty: _____ Specialty: _____

Ph #: _____ Ph #: _____ Ph #: _____

Date of Last Visit: _____ Date of Last Visit: _____ Date of Last Visit: _____

Health Concerns

What are your child's main health concerns in order of importance?

1. _____
2. _____
3. _____
4. _____

Supplements

Please list all vitamin/mineral/herbal/homeopathic supplements your child is currently taking.

Supplement (Including Brand)	Dosage	When did your child begin this supplement?

Medications

Please list all prescription and non-prescription medications your child is currently taking.

Medication	Dosage	When did your child begin this medication?

Please list all prescription medications your child has taken in the past for longer than 6 months. Indicate how long your child took each medication.

_____

_____

How many times has your child been treated with antibiotics? _____

Vaccinations

- ☐ DPT (Diptheria, Pertussis, Tetanus)
- ☐ MMR (Measles, Mumps, Rubella)
- ☐ Chicken Pox
- ☐ Polio
- ☐ Smallpox
- ☐ Tetanus Booster (When? _____)
- ☐ Flu Shot
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Other _____

Did your child experience any symptoms from them? If yes, please explain:

_____

Family History

Please indicate if any of your family members have experienced the following:

Condition	Relative	Condition	Relative
Alcoholism/Addiction		High Blood Pressure	
Alzheimer's Disease/Dementia		Insomnia	
Allergies (Food/Hayfever)		Kidney Problems	
Arthritis (osteo/rheumatoid)		Liver Disease	
Asthma/Emphysema		Mental Health Problems	
Autoimmune disease (MS, RA, etc.)		Migraines/Headaches	
Cancer (please specify type)		Osteoporosis	
Diabetes		Skin conditions	
Digestive Problems		Thyroid problems	
Heart Disease		Other	

☐ I do not know my child's family medical history.

Medical History

How would you describe your child's general state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any major illnesses or diseases that your child currently has or had in the past:

_____

_____

Please list any injuries and/or major surgeries your child has had and when they occurred:

_____

_____

Does your child get regular screening tests done by another Doctor (blood, vision, hearing)? ☐ Yes ☐ No

Does your child have any allergies (medicines, environment, etc)? If yes, please list:

_____

_____

Development

Child's health during the first year of life: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Unknown

How would you describe your child's temperament?

_____

_____

Areas of your child's development you are concerned about (physical, mental, emotional, social)?

_____

_____

Prenatal Health

What was the health of the child's parents at conception?

Mother: □ Excellent □ Good □ Fair □ Poor □ Unknown

Father: □ Excellent □ Good □ Fair □ Poor □ Unknown

What was the health of the mother during pregnancy?

□ Excellent □ Good □ Fair □ Poor □ Unknown

What was the mother's age at child's birth? _____

How was the mother's diet during pregnancy?

□ Excellent □ Good □ Fair □ Poor □ Unknown

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

□ Bleeding □ High Blood Pressure □ Nausea □ Vomiting

□ Diabetes □ Thyroid problems □ Physical or emotional trauma

Please list all medications taken during the pregnancy: _____

Did the mother use any drugs or alcohol during the pregnancy? □ Yes □ No Types: _____

Birth History

Term Length: □ Full □ Premature: _____ weeks □ Late: _____

Length of Labour: _____ Any complications? _____

Child's Weight at Birth: _____ Child's Length at Birth: _____

Please indicate if any of the following interventions were applied:

□ Induction □ Vacuum extraction □ Forceps □ C-section □ Epidural

□ Antibiotics □ Oxytocin/Pitocin □ Other: _____

Diet and Digestion

How was the infant fed? □ Breastfed (How Long? _____) Formula: □ Milk □ Soy □Other: _____

What solid foods were introduced at 6 months of age? _____

How is your child's appetite? □ Excellent □ Good □ Fair □ Poor

Did your child ever experience colic? □ Yes □ No How severe? □ Mild □ Moderate □ Severe

How often does your child have a bowel movement (per day or per week)? _____

Is the child's diet: □ Non-Vegetarian □ Vegetarian □ Vegan For how long? _____

Does the child have any dietary restrictions for religious reasons?

_____

Please list all food allergies/intolerances/sensitivities:

_____

Personal Habits and Lifestyle

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

Parent's Marital Status:

□ Single □ Married □ Common Law □ Divorced □ Separated □ Other: _____

Number of Siblings: _____ Ages: _____

Who lives with the child? _____

What are your child's favourite activities? _____

How much screen time (television, computer, video games, etc) does your child get per day? _____

How many hours of sleep does your child get on average? _____

Does your child feel refreshed in the morning? □ Yes □ No

Does your child exercise? □ Yes □ No If yes, how often? _____

What does your child do for exercise? Please indicate the activity, frequency, intensity, and duration:

_____

_____

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

Is the child regularly exposed to animals? □ Yes □ No

Is the child regularly exposed to any toxins or chemicals (home, other's work, hobbies, school, etc)?

□ Yes □ No What types: _____

How is the child's home heated? _____

Is the child particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints, etc)?
□ Yes □ No

PREPARATION FOR YOUR FIRST APPOINTMENT

Please bring all supplements and medications with you to your appointment.

Please also bring in a copy of your most recent blood work and/or any other relevant tests you have had done, if possible.

This information is helpful, however it is not crucial. If you do not have any recent results or are unable to obtain them, your first appointment will not be significantly affected.