NATUROPATHIC MEDICINE AND REGISTERED ACUPUNCTURE

PEDIATRIC INTAKE FORM

Dear Parent/Guardian,

Please fill this form out entirely and bring it with you to your first office visit.

This form is meant to gather as much information as possible. Please fill it out to the best of your knowledge. If there are areas you cannot or would not like to answer, please leave that area blank.

Today's Date: _____

Contact Information

Child's Full Name: _____
Address:_____City_____Postal Code_____
Telephone: best number to reach caregiver on_____Other_____
Email Address: _____
Would you like to receive our quarterly email newsletter? Yes No
Date of Birth (mm/dd/yyyy)_____Age_____Gender: Male / Female

Mother's Name:_____ Phone Number: _____
Father's Name: _____ Phone Number: _____

Who does the child live with?
- ○ Mother
- ○ Father
- ○ Both
- ○ Other please specify_____

Who should we contact in case of Emergency?
Name: _____ Relationship: _____
Phone Numbers: _____

Who has permission to bring in your child to our office for treatment?

Name	Relationship to child	Phone Number
_____	_____	_____
_____	_____	_____

Name of Child's Physician: _____ Phone Number:_____

List reasons for visit in order of importance (include date of onset with each concern):
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Is your child currently receiving any treatment for these concerns? Have they been effective?

_____
_____

List any medication he/she is taking or has taken in the past (include duration, dosage and frequency):

_____
_____
_____
_____

List any vitamin, mineral, or herbal supplements he/she is taking or has taken in the past (include duration, dosage and frequency):

_____
_____
_____
_____

List any screening tests done recently (blood work, X-rays, etc.; include year and results):

_____
_____
_____
_____

List any surgeries, hospitalizations, accidents or serious injuries:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List any known allergies or intolerances:

_____
_____
_____

IMMUNIZATIONS

Is your child immunized?

- ○ Yes
- ○ No

If yes, please select the following:

- ○ All regular immunizations
- ○ Modified immunization schedule

Has he/she had any adverse reactions to any immunizations? If yes, please describe.

_____

FAMILY HISTORY

Have family members (including immediate family, grandparents, aunts and uncles) had any of the following conditions:

- Diabetes
- Headaches
- Cancer
- Epilepsy
- Arthritis
- Heart Disease
- Mental Illness
- Asthma
- Hypertension
- Alcoholism
- Birth Defects
- Stroke
- Drug Addiction
- Anemia
- Kidney Disease
- Allergies
- Other?_____

CHILDHOOD ILLNESSES

Has he/she ever had any of the following? Or other:_____

- Chicken Pox
- Ear Infections
- Frequent Colds
- Measles
- Mumps
- Pneumonia
- Polio
- Rheumatic Fever
- Rubella
- Scarlet Fever
- Tonsillitis
- Whooping Cough

PRENATAL HISTORY

	Poor	Fair	Good	Excellent
Health of father at conception:	O	O	O	O
Health of mother at conception:	O	O	O	O
Physical Health of mother during pregnancy:	O	O	O	O
Emotional Health of mother during pregnancy:	O	O	O	O
Emotional Health of mother following pregnancy:	O	O	O	O
Mother's diet during pregnancy:	O	O	O	O

Number of pregnancies: _____ Number of miscarriages: _____ Mother's age at birth of child: _____
List any illnesses or other difficulties during pregnancy: _____
_____
_____

Indicate usage during pregnancy.

- ☐ Drugs
- ☐ Alcohol
- ☐ Cigarette Smoking

List any medication, supplements or herbal remedies taken during pregnancy: _____
_____
_____
_____

LABOR AND DELIVERY

Location of the birth:_____ Duration of Labor: _____ Birth Weight: _____

Description of birth:

- ☐ Induced
- ☐ Forceps
- ☐ C-section
- ☐ Late
- ☐ Pain medication
- ☐ Spontaneous
- ☐ Epidural
- ☐ Natural
- ☐ Premature
- ☐ Other: _____

NEONATAL HISTORY

List any difficulties or complications soon after birth:

_____

List any therapies or medications administered:

_____

	Poor	Fair	Good	Excellent
Health of child at birth:	O	O	O	O
Health of child in first year:	O	O	O	O
Sleep patterns in first year of life:	O	O	O	O
Eating patterns after weaning :	O	O	O	O

GROWTH AND DEVELOPMENT

- O All growth and development milestones reached on time
- O Delays in the following areas
  - ○ Crawling
  - ○ Toilet Training
  - ○ Sitting
  - ○ Teething
  - ○ Walking alone
  - ○ Saying first words

Any concerns (by parents and/or teachers) in regards to his/her physical, social or mental development?

_____
_____
_____

NUTRITION

Infant feeding: Breast fed? Yes / No For how long?_____
Formula? Yes /No What type? (circle) Milk Cow Goat Soy Nut

Current Weight: _____ Current Height: _____
Age of introduction to solid foods: _____ What foods introduced first? _____
Favourite foods: _____
Excluded foods: _____
Does he/she consume any of the following at least once per week?

- ☐ Sweets
- ☐ Fried foods
- ☐ Luncheon Meats
- ☐ Distilled Water
- ☐ Excess Salt
- ☐ Margarine
- ☐ Soft Drinks
- ☐ Artificial Sweeteners

LIFESTYLE / ENVIRONMENTAL FACTORS

Is he/she exposed to any chemicals at home or at school? Explain
_____

What are his/her special interests?
_____

How is his/her energy level? Rate on a scale of 1 to 10 (1= very low, 10=excellent) _____

Emotional climate at home: O Very Stable O Stable O Stressful O Very Stressful
How old is his/her residence? _____ Type of heating: _____
Any Pets: _____
Type of flooring (hardwood, carpet, Linoleum, Tile etc.): _____
Has your child ever traveled outside your community? O Yes O No
Where? _____ When? _____
What was his/her response?_____

Please use the space below to include any further information regarding your child's personal health history, Family history, past medical history or lifestyle / environmental factors that may be of relevance to your service provider:
_____
_____
_____
_____
_____
_____
_____

Signature of parent / guardian: _____ Date: _____