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Naturopathic Medicine – Pediatric Intake Form

Please take 15-20 minutes to complete the following form. It will provide us with the background information we need to better serve you. Please email completed form to **info@natcanintegrative.ca** prior to your first appointment. *Thank you for your trust!!!*

Contact Information:

Child's Name ______________________ School Name ______________________

Date of Birth ______________________ School Phone ______________________

Child's Age ______________________ School Address ______________________

Gender ______________________ OHIP Number ______________________

List contact information in order of preference.

Primary Contact:

Name ______________________ Home Phone ______________________

Relationship to Child ______________________ Work Phone ______________________

Address ______________________ Mobile Phone ______________________

______________________ Email ______________________

Secondary Contact:

Name ______________________ Home Phone ______________________

Relationship to Child ______________________ Work Phone ______________________

Address ______________________ Mobile Phone ______________________

______________________ Email ______________________

Care Co-ordination:

Medical Doctor ______________________ Specialist ______________________

Medical Doctor # ______________________ Specialist # ______________________

Medical Doctor Address ______________________ Specialist Address ______________________

Email ______________________ Email ______________________

Dentist ______________________ Specialist ______________________

Dentist # ______________________ Specialist # ______________________

Dentist Address ______________________ Specialist Address ______________________

Email ______________________ Email ______________________

Please List any other Medical Providers:

Type of Medical Provider	Name	Phone #	Address

Health Priorities / Chief Concerns:

List your main heath concerns (or reasons for visiting the clinic) in order of importance.

1. ___
2. ___
3. ___
4. ___
5. ___

Medical History:

How would you describe your general state of health? ___Excellent ___Good ___Fair ___Poor

Medical conditions: Please indicate any serious illnesses, conditions, or reasons for hospitalizations.

Medical Condition/ Hospitalization	Date of Diagnosis/ Diagnosed by whom	Is the condition still present?	Symptoms

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Allergies or Food sensitivities: Please indicate any allergies and/or serious food sensitivities.

Allergy/Sensitivity	Severity of reactions

Medications/Supplements: Please list all current medications/supplements.

Medication/Supplement	Dose (if known)/ Length of Use	Prescribing Physician	Condition it is treating

Has your child taken antibiotics within the last 5 years (circle one)?: YES / NO

How many times have you taken antibiotics within the last 5 years? _______________

Past Conditions:

Illness		Age	Duration	Complications/Hospital Admittance
Asthma	Yes / NO			
Cold & Influenza	Yes / NO			
Fever (above 105	Yes / NO			
Cough	Yes / NO			
Jaundice	Yes / NO			
Diabetes	Yes / NO			
Ear infections	Yes / NO			

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Illness		Age	Duration	Complications/Hospital Admittance
Measles	Yes / NO			
Mumps	Yes / NO			
Rubella	Yes / NO			
Whooping Cough	Yes / NO			
Chicken Pox	Yes / NO			
Rheumatic Fever	Yes / NO			
Scarlet Fever	Yes / NO			
Polio	Yes / NO			
Strep throat	Yes / NO			
Mononucleosis	Yes / NO			
Impetigo	Yes / NO			
Eczema	Yes / NO			
Warts	Yes / NO			

Vaccinations: Please indicate which vaccinations you have received.

Vaccination against:		Age	Side Effects/Hospital Admittance
Measles, Mumps, Rubella (MMR)			
Diphtheria, Pertussis, Tetanus (DPT)			
Haemophilus Influenza B (Hib)			
Chicken Pox (Varicella Zoster)			
Rabies			
Hepatitis A			
Hepatitis B			
Tetanus			
Polio			

Vaccination against:		Age	Side Effects/Hospital Admittance
Flu			
Other:			

Prenatal History:

What was the general health of the mother during pregnancy?__Excellent __Good __Fair __Poor __Unknown

Was the mother exposed to any of the following during pregnancy (check the box next to the listed exposure)?

Alcohol		Radiation		Trauma
Tobacco		Chemotherapy		Stress
Recreational drugs		Excessive UV		Other:
Prescription drugs		Infectious disease		

Pregnancy Complications: check the box next to the listed complication.

Nausea/Vomiting		Pre-eclampsia		Thyroid problems	
Diabetes		Hemorrhaging		Other:	

Please indicate supplements taken during pregnancy:____

____

Are you a single parent?: YES / NO

Did you have adequate support or prenatal care during the pregnancy?: YES / NO

____

____

Birth History: Please check the box that applies to your history.

Vaginal		Forceps		Epidural/Drugs	
Cesarean Section		Suction		Vacuum Extract	

Length of labor: _______________________ _____pre term _____post term How many weeks late?_______

Weight at birth: ___________________________ Number of births: ________________

Where did the birth occur? ____home _____hospital _____birthing centre

Did you use a midwife, doula or both? _____midwife _____doula _____both midwife and doula

(Birth History Cont'd)

Was the birth traumatic on you, the baby or both? _____mother _____baby _____both mother and baby

List complications during birth if present: ____

Neonatal History: Check the box next to the listed complication.

Neonatal jaundice		Colic		Rashes	
Breathing problems		Deformities (cleft palate)		Other:	

Growth and Development:

Age child began to crawl ________

Age child began to sit up ________

Age child began to speak (mama, dada) ________

Age child began to teethe ________

Age child began to walk ________

How would you rate your child's health in their first year? __Poor __Fair __Good __Excellent __Unknown

Sleep: Hours per day ___________________________ Hours per night: _________________________

Quality of Sleep: __easily aroused ___hard to wake ___nightmares ___sleep on stomach ___sleep on back

Feeding History:

__breast fed __bottle fed Length of breast/bottle feeding: __________________ Picky eater: YES / NO

Most Common Eating Style: ___home made (from scratch) ___home made (packaged food) ___ eating out

Age when solid foods were introduced: _____________ Feeding complications: _________________________

What foods were introduced before 6 months: ____

List the solid foods introduced: ____

Does your child have any dietary restrictions (religious, vegetarian / vegan etc.): _________________________

Please list any food cravings your child has: ____

Please list any food aversions your child has: ____

Describe a typical day's diet.

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks/ Beverages: ____

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Social History:

Please describe the disposition of your child when interacting with other children, parents, and other caregivers: ____________________

Describe your child's behaviour and performance at school:____________________

Is your child physically active?: YES / NO How much, how often? ____________________

How many hours of TV per day? ____ How many hours on computer? ____ How many hours outside? ____ How many hours are spent reading with your child outside of school? ____

Schooling: __daycare __preschool __school

List the extracurricular activities your child is involved in or favourite activities:____________________

____

Family History:

Illness		Family Member	Complications/Severity
Allergies			
Asthma			
Diabetes			
Heart Disease			
Cancer			
Depression			
Other mental illness			
Kidney disease			
Infertility			
Post-partum depression			
High Blood Pressure			
Other			
Family History Unknown			

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Home Environment: Check the boxes that apply.

Age of home? ______ Any recent renovations? ____

Upkeep of Home: __good __bad How is the home heated: ___________________________________

Lead Paint: ______ Asbestos: ______ Carpet: ______ Mildew: ______ Pets: ______ Smokers: ______

Home Location? Airport: ______ Industry: ______ Suburb: ______ City: ______ Highway: ______

Describe any known toxins or hazards the child is exposed to at home, daycare, hobbies outside environment etc.):____

Describe the emotional climate of the child's home:____

____

Review of Systems: Please list conditions or concerns that involve the following systems.

SKIN (eg. eczema, psoriasis, hives, rashes) ____

HEAD *(eg. headaches)* ____

EYES *(eg. itching, pain, infection, corrective lenses)* ________________________________

EARS *(eg. wax, discharge, hearing impairment)* ______________________________________

NOSE *(eg. sinus problems, pain, nose bleeds)* _______________________________________

MOUTH *(eg. difficult dentition, cavities, loss of taste, problems swallowing)* ____________

NECK *(eg. stiffness, tenderness, hoarseness, tonsillitis, swelling)* ___________________

HEART *(eg. rheumatic fever, murmurs, chest pain)* ___________________________________

LUNGS *(eg. cough, asthma, wheezing)* ____

GASTROINTESTINAL *(eg. vomiting, swallowing, diarrhea, constipation)* __________________

URINARY *(eg. pain, increased frequency, blood)* _____________________________________

MALE *(eg. hernias, pain or masses in scrotum/testes)* ______________________________

FEMALE *(eg. urgency, menstruation/menarche, discharge, pain or masses in ovaries/uterus)*

____

MUSCLE AND SKELETON *(eg. joint pain, stiffness, weakness, back pain, fractures)*

____

NEUROLOGICAL *(eg. seizures, paralysis, clumsiness, memory, vision changes, speech problems, sensation alteration)* ____

NatCan Integrative Medical & Wellness Centre
#102 - 3905 Major Mackenzie Drive West, Woodbridge, ON, L4H 4J9

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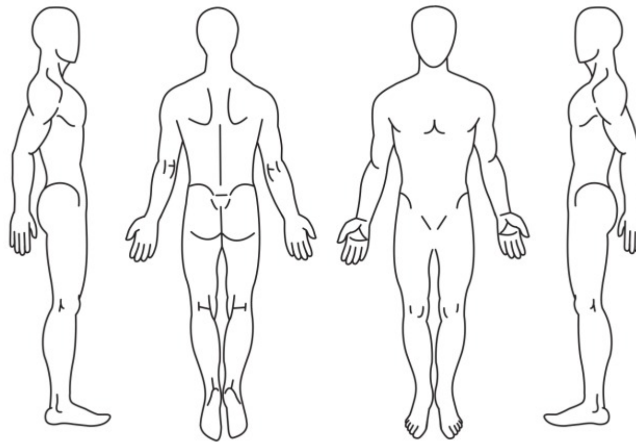
Please indicate where you are feeling discomfort– provide as much detail as possible.



Additional Information– If there is any other relevant information pertaining to your health that was not covered in this intake please state it below: