Nature's Touch
NATUROPATHIC CLINIC

CONFIDENTIAL PEDIATRIC INTAKE FORM

(please print clearly)

Child's Name: _____Gender: _____ Age: _____
Date of birth: _____
Height: _____ Weight: _____
Address: _____
_____
_____

Phone (home): _____ (work): _____

Who is filling out this form? (Name and relationship)
_____
Who does the child live with?
_____

E-mailAddress:_____
Empower your health with monthly health tips by Nature's Touch: YES NO

Doctor/Pediatrician/ Specialist:_____

****Naturopathic medicine works the best when the doctor has a complete picture of the physical, emotional and mental symptoms. Therefore, please take the time to thoroughly complete this health questionnaire.****

Emergency Contact Information
Name and relation to child: _____
Address:_____
Phone # (home): _____Work: _____Cell:_____
May we leave messages or email relating to your visits? Y / N

How did you hear about our Clinic? _____
If referred, who were you referred by:_____

Primary Health Concerns
In your opinion, what are your child's most important health concerns?
1. _____
2. _____
3. _____
4. _____
5. _____

Prenatal Health:
Age of biological mother at the time of the child's birth: _____
Number of previous pregnancies carried to term: _____
Number of previous pregnancies not carried to term (miscarriage, stillborn, abortions) _____
Was the pregnancy planned? Y N
Emotional state of mother during pregnancy:_____

Supplements and medications used during pregnancy:

_____

Complications during pregnancy and any tests performed:

_____

Prenatal Health- Father's Health before Conception

Father's age at child's birth: _____
Did the father smoke prior to conception? Y N During the pregnancy? Y N
Did the father use drugs or alcohol preconception? Y N
If yes, type and amount:

_____

Please check if any of the following occurred during the biological mother's pregnancy:

Difficulty getting pregnant		Hypertension	
Infertility drugs used		Diabetes	
In vitro fertilization		Pre-eclampsia	
Drink alcohol		Bleeding	
Smoke tobacco before conception		Excessive vomiting, nausea >3	
Smoke tobacco during pregnancy		Travel	
Have a viral infection		Colds/Flus	
Have a yeast infection		Group B strep infection	
Have amalgam fillings put in teeth		Have house exterminated	
Have any amalgams removed from		Have house painted	
How many fillings in teeth during		Chemical exposure	
Have an x-ray		Family Support	

Natal History:

Place of birth: Hospital _____ Home _____ Clinic _____ Other _____
Delivered by whom?_____
Length of pregnancy (weeks): _____ Was pregnancy: EASY DIFFICULT
Length of labor: _____ Induced_____ Caesarian _____ Interventions used (eg. forceps, vacuum, c-section)?
Length of hospitalization for mother: _____ Baby: _____
Describe any physical or emotional complications with the delivery or after birth:

_____
_____

Did breastfeeding begin immediately? Y N. If no, when did it begin?

_____

Please place a check mark beside any of the following conditions that applied to your baby at birth

Seizure _____	Respiratory distress _____	Jaundice _____	Problems with feeding _____
Vitamin K Administered _____	Antibiotic Eye Drops _____	Congenital Abnormalities__ _	Respiratory Abnormalities ___

Baby's birth weight: _____ Baby's birth length: _____
APGAR Scores: _____

Developmental History:
Please indicate the approximate age for the followings:

Weaned		Absent bedwetting		Took first steps	
Sitting up		First words		Walked alone	
Crawling		Spoke clearly		Dressed self	
Pulled to stand		Ate solid foods		Tied shoe laces	
Potty trained		Fed self		Rode 2-wheeled bike	

Please explain any developmental problems: _____
_____

Medical History/Review of Systems:
Please put an N if your child has the condition now, P for in the past, B for both)

Abdominal bloating		Diphtheria		Meningitis	
Acne		Dizziness		Mitral valve prolapse	
Allergies-Seasonal		Earaches		Mononucleosis	
Allergies-Environmental		Early menses (<age 12)		Multiple Sclerosis	
Anal fissures		Eczema		Mumps	
Anemia		Encephalitis		Nose bleeds	
Anxiety		Eye crusting		Palpitations(fast heart rate)	
Appendicitis		Fevers		Paralysis	
Asthma		Frequent infections		Pleurisy	
Back aches		Frequent runny nose		Pneumonia	
Bladder infection		Headaches		Polio	
Body odour		Heart murmur		Psoriasis	
Bronchitis		Hemorroids		Recurring ear infections	
Cancer		Herpes		Rheumatic fever	
Cerebral Palsy		High blood pressure		Ringing in the ears	
Conjunctivitis		HIV		Roseola	
Cold sores		Hives/rashes		Rubella	
Colic		Hyperthyroid		Scarlet fever	
Colitis		Hypoglycemia		Seizures	
Constipation		Hypothyroid		Severe head injury	
Cough/wheezing		Indigestion/ Gas		Strep throat	
Cradle cap		Influenza		Tonsillitis	
Croup		Impetigo		Ulcers	
Diaper rash		Jaundice		Vitilgo	
Diabetes		Joint pain		Vomiting	
Diarrhea		Measles		Whooping cough	

Hospitalizations/Surgeries and dates:

_____

Congenital abnormalities:

_____

Dental History:

Was the process of teething was difficult for your child? Y N Age of first teeth:_____
Has your child been to the dentist? Y N Is your child's toothpaste fluoridated? Y N
Does your child grind teeth? Y N
Describe any dental work done:

_____
Describe your child's oral hygiene practice:

_____

Vision History:
Does your child wear glasses? Y N
Describe any vision problems: _____

Bowel/Urinary Habits:
Frequency of stool: _____ times per day
Describe the stool_____
Does your child have pain on passing stool? Y N
Have you noticed any abnormalities in your child's stools? (colour changes, consistency, undigested foods)_____
Does your child experience any urinary tract infections? Y N

Sleep:
Time child wakes up at_____ time child goes to sleep at_____ How many hrs./night_____
I would rate my child's sleep as: _____ (Scale of 1-10, Where 10 is excellent and 1 is poor.)

Please check if your child experiences the following:

	YES	NO	COMMENTS
Dreams/nightmares			
Naps (time and length)			
Refreshed after sleeping			
Uninterrupted sleep			
Wakes often			
Wakes for food			
Wakes up irritable			
Night sweats			
sleepwalking			
Bed wetting			

Immunization Record
Are vaccinations up to date?_____

Has the child had an adverse reaction to any of the vaccinations given please describe reaction below:

_____

Medication/Supplements/Antibiotics:

	Past/Current	Dose	Duration	Side Effects	Why
1.					
2.					
3.					
4.					

Family History

Mother's side	Mother	Father	Grandfather	Grandmother	Siblings
Age or If deceased: at what age?					
Cause of death?					
Father's side					
Age or If deceased: at what age?					
Cause of death?					

Diet History:
Typical diet for your child:
Breakfast:-

_____
Lunch:

_____
Dinner:

_____
Snacks:

_____
Beverages:

_____

My child was: Breast fed ____ formula _____ both _____ for how long? _____

Solid foods were introduced at age _____

Please indicate foods that were newly introduced and any adverse reactions (eg. Colic, bloating, gas, diarrhea, constipation, nausea, vomiting, or rashes):

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

Current food allergies:

_____

Dietary restrictions (eg. vegetarian, religious)

_____

Child's appetite in general

_____

Social/Home Involvement:

Who takes care of the child primarily?_____
Does the child have a babysitter/nanny? Y N
How are problem behaviors, generally handled?

_____
Does your child get along with other children? Y N
Explain_____
How much time does your child spend in front of the TV/Computer _____

What extra activities is your child involved in?

_____
List any chemicals, fumes, dust, pesticides that your child is repeatedly exposed to (including cigarette smoke, molds in the house:_____

Trauma (Physical, Emotional, Sexual):

_____

Education:

My child is currently in: daycare_____ school _____ home _____
Type of school: _____ Grade: _____ What grades do they usually receive?_____

Behaviour/Emotions:
Please check which behaviours/emotions your child exhibits:

Affectionate		Crying spells		Head banging	
Generous		Depression		Organized	
Shares		Shy/Timid		Hurts animals	
Confident		Talks back		Lies frequently	
Cooperative		Short attention span		Thumb sucking	
Irritable		confidence		Tantrums	
Moody		Memory difficulty		Poor attention	
Frustrated easily		Low self-esteem		Hyperactive	
Restless		Anxiety		Pica (dirt, ice, paint, plastic)	
Angry		Separation anxiety		Bites nails	
Rage		Introvert		Prefers to play alone	
Aggressive		extravert		Prefers to play with others	
Defiant		Imaginary friends		Attachment to dolls	
Sad		Bullies/Threatens		Selfish	

Grief:
List major experiences of grief/loss in your child's life:

_____

_____

Fears:
What fears does your child have?

_____

How do they react to their fears?

_____

****Thank you for taking the time to fill out this intake form.**
Any information received will remain confidential.**