## **Pediatric Intake**

## Date

Child's name:	Parent's names:
Date of Birth:	Marital status:
Age: Sex:	Child lives with:
Weight: Height:	orma mroo man
Weight at birth: at 1 year:	Home Address
Height at birth: at 1 year:	Address:
Blood type: Handedness: R _ L _	City:
Child's Current Medical Conditions	Province: Postal Code:
1.	Phone:
2.	5 / 1 W 1 B 1
	Father's Work Phone Number:  Mother's Work Phone Number:
3.	Mother's Work Phone Number.
4.	Email:
5.	Family Physician Information
6.	Name:
Major Surgical Operations (date)	Address:
1.	Di
2.	Phone:
3.	
	Contact in Case of Emergency:
Allergies	Contact in Case of Emergency:
Drugs:	1.
Food:	2.
Environmental:	3.
Medications, Vitamins & Health Foods	What are you most concerned about
1.	regarding your child's health?
2.	
3.	
4.	
5.	How did you hear about Naturopathic
6.	medicine?
7.	
Birth History	Prenatal Health
Term length:	Mother's age at child's birth
Full Premature: weeks	means o ago at sima o bitti
Late: weeks	Mother's diet during pregnancy
	Poor Fair Good Excellent Unknown
Length of labour:	. 33. Tall Good Excellent Officiowii
Weight at birth:	Birth was attended by: (please circle)
Complications?	OB/GYN MD Midwife
	Hospital birth or Home birth?
Describe birth experience: (vaginal,	Did mother experience any of the following
induced, anesthesia, joyous, etc.)	during pregnancy:
	_ Bleeding _ High BP _ Nausea/vomiting
	Diabetes Thyroid Trauma

Name:
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**Family History of Child** 

Relation	Sex	Age	State of Health	Age of Death and Cause (if applicable)	Check and Designate if Near Relatives Had
Grandmother (maternal)					_ Tuberculosis _ High Blood Pressure
Grandfather (maternal)					_ Heart Disease _ Migraine
Grandmother (paternal)					_ Strokes _ Cancer
Grandfather (paternal)					_ Allergies/Asthma _ Arthritis
Mother					_ Kidney Disease
Father				•	_ Nervous Troubles
Sibling					_ Diabetes
Sibling					

	Personal History	
Has your child ever had or has r Scarlet Fever, Erysipelas Measles Rubella (German Measles) Mumps Chicken Pox or Shingles Infectious Mono Whooping Cough Colic Psoriasis, Eczema or Rash Swollen Glands Night Sweats or Fevers Unexplained Weight Loss Frequent Colds or Flus Ear Infections Hearing Loss or Ringing Sinusitis Tonsillitis Nasal Problems or Congestion Eye Infections	now (please check at left of Rheumatic Fever Shortness of Breath Chest Pain or Pressure Excess Sweating Goitre or Thyroid Diseases Cough or Sputum Asthma or Wheezing Pneumonia or Pleurisy Blood in Sputum Hoarseness Indigestion Trouble Swallowing Abdominal Pain Diarrhea Constipation Bladder or Kidney Problems Anemia or Blood Disease Moles Warts and Athletes Foot	each item) Liver Disease Jaundice or Hepatitis Diabetes Sports Injury Car Accident Knee Trouble Joint Disease Headache Numbness or Tingling Tremor Insomnia Nightmares Worries and Stress Problems Concentrating Depression Anxiety or Phobia Acting out Temper Tantrums Heart Problems
Has your child been vaccinated?	<u> </u>	
	Dietary Assessment	
	ast fed. How long? nula – milk/soy/other:	
What foods were introduced before	6 months? (please list appro	ximately at what month)
6 –12 months?		

Name:				
Dietary Assessment (con't)				
Is your child sensitive to any foods? Please list.				
How many times does your family eat at fast food restaurants, per week?				
Describe a typical day's diet  Breakfast				
Lunch				
Dinner				
Snacks				
Beverages (list quantities)				
Health and Development				
How was your child's health in the first year? Poor Fair Good Excellent Unknown At what age did you child begin to				
Sit up Crawl Walk Talk				
Describe you shild's record and helpovieur at here.				
Describe you child's mood and behaviour at home				
How is your child's behaviour and performance at school?				
<b>-</b>				
Is your child in school, daycare, home care or other?				
13 your critica in school, daybare, nome care or other:				
What are your child's favourite activities?				
Does your child exercise regularly? Y or N. How much, how often?				
boos your offind exercise regularly. The real real real real real real real rea				
How much television does your child watch? hours a day/week				
How much computer time? hours a day/week				
Does anyone in the child's household smoke? Y or N  Are there animals in the house? Y or N				
Are there animals in the house? Y or N  How is the family home heated?				
Thew is the family home heated.				
Do you know of any toxins or other hazards the child is regularly exposed to (home,				
hobbies, school, etc.)? Please describe.				
Describe the emotional climate of the child's home.				
Anything else of importance you would like to add?				