BIHC | Belleville Integrative Health Centre
WORKING TOGETHER FOR YOUR HEALTH

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Doctor of Naturopathic Medicine

Naturopathic Pediatric Intake Form (Child 0-13 yrs)

Child's name:______________________________

Parent/Guardian's name(s):_________________________

____

Address: ______________________________________

____

Age: ____ Date of Birth: DD/MM/YYYY Sex: ☐ M ☐ F

Gender (if different than sex): ___________________

Emergency contact name: _______________________

Relationship: _____________________________

Siblings (names & ages):________________________

____

Emergency contact phone number: (____)___________

1 - Phone #: (___)________________

☐ Home ☐ Work ☐ Cell

2 - Phone #: (___)________________

☐ Home ☐ Work ☐ Cell

Email: ___________________________

Preferred method of contact:

☐ Phone (1 or 2)

☐ Email

☐ Do not contact

May we leave messages regarding visits? ☐ Yes ☐ No

Child's Other Health Care Practitioners (Family doctor, midwife, pediatrician, etc.)

Name: _______________________________________ Profession:_______________
Phone (_______)______________ Fax (_________)________________
Address: ____
Date of last visit:_______________
Findings of concern? ____

Name: _______________________________________ Profession:_______________
Phone (_______)______________ Fax (_________)________________
Address: ____
Date of last visit:_______________
Findings of concern? ____

Name: _______________________________________ Profession:_______________
Phone (_______)______________ Fax (_________)________________
Address: ____
Date of last visit:_______________
Findings of concern? ____

If you were referred, please state by whom:____

What is your child's chief health concern? Date of onset: ___________________

____

____

____

What treatments are you currently trying/have you tried and what were the results?

____

____

____

Please list in order of importance any other health concerns that are troubling your child:

2.____

____

____

Date of onset: _____________

3.____

____

____

Date of onset: _____________

4.____

____

____

Date of onset: _____________

5.____

____

____

Date of onset: _____________

Have the above condition(s) been diagnosed by a health practitioner? Y / N If Yes, when and by whom?____

____

Does your child receive an annual physical exam or well-child check-up? Yes / No

How would you describe your child's current overall state of health?

Excellent / Good / Fair / Poor

On a scale of 0-10 (10 being highest), what is your child's current overall level of energy?

0 1 2 3 4 5 6 7 8 9 10

CHILD'S HEALTH HISTORY

Allergies:____

Sensitivities:____

Hospitalizations & Surgeries (reasons and dates):

At what age did your child begin: teething_____________ sitting ___________ crawling ___________

walking __________ talking _____________ potty training _____________

Were there any problems or concerns at any of these stages?

Please indicate whether your child has experienced any of the following conditions:

Allergies		Asthma		Bed wetting		Bladder infections	
Bloody urine		Body/breath odor		Bronchitis		Burning urine	
Chicken pox		Colds		Constipation		Cough	
Cradle cap		Croup		Diarrhea		Ear infections	
Easy bleeding		Easy bruising		Eczema		Emotional trauma	
Eye infections		Fatigue		Fever		Fractures	
Frequent urination		Fungal infections		Gas		Growing pains	
Hair loss		Hearing problems		Lice		Measles	
Meningitis		Mood changes		Mumps		Nausea	
Nervousness		Night sweats		Nose bleeds		Pneumonia	
Physical trauma		Rash		Rheumatic fever		Rubella	
Scarlet fever		Seizures		Sleeping problems		Sore throat	
Stomach flu		Strep throat		Tonsillitis		Unusual fears	
Vision problems		Vomiting		Coordination problems		Whooping cough	
Learning difficulties		Behaviour problems		Eating problems		Other	

If other, please describe:

Is there any condition from which you feel your child has never been well since?

IMMUNIZATION HISTORY

Please indicate immunizations and approximate dates:

Vaccination	Date	Vaccination	Date
Measles, Mumps, Rubella (MMR):		TB:	
Diphtheria, Polio, Pertussis, Tetanus (DPPT):		Chicken Pox:	
Haemophilus influenzae B (HIB):		HPV (Gardasil):	
Hepatitis B:		Pneumovaccine:	
Hepatitis A:		Flu:	
		Other:	

Any adverse reactions following vaccination?

Fever		Excessive crying		Pain/Swelling		Behaviour Changes	
Joint pain		Limping		Mood changes		Rash	
Loss of appetite		Vomiting		Insomnia		Other	

If other, please describe:

____

____

MEDICATION HISTORY

Taking CURRENTLY:	Dose:	Reason for Use:	Dates of Use:
Taken in the PAST:	**Dose:**	**Reason for Use:**	**Dates of Use:**

PERINATAL HISTORY

Parents' health at time of conception: Mom: excellent / good / fair / poor / unknown

Dad: excellent / good / fair / poor / unknown

Parents' age at time of conception: Mom: __________ Dad: __________

Was the pregnancy planned? ______________

How was the mother's overall health during the pregnancy? excellent / good / fair / poor / unknown

How was the mother's diet during the pregnancy? excellent / good / fair / poor / unknown

How would you describe the pregnancy?

____

____

Did mom experience any of the following conditions **during the pregnancy?**

Diabetes		Edema (swelling)		Emotional trauma		Fainting	
German Measles		Rash		High blood pressure		Infection	
Nausea/Vomiting		Physical trauma		Preeclampsia		Anxiety/Fear	
Bleeding		Weight gain/loss		Depression		Thyroid Problems	
Group B Strep		Candida/Yeast		Antibiotics		Other:	

If other, please describe:

____

____

Medications (over-the counter and prescription), vitamins, supplements etc. taken during the pregnancy:

____

____

Was mom exposed to any of the following during the pregnancy?

		If yes, how much, how often?
Tobacco	Y / N	
Second-hand smoke	Y / N	
Alcohol	Y / N	
Caffeine	Y / N	
Recreational drugs	Y / N	Please also note which drugs were used ________________ ________________

Please describe any emotional traumas during the pregnancy?
____
____
____

Duration of pregnancy? __________weeks + ________ days

Duration of prelabour? ________________________

Duration of active labour? __________________________________

Was labour spontaneous? Y / N

If no, how was labour induced?____

Type of delivery? Vaginal / Scheduled C-section/ Unplanned c-section / Emergency c-section

Location of delivery? Home / Hospital / Birthing Centre / Other ______________________

Interventions used? Antibiotics_________ Pain medication_______ Anesthesia_______

Epidural _______ Episiotomy ______ Forceps _______ Vacuum ________Other ___________

Interventions performed soon after birth: Eye drops _______________ Incubation _____________
Medication _________________________ Respirator __________

Surgery ____________ Bili-lights _________

Other __________________________

Birth weight: _______________ Birth length: _______________

APGAR scores: 1 minute: ______________ 2 minutes: _______________ 5 minutes: ________________

Had there been any history of complications or concerns with a previous pregnancy?
____
____

Did your child experience any of the following soon after birth?

Allergic reaction		Birth defects		Feeding difficulty		Jaundice	
Fever		Failure to thrive		Hypoxia		Colic	
Infection		Rash		Respiratory difficulty		Seizure	
Unusual Wt. Changes		Blood sugar problems		Other		Other	

If other, please describe:
____
____

How was the mother's physical and emotional health during the postpartum or recovery period?
____
____
____

NUTRITIONAL HISTORY

Was your child breastfed? Y / N If yes, for how long? ____

Any breastfeeding concerns?

____

____

What type and brand of infant formula if used?

____

What was the first liquid introduced to your child after breastmilk or formula?

____

How would you describe your child's eating habits?

____

____

____

Is your child a vegetarian? Y / N

Food aversions?____

Any food cravings?____

Please list the solid foods introduced prior to 12 months of age, and any reactions noted:

Food	Age Introduced	Response or Reaction

Please outline your child's typical daily food intake:
Breakfast:

____

____

Lunch:

____

____

Dinner:

____

____

Snacks:
____
____

Water intake: ____

Other fluids (juice, soda, milk, etc): ____

SLEEP

Does your child sleep through the night? Y / N Bedtime: _________

Wakes for the day at: _________________

Wakes through the night at:____

# of hours of sleep per night:__________

Naps:
____

Bad dreams or nightmares? Y / N

Have you observed any of the following during your child's sleep? sleepwalking / talking / laughing / shouting / moaning / teeth grinding / twitching / perspiration / other _________________________

FAMILY HISTORY

Please indicate whether any **blood relatives** have experienced the following conditions:

Allergies		Anxiety		Asthma		Autoimmune disease	
Birth defects		Bleeding disorder		Anemia		Deafness	
Depression		Diabetes		Eczema		Heart disease	
Hepatitis		Venereal disease		HIV/AIDS		High blood pressure	
Kidney disease		Mental illness		Diabetes		Cancer	
Tuberculosis		Visual problems		Arthritis		Cataracts	
Stroke		Hypoglycemia		Thyroid disease		Other:	

If other, please describe:
____
____

Relative:	Age if Living:	Health Conditions:	Age at Death:	Cause of Death:
Mom				
Dad				
Sibling(s)				

Mom’s mother				
Mom’s father				
Dad’s mother				
Dad’s father				
Other blood relatives with notable health history (e.g. cancer, heart disease, stroke, mental illness, etc.):				

HOME ENVIRONMENT

How many people live in your home? ___________Pets in the home? ______________

Potential allergens? (e.g. mould, dusts, etc)?____________________

Potential toxins? (e.g. lead in water, new carpet, etc.) ______________________

Approx. age of home? _______________How is your home heated? ________________

Smoking in the home?___________

How would you describe the emotional climate in the household? _______________________________

Stress level in the home (scale of 0 to 10):

0 1 2 3 4 5 6 7 8 9 10

SOCIAL HISTORY

How would you describe your child's temperament?

How does your child interact with other children?

With adults?

Please indicate any emotional traumas your child has experienced:

How does your child handle stress?

How does your child express his or her emotions?

How is your child's performance in school?

Have any behavioral or learning problems been noted?

What are your child's favorite activities?

How much physical activity does your child get?

Which countries outside Canada has your child travelled to?

Is there anything else you feel may be important to your child's health?