



Pediatric Intake Form (birth to 3 years of age)

Due to the chemical sensitivity of some of our patients, we ask that you please refrain from wearing perfume/cologne when visiting our office. Thank you.

Name _____ Date _____
Age _____
Date of Birth ____/____/____ Gender: female ____ male ____
Address _____
City _____ Prov _____ Postal Code _____
Telephone# (home) _____ Parent/Guardian (Work) _____
Name of Parent/Guardian _____
Email of Parent/Guardian _____
Email address will only be used for correspondence from the Centre for Natural Medicine
MHSC (6 digit): _____ PHIN (9 digit): _____

How did you hear about this clinic? _____

Name of doctor's office/hospital/clinic where your child's health records are kept: _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS

What are his/her most important health problems that he/she is seeking treatment for or is currently being treated for? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____

MEDICATIONS

NOW	PAST		NOW	PAST	
<input type="checkbox"/>	<input type="checkbox"/>	Asprin	<input type="checkbox"/>	<input type="checkbox"/>	Decongestants
<input type="checkbox"/>	<input type="checkbox"/>	Tylenol	<input type="checkbox"/>	<input type="checkbox"/>	Anti-histamine
<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Ibuprofen	Allergies to medications: _____		

MEDICAL HISTORY

<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Tonsillitis – Frequency _____
<input type="checkbox"/> Measles	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Ear Infections – Frequency _____
<input type="checkbox"/> Mumps	<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Strep Throat – Frequency _____
<input type="checkbox"/> Rubella	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Other _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING: WHEN WHERE RESULTS

Electroencephalogram (EEG): _____

Psychological evaluations: _____

Hearing test: _____

Speech/language test: _____

Injuries/surgeries/hospitalizations (please list): _____

IMMUNIZATIONS

<input type="checkbox"/> MMR	<input type="checkbox"/> DPT	<input type="checkbox"/> Chicken Pox	Others: _____	
<input type="checkbox"/> Measles	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Small Pox	Adverse reactions?	YES NO
<input type="checkbox"/> Mumps	<input type="checkbox"/> Tetanus	<input type="checkbox"/> H. influenza	If so, what? _____	
<input type="checkbox"/> Rubella	<input type="checkbox"/> Polio	<input type="checkbox"/> Flu	_____	

FAMILY HISTORY

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Birth Defects
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Allergies	<input type="checkbox"/> Asthma
<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Other significant: _____

PRENATAL HISTORY

Previous pregnancies by natural mother, miscarriages, or complications? _____

Mother's age at child's birth: _____

Mother's health during pregnancy:

- | | | |
|--------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Nausea | <input type="checkbox"/> Physical or emotional trauma |
| <input type="checkbox"/> Illnesses | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cigarettes, alcohol, drug consumption |
| <input type="checkbox"/> Medications | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Thyroid problems |

BIRTH HISTORY

Term: Full Premature Late

Duration of labour: _____ Complications: _____

Birth City & Province: _____ Birth Time: _____ Birth Weight: _____

Did your child have any of the following problems shortly after birth?

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Birth Injuries | <input type="checkbox"/> Blue Baby |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Colic | <input type="checkbox"/> Fever | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Other: _____ | | |

Child's sleeping patterns (1st year): _____

Food intolerances: _____

Breast fed: YES NO If yes, how long: _____

Formula: YES NO Type (milk, soy, etc.): _____

Age began solids: _____ Which foods: _____

Age began... Sitting _____ Crawling _____ Walking _____ Talking _____

DIET

Please describe your child's typical daily diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

SYMPTOMS

- | | | | |
|---------------------------------------|---|---|--|
| <input type="checkbox"/> Hives | <input type="checkbox"/> Burning urine | <input type="checkbox"/> Bloody urine | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Cries easily | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Nervous |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Vomiting spells | <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Anemia | <input type="checkbox"/> Night sweats | <input type="checkbox"/> High fevers |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sensitive to light | <input type="checkbox"/> Chronic rash | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Sore throats |
| <input type="checkbox"/> Flat feet | <input type="checkbox"/> No appetite | <input type="checkbox"/> Body/breath odour | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Unusual fears |
| <input type="checkbox"/> Wheezing | <input type="checkbox"/> Joint pains | <input type="checkbox"/> Excessive fatigue | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Allergies |

Is there any information about the child's health that you would like to add?

OFFICE POLICIES

Cancellation Policy: Scheduled appointments are reserved especially for you. Patients with same day cancellations or no-shows will be charged half of their original appointment fee. We require 48 hour notice for cancellations or rescheduling

Fragrance Free Policy: Due to the chemical sensitivity of some of our patients, we ask that you please refrain from wearing perfume/cologne when visiting our office.

Thank you for your cooperation.

Please Print:

I _____ (parent or legal guardian) of _____ (patient's full name) **agree** to pay my full account at the time of each visit or treatment, including fees for appointments, services, cost of supplements and remedies, cost of laboratory tests, administrative fees, missed appointment fees as well as other applicable fees. **Note:** Submit your paid receipt to your insurance provider and/or for personal income tax.

Date: _____ Signature of parent or legal guardian: _____