Centre for NATURAL MEDICINE
Naturopathic Health and Wellness Clinic

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	
☐	☐	Asprin	☐	☐	Decongestants
☐	☐	Tylenol	☐	☐	Anti-histamine
☐	☐	Antibiotics	☐	☐	Other _____
☐	☐	Ibuprofen	Allergies to medications: _____		

MEDICAL HISTORY

☐	Chicken Pox	☐	Scarlet Fever	☐	Tonsillitis – Frequency _____
☐	Measles	☐	Pneumonia	☐	Ear Infections – Frequency _____
☐	Mumps	☐	Frequent Colds	☐	Strep Throat – Frequency _____
☐	Rubella	☐	Rheumatic Fever	☐	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

☐ MMR	☐ DPT	☐ Chicken Pox	Others: _____
☐ Measles	☐ Diptheria	☐ Small Pox	Adverse reactions? **YES** **NO**
☐ Mumps	☐ Tetanus	☐ H. influenza	If so, what? _____
☐ Rubella	☐ Polio	☐ Flu	_____

FAMILY HISTORY

☐ Heart Disease	☐ Diabetes	☐ Birth Defects
☐ Hypertension	☐ Arthritis	☐ Tuberculosis
☐ Cancer	☐ Allergies	☐ Asthma
☐ Mental Illness	☐ Osteoporosis	☐ Other significant: _____

PRENATAL HISTORY

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

_____

Mother's age at child's birth: _____

Mother's health during pregnancy:

☐ Bleeding ☐ Nausea ☐ Physical or emotional trauma

☐ Illnesses ☐ Hypertension ☐ Cigarettes, alcohol, drug consumption

☐ Medications ☐ Diabetes ☐ 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?

☐ Rashes ☐ Birth Injuries ☐ Blue Baby

☐ Jaundice ☐ Seizures ☐ Cerebral Palsy

☐ Colic ☐ Fever ☐ Birth Defects

☐ 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

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

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: _____