North Bay Naturopathic Clinic
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Pediatric Intake

Date: _____

Name: _____

Who is filling out this form (name and relation)? _____

How did you hear about our clinic? _____

Personal Information

Date of Birth: _____ Age: _____ Gender: M F

Height: _____ Weight: _____

Ethnicity: _____

Religious practices: _____

Contacts

Name: _____

Address: _____

Phone: H_____ W_____ Other_____

Relation to child: _____

Emergency Contact: _____ Phone: H_____ W_____

Other health care providers

1. **Name:_____ Occupation:_____Phone:_____**
2. **Name:_____ Occupation:_____Phone:_____**
3. **Name:_____ Occupation:_____Phone:_____**

What are the child's chief concerns

1. **_____**
2. **_____**
3. **_____**
4. **_____**

Prenatal Health

What was mother's age at childbirth? _____

Did mother receive prenatal health care? Y N Unknown
If yes, what type? Midwife, Doula, Natruropath Other: _____

What was mother's health like at conception?
Poor Fair Good Excellent Unknown

What was mother's health like during pregnancy?
Poor Fair Good Excellent Unknown

During pregnancy did the mother experience any of the following:

Nausea	**( )**	**Diabetes**	**( )**
Vomiting	**( )**	**Thyroid problems**	**( )**
High blood pressure	**( )**	**Physical trauma**	**( )**
Bleeding	**( )**	**Emotional trauma**	**( )**
Eclampsia	**( )**	**Depression**	**( )**

Other: _____

Did the mother use any of the following during pregnancy:
(list amount, frequency and length of time used)

Tobacco: _____
Alcohol: _____
Recreational drugs: _____
Prescription drugs: _____
Fertility drugs: _____
Supplements: _____
Other: _____

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

Pets	**( )**
Paint	**( )**
New carpeting	**( )**
Natural gas	**( )**
Carbon Monoxide	**( )**
New home	**( )**
Cleaning products	**( )**
Other	**( )**

Birth History

Term length: Full ( ) Premature ( ) #wks____ Late ( ) #wks ____

Length of labour: _____

Any complications at birth? (I. e. breech, trauma) _____

Type of birth: Vaginal ( ) C-section ( ) Induced ( ) Forceps ( ) Vacuum ( )

Were any of the following drugs used during labour?

Demerol Y N

Nitrous oxide gas Y N

IV Epidural Y N

Spinal Epidural Y N

Anaesthetic Y N

Antibiotics Y N

Any complications for the child after birth?

Low birth weight Y N

Jaundice Y N

Respiratory difficulties Y N

Low APGAR score Y N

Rashes Y N

Seizures Y N

Birth injuries Y N

Birth defects Y N

Other: _____

Nutrition

Was child breast fed? Y N How long? _____ Any problems with weaning? Y N

Was child formula fed? Y N Milk/Soy/Other: _____

What foods were introduced:
Before 6 months:

Any reactions:

Between 6-12 months

Any reactions

When where the following foods introduced (approximate age):

Milk _____Wheat _____Soy _____Citrus _____Sweets _____

Who prepares the child's food? _____

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Fluids (quantity): _____

Does the child have any of the following?

Food intolerances: _____

Food Cravings: _____

Aversions to food: _____

Review of Symptoms

Circle any of the following which currently apply or have applied in the past to the child:

GENERAL- fever, chills, fatigue, weakness, malaise
Other: _____

SKIN – dryness/moistness, rashes, mole/birthmarks, acne, boils, lesions, eczema, hives, itching, hot/cold
Other: _____

HEAD- headache, head injury, dizziness, rashes, dryness, itchy
Other: _____

EYES- impaired vision, glasses/contacts, pain, discharge, redness, itching, tearing or dryness
Other: _____

EARS- impaired hearing, earache, itching, discharge, ear infections (how many? ____)
Other: _____

NOSE and SINUSES- frequent colds (how many per year? ____), nose bleeds, stuffiness, itching, discharge, sinus problems
Other: _____

MOUTH and THROAT– frequent sore throat, sore tongue/mouth, gum problems, hoarseness, dental cavities (how many? ____), teething, drooling, lesions, loss of taste
Other: _____

NECK- lumps, swollen glands, goitre, pain or stiffness
Other: _____

RESPIRATORY- cough, spitting up blood, wheezing, asthma, bronchitis, pneumonia, pleurisy, emphysema, pain on breathing, difficulty breathing, shortness of breath, Tuberculosis, Tuberculin test, last chest x-ray (date): _____
Other: _____

CARDIOVASCULAR- murmurs, rheumatic fever, chest pain, difficult feeding, sweating, palpitations, cyanosis, past ECG, other heart tests: _____
Other: _____

GI- trouble swallowing, change in thirst or appetite, food allergy, diarrhoea, constipation, nausea vomiting, vomiting blood, bloating
# of bowel movements/day___, is this a change Y N, color of stool_____, is this a change, black tarry stool, belching, passing gas, jaundice (yellow skin), indigestion, rectal bleeding, haemorrhoids, abdominal pain, hernias.
Other: _____

Review of Symptoms continued

GU- rash, redness, pain on urination, discharge, increased frequency, frequency at night, frequent infections, inability to hold urine, urgency, hesitancy, blood in urine
Other: _____

MUSCULOSKELETAL- joint pain, joint stiffness, joint swelling, arthritis, weakness, sprains/strains, broken bones, muscle spasms or cramps, backache.
Other: _____

PERIPHERAL VASCULAR- leg pain, cold hands/feet, leg cramps, extremity numbness, swelling or ulcers
Other: _____

NEUROLOGIC- tremor, irritability, seizures/convulsions, fainting, paralysis, muscle weakness, numbness or tingling, loss of memory, involuntary movement, loss of balance, speech problems, difficulty concentrating
Other: _____

ENDOCRINE- heat or cold intolerance, thyroid trouble, excessive thirst, hunger, increase in urination, sweating, diabetes, hypoglycaemia, hormone therapy
Other: _____

BLOOD/LYMPHATIC- anaemia, easy bleeding, easy bruising, past transfusions, enlarged lymph nodes
Other: _____

EMOTIONAL-depression, mood swings, anxiety, nervousness, tension, fears and phobias, alcohol abuse, drug abuse, insomnia, emotional trauma, physical trauma
Other: _____

SLEEP- trouble falling asleep, trouble staying asleep, recurrent dreams/nightmares, sleepwalk, night terrors, bed wetting
Other: _____

Medical History

How would you describe the child's general health status:

Excellent Good Fair Poor

Please indicate if your child has had any of the following with approximate dates:
Serious illness:

_____
_____

Hospitalizations: _____
_____

Surgery: _____
_____

Injury: _____
_____

Has your child been vaccinated for any of the following (provide dates):

DPT (diphtheria, pertussis, tetanus)	**Y N Date: _____**	**"Flu"**	**Y N Date:_____**
Polio	**Y N Date: _____**	**Hep B**	**Y N Date:_____**
MMR (measles, mumps, rubella)	**Y N Date: _____**	**Hep A**	**Y N Date:_____**
Haemophilus influenza B	**Y N Date: _____**	**Tetanus booster**	**_____**

Has your child had any adverse reactions to any vaccination? Y N

Has your child had any of the following (provide dates):

Rubella	**Y N**	**Measles**	**Y N**	**Impetigo**	**Y N**
Roseola	**Y N**	**Scarlet fever**	**Y N**	**Mononucleosis**	**Y N**
Chicken pox	**Y N**	**Whooping cough**	**Y N**	**Ear infections**	**Y N**
Mumps	**Y N**	**Strep throat**	**Y N**		

Please list all current medications: _____
_____
_____
Please list all current supplements: _____
_____
_____
Please list past prescription medications: _____
_____
_____
How many times has your child used antibiotics?_____

Please list any allergies

Food: _____
Drugs: _____
Environmental: _____
Do you use an Epi-pen? Y N
Do you have a medical alert bracelet? Y N
Did your child ever have colic? Y N How severe? Mild Moderate Severe

Family History

Maternal grandmother	**Maternal grandfather**
Paternal grandmother	**Paternal grandfather**
Mother	**Father**
Sibling	**Sibling**
Other	**Other**

I don't know my family medical history ( )

Environmental History

Is this child in daycare ( ) homecare ( ) school ( ) Grade:_____ other ( )

What types of physical activities does this child participate in? _____
How often? _____

What are the child's extracurricular activities? _____

How much time does the child spend watching television and/or playing on computers/video games? _____ Hours per day/week?

Does anyone in the child's home smoke? Y N

Are there any animals in the child's home? Y N

How is the child's home heated/cooled? _____

Are there any other substances that you believe your child is being exposed to on a regular basis?
_____

How is the child's temperament? _____

Does the child have mood swings? Y N How often? _____

How is the child's performance at school? _____

Has the child ever been diagnosed with a learning disability? Y N

Does the child have any fears or anxieties? Y N

How would you rate the stress level in your household on a scale of 1-10, 10 being the most stressful:
_____

Any other concerns or considerations you would like the Naturopath to know about:_____
_____
_____
_____
_____
_____
_____