Women's Balance Health
9505-163 Street, Edmonton Alberta, T5P 3M6 (780) 919-6870

PEDIATRIC INTAKE FORM

As your child's Naturopathic Doctor, it is important that I am aware of your child's current health status, his/her complete medical history, as well as what areas of his/ her health you would like to see change in the future. Please complete this form as thoroughly as possible, as your responses will greatly assist in the development of a personalized treatment plan.

*Please bring all of the completed forms in this package with you to your first visit.

Identifying Information

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

Child's Name: _____ Age:_____ Sex: _____ Date of Birth:_____

Height: _____ Weight: _____ Grade level: _____

AHC# _____

Parents Names: _____ Occupation: _____

_____ _____

Contact Information for child's primary caregiver(s) (Who the child lives with):

Name: _____ Relation:_____

Address: _____

Postal Code: _____

Phone Numbers: (H): _____(W): _____

Email: _____

Contact Information for child's secondary caregiver(s):

Name: _____ Relation: _____

Address: _____

Phone Numbers: (H): _____ (W): _____

Emergency Contact:

Name: _____ Relation: _____

Phone Numbers: (H): _____ (W): _____ (C): _____

Family Doctor/ Pediatrician: _____

Phone Number: _____ (Fax): _____

Chief Concern #1 (Please Explain):

_____

_____

Chief Concern #2 (Please Explain):

_____

_____

Chief Concern #3 (Please Explain):

_____

_____

List of Current Medications/ Natural Health Products:

_____

_____

Prenatal Information

Adopted: Y / N Previous History of Infertility: Y / N

How was pregnancy achieved? (e.g. intercourse, IVF, AI, sperm donation, other): _____

Was the pregnancy planned?: Y / N

Birth Order: _____ Siblings Names & Age: _____

Age of Mother at Conception: _____ Age of Father at Conception: _____

Number of Previous Pregnancies: _____ Number of Previous Deliveries: _____

Conditions Mom experienced during pregnancy: (e.g. elevated blood pressure, gestational diabetes, bleeding, infections, thyroid problems, nausea, vomiting, bed rest, edema(swelling), fainting, anemia, weight gain/ loss, physical trauma): _____

_____

Did the Mother use any of the following during pregnancy?:

Substance:	**Yes / No**	**Please List (specific type, how much, how often):**
Tobacco		
Alcohol		
Recreational Drugs		
Caffeine		
Medications (prescribed or over the counter)		
Supplements		
Other		

Tests performed during pregnancy: (ultrasound, amniocentesis, chorionic villi sample, triple screen, maternal serum screening, other)

_____

Please indicate any physical or emotional traumas Mom experienced during pregnancy:

_____

Does the Mother work outside of the home?: Y / N

If Yes, please indicate at what point in the pregnancy did the mother take maternity leave: _____

How would you describe the pregnancy?: _____

Birth History

Term Length: Preterm (37wks or less) Full-term (38-42wks) Post-term (42+wks)

Location of delivery (e.g. home, hospital, birthing centre, other): _____

Length of labour: _____

Was the labour spontaneous?: Y / N If No, How was it induced?: _____

Type of Delivery: Vaginal / Cesarean Section / Breech / Emergency C-Section (Please Circle)

Interventions of Birth (e.g. anesthesia, epidural, episiotomy, forceps, vacuum, other):

_____

Birth injuries: Y / N, If Yes please describe: _____

Congenital defects: Y / N, If Yes please describe: _____

Caregivers involved in the birth (e.g. Obstetrician, Midwife, Doula, Family Doctor):

_____

Birth Weight: _____ Length: _____ APGAR Score (if known): _____

Early complications (e.g. failure to thrive, illness, jaundice, hypoglycemia, respiratory difficulty, meningitis, rashes, seizures, difficulty feeding): _____

Interventions following birth: (e.g. medications, respirator, surgery, phototherapy, other)

_____

Nutritional History

Breastfed: Y / N I If No, Why?: _____

Substitute Formula used: _____

If Yes, Duration:_____

Mother's diet while breastfeeding: (e.g. foods typically enjoyed, food cravings, foods avoided, child's reactions): _____

_____

Did the child experience colic? Y / NIf yes, for how long? _____

Weaning History (e.g. when, child's response, etc.): _____

First Food(s) Introduced:

Food	When (e.g. 6, 9, 12 months)?	Reactions (if any)?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the child have any dietary restrictions? (e.g. religious, vegetarian, vegan, etc):

_____

Food Allergies / Intolerances: _____

How would you describe the child's eating habits?:_____

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Water Intake (total quantity): _____

Other Fluids (total quantity): _____

Child's food cravings: _____

Medical History

How would you describe the child's general state of health?: _____

Please indicate any serious conditions, surgeries, illnesses or injuries, and any hospitalizations; along with approximate dates: _____

_____

Please list past prescription medications:

_____

_____

How many times has the child been treated with antibiotics?: _____

Does the child have any allergies? (e.g. food, medicines, environmental, etc.):

_____

What screening tests has the child had to date? (e.g. blood, hearing, vision, etc. including approx. date):

_____

Immunization History

Vaccination	**Approximate Date(s)**	**Child's Reaction**, if any (e.g. fever, rash, pain, insomnia, vomiting, swelling,mood changes, or other)
DPT (diphtheria, pertussis, tetanus)		
Polio (IPV)		
Hib (Haemophilus Influenzae type b)		
MMR (measles, mumps, rubella)		
Hepatitis B		
Influenza, "Flu"		
Varicella "chicken pox"		
HPV		
Meningococcal Conjugate		
Pneumococcal Conjugate		
Hepatitis A		
Tetanus Booster (Td, Tdap or Td-IPV)		
Other:		

Please circle any that apply to the child N = Never, P = In the Past, C = Currently

Skin:		**Ears**:		**Gastrointestinal:**	
Rashes	N P C	Infection	N P C	Trouble swallowing	N P C
Eczema	N P C	Hearing Loss	N P C	Nausea & vomiting	N P C
Psoriasis	N P C	Ringing in ears	N P C	Bloating	N P C
Vitiligo	N P C	Nose & Sinuses:		Abdominal Pain	N P C
Dryness	N P C	Nasal Stuffiness	N P C	Diabetes	N P C
Hives	N P C	Nose Bleeds	N P C	Excessive Gas	N P C
Boils	N P C	Infections	N P C	Constipation	N P C
Warts	N P C	Mouth & Throat:		Blood in Stool	N P C
Fungal Infections	N P C	Thrush	N P C	Weight loss/gain	N P C
Impetigo	N P C	Bad breath/odour	N P C	Diarrhea	N P C
Mind:		Tonsillitis	N P C	**Childhood Illnesses:**	
Nervousness/anxiety	N P C	Sore Throat	N P C	Stomach Flu	N P C
Head:		**Cardiovascular:**		Chicken Pox	N P C
Cradle Cap	N P C	Heart Murmurs	N P C	Croup	N P C
Hair loss	N P C	Rheumatic fever	N P C	Measles	N P C
Headaches	N P C	Respiratory:		Mumps	N P C
Dizziness	N P C	Cough	N P C	Meningitis	N P C
Dandruff	N P C	Wheezing	N P C	Pneumonia	N P C
Lice	N P C	Colds	N P C	Mononucleosis	N P C
Head Injury	N P C	Asthma	N P C	Rubella	N P C
Eyes:		Bronchitis	N P C	Strep Throat	N P C
Redness	N P C	Infection	N P C	Scarlet Fever	N P C
Discharge/Infection	N P C	**Genitorurinary:**		Whooping Cough	N P C
Vision problems	N P C	Frequent urination	N P C	**Other:**	
Double vision	N P C	Bladder infection	N P C	Fevers	N P C
Blurred vision	N P C	**Haematological:**		Growing pains	N P C
Neurological:		Easy bleeding	N P C	Fracture	N P C
Seizures	N P C	Blood Transfusions	N P C	Allergies	N P C
Tingling/numbness	N P C	Anemia	N P C	Fatigue	N P C
		East Bruising	N P C	Hernia	N P C

Developmental History

Did the child experience any developmental delays? Y/N If so, describe:

Developmental Milestone: Age of Child:

Rolling over	_____	Crawling	_____
Sitting on own	_____	Walking	_____
Talking	_____	Eruption of Teeth	_____

Family Medical History

Relation	Significant Health Concerns	If deceased, list cause & age of death
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings		

Sleep History

Where does the child sleep? (e.g. own bed, parent's bed, crib, with siblings): _____

Age when child first began to sleep through the night: _____

Describe the child's sleep pattern (e.g. bed time, avg. length of sleep, naps):

_____

Does the child have any difficulty falling asleep or waking up? _____

Does the child experience nightmares?: Y / N or night terrors?: Y / N

Frequency:_____

Describe repetitive dreams/ nightmares/ night terrors:

_____

Occurrence of sleepwalking: Y / N If Yes, Frequency: _____

Occurrence of Bedwetting: Y / N If Yes, Frequency: _____

How it is dealt with?: _____

Environmental Exposures

Occurrence of moving/ painting/ renovations during pregnancy: Y / N _____

How long has the child lived in this location?: _____

Age of Home: _____

What is the flooring in the house? (e.g. carpet, hardwood flooring): _____

How is the child's home heated?: _____

Does anyone in the child's household smoke?: Y / N

Indicate if there are any pets in the child's home: _____

Water source (e.g. well water/ city water/ bottled/ filtered – what kind, other):

_____

Do you know of any toxins or other hazards the child is regularly exposed to (e.g. home, other's work, hobbies, etc)? Please describe. _____

_____

Travel history (please include destinations and date of travel):

_____

_____

Lifestyle

Where does the child spend his/ her time during the day? (e.g. home, daycare, school, babysitter):

_____

How would you describe the child's temperament?: _____

How does the child interact with other people?: _____

Have you ever noticed any behavioural problems at home/ school/ daycare/ sitters?:

_____

How is the child's performance at school?: _____

Has the child experienced any emotional trauma(s)?: _____

How does the child handle stress?: _____

What type of physical activity does the child engage in? how often?:

_____

Child's favorite activities/ hobbies: _____

How many hours per day of TV does the child watch? _____

How often (outside of school) does the child read or is read to by someone?

_____

Additional comments/ Anything you would like to share that hasn't already been covered:

_____

_____

How did you hear about our clinic? _____

SIGNATURE

I, _____ attest that the information provided is true and accurate to the best of my knowledge.

Signature: _____ Date: _____