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Pediatric Intake **Today's date**:

I appreciate the time you take to fill in this form, It provides me with a concise history of you and your child. If there is any information you are not comfortable providing please do not, or, if there is something you want to add please add it.

Child's Name:_____Birthdate:_____

☐ Male ☐ Female Present height :_____ and Weight:_____

Your Name:_____Relation:_____

Who does the child live with?_____

Primary contact:_____Relation:_____

Home phone:_____ Other phone:_____

Address:_____

In the event of an emergency it is understood that the primary contact will be called.

Who are this child's other health care providers? (phone # and/or address please)

1._____

2._____

3._____

What are the child's key health concerns? (in order of importance medications)

1._____

2._____

3._____

4._____

Pregnancy and Birth History

Term of pregnancy: □ Full □ Premature _____ weeks □ Over term ___ weeks

Length of labour_____ Baby's birthweight _____APGAR score____

Any complications?_____

Were any of the following interventions used before or during the birth?

□ ultrasound □ amneocentesis □ epidural □ induced labour
□ forceps □ suction □ c-section □ anesthesia

Did the mother experience any of the following during pregnancy?

□ Bleeding □ High blood pressure □ Nausea □ Vomitting
□ Diabetes □ Thyroid problems □ Physical or emotional trauma

Did the baby experience any of the following at or shortly after birth?

□ Jaundice □ Rashes □ Seizures □ Birth injures □ Meconium □ Difficulty feeding
□ Infections. Other_____

Any physical abnormalities? _____

Mother's History

Age at the birth of this child:____ Number of previous pregnancies ___, births___

Mother's primary occupation □ in the home, □ outside the home- profession_____

Did the mother have prenatal naturopathic care? □ Yes □ No

Did the mother have prenatal medical care?: □ Yes □ No

Were there any fertility issues prior to the pregnancy? □ Yes □ No.

Please describe_____

Mother's emotional state during this pregnancy and since:

□ Excellent □ Fair □ Poor □ Unknown

Mother's overall state of health during this pregnancy and since:

□ Excellent □ Fair □ Poor □ Unknown

Mother's diet during this pregnancy and since:

□ Excellent □ Fair □ Poor □ Unknown

Was the mother exposed to any toxic substances during pregnancy?

_____

Lifestyle and Environment

How would you describe the emotional climate in the child's home?

_____

_____

Are there any pets in the child's home? □ Yes □ No. If so, what type_____

Are you aware of any toxins or other hazards the child may be exposed to (home, hobbies, other's homes). Please describe:_____

Does the child attend □ daycare, □ preschool, □ school, □ home care, □ Other _____

Child:

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

How many hours of exercise per day does the child get? _____

What are the child's favourite activities?_____

How often does your child read? □ Daily □ Several times/week □ Weekly □ Less

Mother:

Alcohol □ Yes □ No Drinks per day _____

Cigarette Smoking □ Yes □ No Cigarettes per day_____

Does anyone else smoke in the house? □ Yes □ No

Prescription drugs □ Yes □ No Names and doses:_____

Supplements: □ Yes □ No List:_____

Regular exercise? □ Yes □ No Consistent throughout the pregnancy? □ Yes □ No

Diet

How was your child fed as an infant

□ Breast fed. How long?_____ □ Formula. □ Milk □ Soy □ Rice □ Other

Comments on feeding (reactions, mood of infant etc):_____

_____

What foods were introduced before 6 months? _____

_____

Any reactions to those foods?_____

Has your child experienced colic? □ Yes □ No. If so, □ Mild □Moderate □ Severe

Does your child have any known food allergies? Please list._____

_____

Any special dietary requirements? (vegetarian, vegan, religious, no food colouring etc.)_____

Describe your child's eating habits today (picky, hearty etc)_____

What are your child's favourite foods?_____

Please describe a typical day's diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Beverages (with total volume)_____

Health and Development

How was your child's health in the first year? □ Poor □ Fair □ Good □ Excellent

At what age did your child first:

Sit up _____ Crawl _____ Walk _____ Talk _____

Has your child been vaccinated? Please provide details of which shots, when.

_____

Has your child ever been hospitalized? □ Yes □ No. Details please_____

_____

Has your child ever suffered any trauma either physical or emotional? □ Yes □ No. Details please._____

_____

Is your child sensitive to □ heat, □ cold, □ light, □ dark?

Describe your child's sleep habits:

□ sound sleeper □ light sleeper □ restless sleeper □ throws covers off
□ sleeps tucked in □ has problems falling asleep □ has problems waking
□ sweats – location_____ □ grinds teeth □ sucks thumb □ nightmares
□ talks in sleep □ walks in sleep Sleeping position _____

What time is bedtime?_____ What time does the child wake? _____

How would you describe your child's temperament?_____

How would you describe your child's behaviour and performance at school?

_____

Does your child have any known drug allergies?_____

Please provide as much information as possible on the following childhood illnesses, include when the illness appeared or frequency of a recurring illness.

Chicken Pox	
Measles	
Mumps	
Ear infection	
General susceptibility	
Other illnesses	

Additional comments:_____

_____

_____

Family History

Number of siblings:_____ Birth order of this child:_____

Please indicate if any member of the family (including grandparents) has experienced any of the following:

	Relative		Relative
Allergies		Diabetes	
Asthma		Kidney disease	
Birth abnormalities		Tuberculosis	
Juvenile arthritis		Other-	
Cancer		Other-	

 the family medical history is of this child is unknown

Do you know of any congenital defects in the immediate families of this child?___

_____

Do either of the parents have a chronic illness? Yes No Please describe

_____

Is there any other information you would like me to have at this time?_____

_____

_____

Thank you