Pediatric Intake

Patient's Name _____
Sex ___ Age ____ Date of Birth _____ Today's Date _____
Mother's Name _____ Father's Name _____
Home Address _____(postal code)_____
Home Phone_____ Alternate Phone no. _____
E-mail _____
Name and Address of Medical Doctor _____
Current Concern(s)/ Reason(s) for Visit _____
_____
_____
_____
_____
Current Treatments for above concerns: _____
_____
Past Treatments for above concerns: _____
_____
Current or Past Care Provided by _____
_____

Medication (no. of times)	Now	Past		Now	Past
Aspirin	_____	_____	Antibiotics	_____	_____
Tylenol	_____	_____	Antihistamines	_____	_____
Decongestants	_____	_____	Ibuprofen	_____	_____

Other _____
Allergies to medicine or other _____

Medical History

Childhood Illnesses

____ Chicken Pox	____ Scarlet Fever	____ Tonsillitis #____
____ Measles	____ Pneumonia	____ Ear Infections #____
____ Mumps	____ Frequent Colds	____ Bronchitis
____ Rubella	____ Rheumatic Fever	____ Other (please list) ____

_____

Has your child had any of the following tests? If so, when, where, and what were the results?
Hearing _____
Speech/Language _____
Vision _____
Psychological Evaluation _____
Electroencephalogram _____
Injuries / Surgeries / Hospitalizations (please list) _____
_____

Immunizations

___ Measles	___ Polio	___MMR	___Smallpox	___ Diphtheria
___ Mumps	___ DPT	___Tetanus	___Influenza	___Hepatitis B

Family History (including siblings, aunts, uncles, grandparents, and great grandparents);

___ Heart Disease	___ Diabetes	___ Birth Defects/Abnormalities	
___ Hypertension	___ Arthritis	___ Tuberculosis	___ Cancer
___ Allergies	___ Asthma	___ Mental Illness	___ Syphilis

___ Gonorrhea ___ Other _____

Mother's health during pregnancy

___ Bleeding ___Physical or Emotional trauma _____
___ Nausea ___ Cigarette, alcohol, drug consumption _____
___ Illness ___ Medications _____
___ High blood pressure ___ Thyroid problems
___ Blood sugar problems or Diabetes
Mother's age at child's birth _____. Previous pregnancies/miscarriages/complications__
_____
_____

Birth History

Number of weeks gestation _____ (full term, premature, late) Birth Weight _____
Length of Labor _____ Complications _____
Has your child had any of the following problems?

___ Jaundice ___ Diarrhea ___ Birth Defects ___ Rashes
___ Colic ___ Fever ___ Cerebral Palsy ___ Allergies
___ Blue Baby ___ Seizures ___ Birth Injuries ___ Other _____

Child's sleep pattern _____
Food Intolerances _____
Feeding: Breast fed ____ How long _____ Formula _____(milk/soy)
Age began eating solid foods _____
Which foods were introduced first? _____
Age began: Sitting _____ Crawling _____ Walking _____ First Words _____

Symptoms (mark **N** if now/current and **P** for past)

___ Hives ___Burning of urine ___ Bloody urine ___ Cough
___ Eczema ___ Frequent urination___ Cries easily ___ Wheezing
___ Bleeding gums ___ Heart murmur ___ Nervous ___Hair loss
___ Nose bleeds ___ Vomiting ___ Sleeping problems ___ Xs fatigue
___ Acne ___ Anemia ___ Night sweats __Nightmares
___ High fevers ___Stomachaches ___Sensitive to light or sounds
___ Chronic rashes ___ Jaundice ___ Body/breath odor ___ Hair loss
___ Hearing loss ___ Easy bruising ___ Motion/car sickness ___ Dizziness
___ Diarrhea ___ Flat feet ___Low or increased appetite
___ Constipation ___ Sore throats ___ Difficult teething ___ Freq colds
___ Gas ___ Headaches ___ Canker sores ___Cold sores
___ Unusual fears ___ Joint pains ___ Behavior changes

Diet Please describe your child's typical daily diet (be honest now).
Breakfast_____
_____
Lunch_____
_____
Dinner_____
_____

Thank you very much for taking the time to fill out this form. It will help me to better understand your child.

White Pines Naturopathic Clinic
Melissa Howe BScN., RN., Naturopathic Doctor
246 5th Concession E. Waterdown, ON L0R 2H1
Tel: 905-690-6123 Fax: 905-847-0970
dr.melissa@whitepinesclinic.ca www.whitepinesclinic.ca