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Pediatric Intake Form

By filling out this comprehensive intake form, you are helping us to provide you with more effective care. We thank you for your time and patience in doing this.

PATIENT INFORMATION Date

Full Name Child goes by:

Care Card Number (PHN)

Birthday (mm/dd/yy) Age ☐ Male ☐ Female

Home Address

City Postal Code

Primary Telephone Other

Contact Email

Would you like an email reminder for your child's appointments? ☐ Yes ☐ No

Name of Parent(s)/Guardian

Name of General Practitioner (MD) Telephone

Name of emergency contact

Relation to child Telephone

Where did you hear about Living Wellness Centre?

Office use only MSP ☐Yes ☐No ☐CND ☐Jane ☐W/C ☐GS

Health History (Part 1)

NAME Date

HEALTH ISSUES

Main Concern

Other Concern(s)

MEDICATIONS Please list any medications/supplements your child is taking and doses.

Medications (prescription, over the counter)

Supplements (multivitamins, herbs, homeopathics, etc.)

Surgeries/ Hospitalizations

HOMELIFE

Any siblings? ☐ Yes ☐ No If yes, please indicate ages:

Are parents divorced/separated? ☐ Yes ☐ No If yes, with whom does the child live?

Occupation of parents:

Any pets? ☐ Yes ☐ No If yes, what type(s)?

BIRTH HISTORY

Birth Weight: Term: ☐ Premature ☐ To Term ☐ Late ☐ Induced

Type of Birth: ☐ Vaginal ☐ Caesarean Any interventions used? (ie forceps)

Location? ☐ Home ☐ Hospital ☐ Other:

Complications (mother or baby):

Age of mother at birth: Did mother smoke during pregnancy? ☐ Yes ☐ No

Any alcohol/drugs consumed during pregnancy? ☐ Yes ☐ No

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Health History (Part 2)

NAME Date

IMMUNIZATIONS

Please check any vaccines your child has had: ☐ Chicken Pox ☐ DTaP ☐ Flu shot ☐ Haemophilus Influenza B ☐ Hepatitis A ☐ Hepatitis B ☐ Meningoccal C ☐ MMR ☐ Polio ☐ Pneumococcal ☐ Rotovirus

Any reactions? ☐ Yes ☐ No If yes, please specify:

ALLERGIES

Please list any allergies or sensitivities in the following categories.

Medications

Foods

Environmental/chemical

FAMILY HISTORY

Please check if your child has a family history of any of the following:

☐ Allergies	☐ Arthritis	☐ Asthma	☐ Autism	☐ Cancer	☐ Depression
☐ Diabetes	☐ Eczema	☐ Epilepsy	☐ High blood pressure	☐ High cholesterol	☐ Kidney disease
☐ Mental illness	☐ Migraines	☐ SIDS	☐ Stroke	☐ Other	☐ History unknown

DEVELOPMENTAL MILESTONES

Please indicate approximate age, if applicable.

Sitting on own	Walking	First tooth
Crawling	Toilet training	First words

Compared to other family members, development was: ☐ Slow ☐ Average ☐ Fast ☐ N/A

HABITS

Does your child exercise regularly? ☐ Yes ☐ No

What activities and how often?

How much time do they spend outdoors?

How much sleep per night? Do they awake well rested? ☐ Yes ☐ No

Do they watch television? ☐ Yes ☐ No If yes, how many hours per day?

Do they have friends? ☐ Yes ☐ No Do they interact well with friends? ☐ Yes ☐ No

What are your child's interests?

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Health History (Part 3)

NAME Date

NUTRITION

Was your child breastfed? ☐ Yes ☐ No If yes, for how long?

At what age were foods introduced? 1st foods?

Any reactions?

Does your child have a good appetite? ☐ Yes ☐ No How many meals per day?

What are their favourite foods?

Do they have any diet regimens or restrictions? ☐ Yes ☐ No

If yes, please specify:

24 HOUR TYPICAL DIET DIARY

Please list a normal day's food and liquid intake for your child.

Breakfast:

Lunch:

Dinner:

Snacks:

Fluids:

EDUCATION

Type of school: ☐ Public ☐ Private ☐ Home-school ☐ Other:

Grade: Does your child enjoy school?

Have they ever been held back in school? ☐ Yes ☐ No If yes, which grade(s)?

HOUSING

How old is the home? Any recent renovations? ☐ Yes ☐ No

Does the home contain any: ☐ Mold ☐ Excess dust ☐ Fungus ☐ Carpets

Is the home's location close to: ☐ Power lines ☐ Airport ☐ Highway ☐ Trees ☐ Industry

ADDITIONAL NOTES OR COMMENTS

Review of systems Please check the appropriate box for any of the following symptoms and add any comments you may feel are important.

Key: **P**=Past **N**=Now **B**=Both

P N B

Head
- ☐☐☐ Headaches
- ☐☐☐ Migraines
- ☐☐☐ Head trauma

Eyes
- ☐☐☐ Itching/redness
- ☐☐☐ Dark circles under eyes
- ☐☐☐ Pain in eyes
- ☐☐☐ Needs glasses

Mouth/Throat
- ☐☐☐ Tonsillitis
- ☐☐☐ Canker sores
- ☐☐☐ Cold sores
- ☐☐☐ Frequent sore throats
- ☐☐☐ Frequent cavities

Nose
- ☐☐☐ Hayfever
- ☐☐☐ Loss of smell
- ☐☐☐ Nosebleeds
- ☐☐☐ Sinus problems
- ☐☐☐ Chronic runny nose

Ears
- ☐☐☐ Frequent earaches/infections
- ☐☐☐ Loss of hearing
- ☐☐☐ Dizziness
- ☐☐☐ Ringing in ear(s)

Lungs/Heart
- ☐☐☐ Asthma
- ☐☐☐ Shortness of breath
- ☐☐☐ Persistant cough
- ☐☐☐ Frequent cough
- ☐☐☐ Bronchitis
- ☐☐☐ Wheezing
- ☐☐☐ Reactive airway disease
- ☐☐☐ Pneumonia
- ☐☐☐ Chest pain
- ☐☐☐ Heart murmurs

P N B

Immune System
- ☐☐☐ Frequent colds/infections
- ☐☐☐ Frequent fevers
- ☐☐☐ Slow wound healing
- ☐☐☐ Chronic swollen glands

Gastrointestinal
- ☐☐☐ Bloating/gas
- ☐☐☐ Belching
- ☐☐☐ Poor digestion
- ☐☐☐ Nausea
- ☐☐☐ Vomiting
- ☐☐☐ Stomachaches
- ☐☐☐ Diarrhea
- ☐☐☐ Constipation
- ☐☐☐ Blood in stool
- ☐☐☐ Hemorrhoids
- ☐☐☐ Hernias
- ☐☐☐ Reflux/heartburn
- ☐☐☐ Celiac disease

_____ # of bowel movements per day

Genitourinary
- ☐☐☐ Bed-wetting
- ☐☐☐ Frequent urination
- ☐☐☐ Frequent infections

Neurological
- ☐☐☐ Seizures/epilepsy
- ☐☐☐ Speech problems
- ☐☐☐ Speech delays

Muscle/Bone
- ☐☐☐ Joint pain
- ☐☐☐ Swollen joints
- ☐☐☐ Stiffness
- ☐☐☐ Muscle aches
- ☐☐☐ Muscle cramps
- ☐☐☐ Bone pain
- ☐☐☐ Fractures
- ☐☐☐ Growing pains

P N B

Skin/Hair
- ☐☐☐ Rash
- ☐☐☐ Itching
- ☐☐☐ Hives
- ☐☐☐ Diaper rash
- ☐☐☐ Acne
- ☐☐☐ Eczema
- ☐☐☐ Lice/nits
- ☐☐☐ Hair loss

Endocrine
- ☐☐☐ Diabetes
- ☐☐☐ Hypoglycemia
- ☐☐☐ Thyroid problems
- ☐☐☐ Heat intolerance
- ☐☐☐ Cold intolerance
- ☐☐☐ Excessive thirst
- ☐☐☐ Excessive hunger
- ☐☐☐ Excessive sweating
- ☐☐☐ Night sweats

Mental/Emotional
- ☐☐☐ Depression
- ☐☐☐ Mood swings
- ☐☐☐ Anxiety/fears
- ☐☐☐ Weeps easily
- ☐☐☐ Nightmares
- ☐☐☐ Poor concentration
- ☐☐☐ Memory problems

Miscellaneous
- ☐☐☐ Anemia
- ☐☐☐ Bruises easily
- ☐☐☐ Slow growth
- ☐☐☐ Rapid growth
- ☐☐☐ Weight gain
- ☐☐☐ Weight loss
- ☐☐☐ Cancer
- ☐☐☐ Other: _____

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Naturopathic Declaration & Consent to Treatment

A Naturopathic Doctor (ND) will conduct a thorough case history and physical examination, and may utilize specific blood, urinary or other laboratory reports as part of your treatment work-up.

Statement of Acknowledgement

As a patient of Living Wellness Centre, I have read the information and understand that the form of medical care given is based on Naturopathic principles and practices. I recognize that even the gentlest therapies have potential complications in certain physiological conditions or in very young children or those on multiple medications.

The information I have provided is complete and inclusive of all heath concerns, including risk of pregnancy and all medications, including over-the-counter drugs.

The slight health risk of some Naturopathic treatments include but are not limited to: aggravation of pre-existing symptoms; allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and spasms.

I also recognize the following:

- Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another healthcare provider licensed to practice in British Columbia.
- I understand that a record of my visits will be kept. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.
- I am aware that I am responsible for payment at the time services are rendered.
- I am aware that 48 hours notice must be given for cancellation of an appointment or a cancellation fee may be applied.
- I understand that the ND reserves the right to determine which cases fall outside his/her scope of practice, in which event the appropriate referral will be recommended.

I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial or federal agencies to gather information without stating so. I accept full responsibility for any fees incurred during care and treatment.

Patient/Guardian Signature Date

Full Name

Naturopathic Physician Signature