Fredericton Naturopathic Clinic

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Pediatric Intake Form

Date: _____

Patient name (full): _____ **Age:** _____

Date of birth: _____ **Sex: M / F Form filled by:** _____

Parents name: _____ **Email:** _____

Address:

_____

Phone (home): _____ **(Work):** _____ **(Cell):** _____

May we leave messages relating to your visits? Y / N Which number: _____

Emergency contact: _____ **Phone:** _____ **Relation:** _____

Pediatrician or medical doctor: _____

Other healthcare providers: 1. _____ **2.** _____ **3.** _____

How did you hear about Dr. Kerri?

- **Google**
- **Referral from a healthcare practitioner**
- **Referral from a friend or family member**
- **Facebook**

Please list your primary concerns regarding your child's health.

1.	Severity (0-10 scale)
2.	
3.	
4.	

How would you describe your child's general state of health?

Excellent **Good** **Fair** **Poor**

Current weight: _____ **Weight one year ago:** _____

Please give a brief history of the present health concern, giving the age of onset, first symptoms and present symptoms:

Child's Medical History

Please indicate any diagnosed medical condition, hospitalization, or surgery.

1.	Date	Ongoing : Y / N
2.		
3.		
4.		

Childhood Illnesses. Indicate severity as mild/moderate/severe.

Illness	Yes/No	Age	Severity
Chicken pox			
Mumps			
Rubella (German			
Rubeola/Measles			
Roseola			
Strep throat			
Scarlet fever			
Whooping cough			
Impetigo			
Mononucleosis			
Ear Infections			

Approximately how many times has your child been treated by antibiotics? _____

Immunizations

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ MMR (measles, mumps, rubella)
- ☐ Varicella (Chicken Pox)
- ☐ Polio

Tetanus Booster - Date: _____
Hemophilus Influenza B
Influenza ("Flu" shot)
Other:

Please describe any adverse reaction if applicable: _____

Please list all **current** medications/vitamins/herbs/ (OTC & prescription)

Medication/vitamin	Dose	Date started	Reason
1.			
2.			
3.			
4.			
5.			
6.			

Please list any **previous** medications/vitamins/herbs (OTC & prescription) (taken for > 3 months)

Medication	Dose	Date started	Reason
1.			
2.			
3.			

Screening Tests (Indicate results)

Blood:_____

Hearing:_____

Vision:_____

Other:_____

Allergies - Indicate type

Medicinal:_____

Food:_____

Environmental:_____

Other:_____

Pre-natal Health (Health of the parents at the child's birth)

Father:	Excellent	Good	Fair	Poor	Unknown
Mother:	Excellent	Good	Fair	Poor	Unknown

Mother's diet: Excellent Good Fair Poor Unknown

Mother's age at childbirth: _____
Father's age at childbirth: _____

Did the mother experience:

- ☐ Bleeding
- ☐ High blood pressure
- ☐ Nausea, vomiting
- ☐ Diabetes
- ☐ Thyroid issues
- ☐ Physical or emotional trauma
- ☐ Exercise
- ☐ Food Cravings

Exposures/Stresses in pregnancy:

- ☐ Tobacco
- ☐ Alcohol
- ☐ Recreational drugs
- ☐ Prescription medication
- ☐ Over-the-counter medication
- ☐ Occupational Risk
- ☐ Coffee/tea: cups per day_____
- ☐ Second-hand smoke:
- ☐ Other:
- ☐ Supplements: _____

Stress levels during pregnancy:

1 2 3 4 5 6 7 8 9 10 - Highest

Child Intake Form

- ☐ Hospital Birth
- ☐ Home Birth
- ☐ Doula
- ☐ Midwife

Check all that apply:

- ☐ Vaginal
- ☐ Forceps
- ☐ C-Section
- ☐ Anaesthesia
- ☐ Induced labor
- ☐ Adoption
- ☐ Surrogate
- ☐ Natural

Term length:

☐ Full term

☐ Premature term:____wks

☐ Late term: _____wks

Length of labor: _____

Weight at birth: _____

Complications (if any):_____

If fertility treatments were used, please name the type: _____

How was your infant fed?

☐ Breast: How long?

☐ Formula: Milk

☐ Other type of formula:

☐ Other type of food:

Has your child ever had colic? Yes No

If yes, what condition? Mild Moderate Severe

What foods were introduced before 6 months?

_____

_____

What foods were introduced at 6-12 months?

_____

_____

Dietary Restrictions:

Religious Vegetarian

Vegan Other:_____

_____

Describe a typical day's diet:

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages (type & quantity):_____

How many cups of the following do you drink on the average day?

Water_____Coffee_____Tea_____(type) Milk_____Fruit Juice_____Veg juice _____

Soft drinks _____

Is there anything you feel is important that has not been covered?

What expectations do you have from this visit to the clinic? Circle the statement that best applies. Be as honest as possible.

1) Seeking information/treatment as a one-time visit only.
2) Hoping to begin the process of resolving my health concerns.
3) Hoping to begin the process of achieving an optimal state of health.
4) No expectations; just curious about naturopathic medicine.

Do you have any long-term expectations or goals in working with a naturopathic doctor?

_____

_____