INTEGRATIVE HEALTH INSTITUTE

Good health enables empowered, authentic living.

Naturopathic Medicine – Pediatric Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 15-20 minutes. When completed, email to: **info@integrativehealthinstitute.ca**

Contact Information:

Child's Name _____

Date of Birth _____

Child's Age _____

Sex ☐Male ☐Female

School Name _____

School Phone _____

School Address _____

OHIP Number _____

List contact information in order of preference:

Primary Contact:

Name _____

Relationship to Child _____

Address _____

_____

Home Phone _____

Work Phone _____

Mobile Phone _____

Email _____

Secondary Contact:

Name _____

Relationship to Child _____

Address _____

_____

Home Phone _____

Work Phone _____

Mobile Phone _____

Email _____

Care Co-ordination:

Medical Doctor _____

Medical Doctor # _____

Medical Doctor Address
Email _____

Dentist _____

Dentist # _____

Specialist _____

Specialist # _____

Specialist Address
Email _____

Additional _____

Additional # _____

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Please List any other Medical Providers:

Type of Medical Provider	Name	Phone #	Address

Chief Concerns:

List your main heath concerns (or reasons for visiting the clinic) in order of importance

1. _____
   _____
2. _____
   _____
3. _____
   _____
4. _____
   _____

Medical History:

How would you describe your child's general state of health? ☐excellent ☐good ☐fair ☐poor

Medical conditions: Please indicate any serious illnesses, conditions, or reasons for hospitalizations

Medical Condition/ Hospitalization	Date of Diagnosis/ Diagnosed by whom	Is the condition still present	Symptoms

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Allergies or Food sensitivities: Please indicate any allergies and/or serious food sensitivities

Allergy/Sensitivity	Severity of reactions

Past Conditions

Illness		Age	Duration	Complications / Hospital Admittance
Asthma	☐Y ☐N			
Cold & Influenza	☐Y ☐N			
Fever (above 105ºF)	☐Y ☐N			
Cough	☐Y ☐N			
Jaundice	☐Y ☐N			
Diabetes	☐Y ☐N			
Ear infections	☐Y ☐N			
Measles	☐Y ☐N			
Mumps	☐Y ☐N			
Rubella	☐Y ☐N			
Whooping Cough	☐Y ☐N			
Chicken Pox	☐Y ☐N			
Rheumatic Fever	☐Y ☐N			
Scarlet Fever	☐Y ☐N			
Polio	☐Y ☐N			
Strep throat	☐Y ☐N			
Mononucleosis	☐Y ☐N			
Impetigo	☐Y ☐N			
Eczema	☐Y ☐N			
Warts	☐Y ☐N			

Medications/Supplements: Please list all current medications/supplements

Medication/ Supplement	Dose (if known)/ Length of Use	Prescribing Physician	Condition it is treating

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Has your child taken anti-biotics within the last 5 years (circle one)? ☐Y ☐N
How many times have you taken anti-biotics within the last 5 years _____

Vaccinations: Please indicate which vaccinations you have received.

Vaccination against:		Age	Side Effects / Hospital Admittance
Measles, Mumps, Rubella (MMR)	☐Y ☐N		
Diphtheria, Pertussis, Tetanus (DPT)	☐Y ☐N		
Haemophilus Influenza B (Hib)	☐Y ☐N		
Chicken Pox (Varicella Zoster)	☐Y ☐N		
Rabies	☐Y ☐N		
Hepatitis A	☐Y ☐N		
Hepatitis B	☐Y ☐N		
Tetanus	☐Y ☐N		
Polio	☐Y ☐N		
Flu	☐Y ☐N		
Other:			

Prenatal History

What was the general health of the mother during pregnancy? ☐Excellent ☐Good ☐Fair ☐Poor ☐Unknown

Was the mother exposed to any of the following during pregnancy (check the box next to the listed exposure)?

alcohol	☐	radiation	☐	trauma	☐
tobacco	☐	chemotherapy	☐	stress	☐
recreational drugs	☐	excessive UV	☐	**OTHER:**	
prescription drugs	☐	infectious disease	☐		

Pregnancy Complications: check the box next to the listed complication

nausea / vomiting	☐	pre-eclampsia	☐	thyroid problems	☐

diabetes	☐	hemorrhaging	☐	**OTHER**:	

Please indicate supplements taken during pregnancy:_____

_____

Are you a single parent? ☐Y ☐N

Did you have adequate support or prenatal care during the pregnancy? ☐Y ☐

_____

_____

Birth History

Please check the box to indicate:

Vaginal	☐	Forceps	☐	Epidural / Drugs	☐
Cesarean Section	☐	Suction	☐	Vacuum Extract	☐

Length of labor: _____ ☐pre term ☐post term How many weeks late _____

Weight at birth: _____ Number of births: _____

Where did the birth occur?) ☐home ☐hospital ☐birthing center

Did you use a midwife, doula or both?) ☐midwife ☐doula ☐both midwife and doula

Was the birth traumatic on you, the baby or both? ☐mother ☐baby ☐both mother and baby

List complications during birth if present:

_____

_____

Neonatal History

Check the box next to the listed complication

neonatal jaundice	☐	colic	☐	rashes	☐
breathing problems	☐	deformities (cleft palate)	☐	**OTHER**:	

Growth and Development

Age child began to crawl _____ Age child began to teethe _____

Age child began to sit up _____ Age child began to speak (mama, dada) _____

Age child began to walk _____

How would you rate your child's health in their first year? ☐Poor ☐Fair ☐Good ☐Excellent ☐Unknown

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Sleep: hours per day _____ hours per night: _____

Quality of Sleep: ☐easily aroused ☐hard to wake ☐nightmares ☐sleep on stomach ☐sleep on back

Feeding History

Feeding: ☐breast fed ☐bottle fed **Picky eater**: ☐yes ☐no

Most Common Eating Style: ☐home made (from scratch) ☐home made (packaged food) ☐eating out at restaurant

Length of breast/bottle feeding: _____ age when solid foods were introduced: _____

Feeding complications:_____

What foods were introduced before 6 months:

_____

List the solid foods introduced:

_____

Does your child have any dietary restrictions (religious, vegetarian / vegan etc.): _____

Please list any food cravings your child has _____

Please list any food aversions your child has _____

Describe a typical day's diet:
Breakfast: _____

Lunch: _____

Dinner: _____

Snacks/ Beverages: _____

Social History

Please describe the disposition of your child when interacting with other children, parents, and other caregivers:_____

Describe your child's behavior and performance at school:_____

Is your child physically active? ☐Y ☐N How much, how often?_____

How many hours of T.V per day?____ How many hours on computer?_____ How many hours outside?____
How many hours are spent reading with your child outside of school? _____

Schooling: ☐daycare ☐preschool ☐school

List the extracurricular activities your child is involved in or favorite activities:_____

_____

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Family History:

Illness		Family Member	Complications / Severity
Allergies	☐Y ☐N		
Asthma	☐Y ☐N		
Diabetes	☐Y ☐N		
Heart Disease	☐Y ☐N		
Cancer	☐Y ☐N		
Depression	☐Y ☐N		
Other mental illness	☐Y ☐N		
Kidney disease	☐Y ☐N		
Infertility	☐Y ☐N		
Post-partum depression	☐Y ☐N		
High Blood pressure	☐Y ☐N		
Other	☐Y ☐N		
Family History Unknown	☐Y ☐N		

Home Environment

Check the boxes that apply

Age of home: _____ Any recent renovations: _____ Upkeep of Home : ☐good ☐bad

Lead Paint: ☐ Asbestos: ☐ Carpet: ☐ Mildew: ☐ Pets: ☐ Smokers: ☐

How is the home heated: _____

Home Location: Airport: ☐ Industry: ☐ Suburb: ☐ City: ☐ Highway: ☐

Describe any known toxins or hazards the child is exposed to at home, daycare, hobbies outside environment etc.):_____

Describe the emotional climate of the child's home:_____

Review of Systems

List conditions that involve the following systems:

SKIN(*eg. eczema, psoriasis, hives, rashes)*

_____

HEAD *(eg. headaches)*

_____

EYES *(eg. itchy, pain, infection, corrective lenses)*

_____

EARS *(eg. wax, discharge, hearing impairment)*

_____

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NOSE *(eg. sinus problems, pain, nose bleeds)*

_____

MOUTH *(eg. difficult dentition, cavities, loss of taste, problems swallowing)*

_____

NECK *(eg. stiffness, tenderness, hoarseness, tonsillitis, swelling)*

_____

HEART *(eg. rheumatic fever, murmurs, chest pain)*

_____

LUNGS *(eg. cough, asthma, wheezing)*

_____

GASTROINTESTINAL *(eg. vomiting, swallowing, diarrhea, constipation)*

_____

URINARY *(eg. pain, increased frequency, blood)*

_____

MALE *(eg. hernias, pain or masses in scrotum/ testes)*

_____

FEMALE *(eg. urgency, menstruation/menarche, discharge, pain or masses in ovaries/uterus*

_____

MUSCLE AND SKELETON *(eg. joint pain, stiffness, weakness, back pain, fractures)*

_____

NEUROLOGICAL *(eg. seizures, paralysis, clumsiness, ↓ memory, vision changes, speech problems, sensation alteration)*

_____

Additional Information

If there is any other relevant information pertaining to your health that was not covered in this intake please state it below or on the back of the form: