Alison Danby
NATUROPATHIC DOCTOR

Please help us provide you with the highest standard of care by carefully completing this intake form. Identify anything you do not understand with a question mark. All information is strictly confidential. Please print clearly.

Confidential Pediatric Intake Form

Child's Name:_____ Date of First Visit:_____

Gender: **M** **F** Age:_____Date of Birth:_____

Who is completing this form:_____ Relationship to child:_____

Address:_____

City:_____Province:_____Postal Code:_____

Telephone (Home):_____ Work:_____

E-mail:_____

Where may we leave a message regarding your child's visits?_____

In case of an Emergency contact:_____

Relationship:_____Emergency Contact # ( ) _____

Address: _____

Medical Care Providers (name, occupation, address, phone #)

Type of Medical Care Provider	Name	Phone Number	Address

How did you hear about the clinic?_____

Has your child seen a Naturopathic Doctor before?_____

Does any of your family receive Naturopathic treatment?_____

Is your child receiving any other type of therapy at this time? If yes please list

_____

Primary Health Concerns:

Please List your child's main heath concerns (or reasons for your child's visit today):

1. _____
2. _____
3. _____

Has anything changed recently or become worse?_____

_____

How would you describe your child's current state of health? **Excellent Good Fair Poor**

Dose your child have any dietary restrictions? **Yes No**

If yes, which ones and why? (religious or other)_____

_____

Has your child ever been prescribed an Epi-pen or had an anaphylaxis reaction? **Yes No**

Reason:_____

Please list all of your child's known allergies (medications, food, pollen etc):_____

_____

_____

Medication & Supplementation History:

Past Medication/ Supplements: please list all medication/supplements your child is taking:

Medication/Supplements	Dosage	Since	Reason

History of antibiotic use (when approximately)_____

How long? _____ For what conditions:_____

_____

Early Life History:

Please check the relevant conditions that apply to the pregnancy:

Uncomplicated	YES NO	High blood pressure	YES NO
Bleeding	YES NO	Physical/Emotional Trauma	YES NO
Diabetes	YES NO	Smoking/Alcohol/drug use	YES NO
Early Labour	YES NO	Thyroid problems	YES NO
Excessive Vomiting	YES NO	Other	

Please list all medications or supplements used during pregnancy:_____

_____

Birth History:

Birth Weight		Weeks carried:	
Full term	YES NO	Vaginal	YES NO
Premature	YES NO	C-section	YES NO
Past term	YES NO	Reason for C-section:	

Mothers age at child's birth:_____Number of previous pregnancies_____, births_____

Birth complications or interventions used? Describe: (forceps, suction, induced labour, epidural)

_____

_____

Was there any fertility issues prior to the pregnancy? **YES** **NO** If YES, please describe_____

_____

Post-Natal Complications:

None	YES NO	Infections	YES NO
Birth Defects	YES NO	Jaundice	YES NO
Birth Injuries	YES NO	Respiratory	YES NO
Cardiac	YES NO	Other (seizures, meconium, rash)	
Gastrointestinal	YES NO		

Nursing/Diet:

Was your child breast-fed? **YES** **NO** If so, how long?_____

Difficulty nursing?_____

Formula used? **YES** **NO** If so, at what age?_____ What brand?_____

When were solid foods introduced?_____ Any reaction? **YES** **NO**

First Foods:_____

Has your child ever experienced colic? **YES** **NO** How severe: **Mild** **Moderate** **Severe**

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

What are your child's favourite foods?_____

Please indicate if your child has had any hospitalizations, surgeries, or serious injuries:

Hospitalizations/Surgery	Age	Compilation

Vaccination History:

Is your child vaccinated? **YES NO** If yes, have all the boosters been given? **YES NO**

Vaccination	Y/N	Adverse Reactions:	Vaccination	Y/N	Adverse Reaction:
(MMR) Measles, Mumps, Rubella			(DPT) Diphtheria, Pertussis, Tetanus		
Haemophilus Influenza B			Chicken Pox/Varicella		
Rabies			Tetanus booster		
Hepatitis A			Polio		
Hepatitis B			Flu shot		
Pneumococcal			Meningococcal		
Other					

Lifestyle and Environment

Are there any pets in the child's home?_____

Are you aware of any toxins or other hazards the child may be exposed to (home, Hobbies etc)

_____

What is the emotional climate in the child's home?_____

Does your child attend: **Daycare** **Preschool** **School** **Homecare** Other:_____

Child:

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

How many hours of exercise dose the child get? What are the child's favourite activities?_____

_____

Mother:

Alcohol: **YES NO** Drink per day:_____ Smoking: **YES NO** Cigarettes per day:_____

Do you or anyone else smoke in the house? **YES NO**

Prescription/recreational drugs? **YES NO** Please list the name and dose:_____

_____

Supplements: _____

_____

Health and Development:

At what age did your child first

Sit up_____ Crawl_____ Walk_____ Talk_____

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

Has your child has an ear infection? **YES NO** If yes how many times?_____

How many times a year does your child get a colds/flu?_____

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 - where_____ ❒ grinds teeth

❒ nightmares ❒ talks in sleep ❒ walks in sleep ❒ bed wetting

Sleeping position:_____

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

How would you describe the child's temperament?_____

_____

Describe your child's behaviour: **Excellent Variable Disruptive** Other:_____

How does your child interact with other children: **Excellent Good Fair Poor**

Family History:

Please indicate each relevant condition for blood relative only:

❒ Addiction	❒ Gout	❒ PMS
❒ ADHD	❒ Hay fever	❒ Pneumonia
❒ AIDS	❒ Heart Disease	❒ Rheumatic fever
❒ Allergies	❒ Hepatitis	❒ Rubella
❒ Autism	❒ Hypertension	❒ Scarlet Fever
❒ Asthma	❒ Kidney disease	❒ Seizures
❒ Cancer type:_____	❒ Learning Disabilities	❒ Sinusitis

Family History continued:

Please indicate each relevant condition for blood relative only:

❒ Celiac Disease	❒ Liver Disease	❒ Skin disease
❒ Chicken Pox	❒ Lupus	❒ Stroke
❒ Depression	❒ Malaria	❒ Strep throat
❒ Diabetes	❒ Measles	❒ Thyroid problems
❒ Eczema	❒ Mental Illness	❒ Tonsillitis
❒ Emphysema	❒ Migraines	❒ Tuberculosis
❒ Epilepsy	❒ Mononucleosis	❒ Typhoid
❒ Eye problems	❒ Multiple sclerosis	❒ Ulcers
❒ Gall Stones	❒ Mumps	❒ Venereal Disease
❒ Goiter	❒ Obesity	❒ Whooping cough
❒ Gonorrhea	❒ Parasites/Worms	❒ Yellow fever

Other: _____

_____

❒ I do not know my family history or the child's family history

Is there anything else I should know about your child?_____

_____

_____

_____

Thank you for completing this extensive health record for your child, your time is appreciated!