



# UNBOUNDED

Naturopathic Medical Clinic

## Confidential Pediatric Intake Form

Date: \_\_\_\_\_

Full Name: \_\_\_\_\_ Male\_\_ Female \_\_

Name you prefer to be called: \_\_\_\_\_

Parents' Names: \_\_\_\_\_

Birthdate (dd/mm/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_ Current age: \_\_\_\_\_

Home phone: \_\_\_\_\_ Parent's Cell: \_\_\_\_\_

Parent's email address: \_\_\_\_\_

Home address: \_\_\_\_\_

Mailing address (if different): \_\_\_\_\_

CareCard Number: \_\_\_\_\_

Family Physician: \_\_\_\_\_

Specialist: \_\_\_\_\_

Dentist: \_\_\_\_\_

How did you find out about our clinic?

Internet/ website

Canpages/ Yellowpages

Referral from: \_\_\_\_\_

Other \_\_\_\_\_

### **Current Health Condition**

Allergies (to medications, pollens, animals, food etc.): \_\_\_\_\_

Do you have any known contagious diseases at this time? Yes\_\_ No\_\_

If yes, what? \_\_\_\_\_

Please list the most important health concerns:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Has anything recently changed or become worse? \_\_\_\_\_

Current Medications (prescription as well as over-the-counter): \_\_\_\_\_

Vitamins, Supplements, Herbs, Homeopathic remedies: \_\_\_\_\_

Blood Type: \_\_A \_\_B \_\_AB \_\_O



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## Health History

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_

### **Childhood illnesses:**

<input type="checkbox"/> Chicken pox	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps
<input type="checkbox"/> Rubella	<input type="checkbox"/> Diphtheria	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Whooping cough
<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Strep throat	<input type="checkbox"/> Ear infections
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Other: _____	

### **Immunizations:**

<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	<input type="checkbox"/> Polio
<input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus)	<input type="checkbox"/> Hep B
<input type="checkbox"/> Haemophilus influenza type B	<input type="checkbox"/> Flu
<input type="checkbox"/> Other: _____	

Reactions to immunizations: \_\_\_\_\_

Surgeries and Hospitalizations (list and give date or age): \_\_\_\_\_

Accidents and Injuries (age and cause): \_\_\_\_\_

Has the child had any of the following?

	NOW	PAST	NEVER		NOW	PAST	NEVER
Acne	___	___	___	Epilepsy/ seizures	___	___	___
Allergies	___	___	___	Fatigue	___	___	___
Anemia	___	___	___	Frequent infections	___	___	___
Asthma	___	___	___	Headaches	___	___	___
Bed wetting	___	___	___	Heart murmur	___	___	___
Birth defects	___	___	___	High fever	___	___	___
Colic	___	___	___	Hyperactivity	___	___	___
Constipation	___	___	___	Insomnia	___	___	___
Cough/ wheeze	___	___	___	Jaundice	___	___	___
Cradle Cap	___	___	___	Learning disorder	___	___	___
Depression	___	___	___	Moodiness	___	___	___
Diarrhea	___	___	___	Stuffy Nose	___	___	___
Dizzy spells	___	___	___	Thrush	___	___	___
Ear infections	___	___	___	Vomiting spells	___	___	___
Eczema	___	___	___	Other _____			
Exposure to cigarette smoke:	___	___	___	_____			



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## Family History (Include blood relatives only)

Father (age)\* \_\_\_\_ Mother (age)\* \_\_\_\_ Brothers (ages)\* \_\_\_\_ Sisters (ages)\* \_\_\_\_

\* If deceased, please list age at death and circle

Please check conditions that apply to blood relatives (including the patient's parents, grandparents, and siblings):

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Allergies     | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Obesity        |
| <input type="checkbox"/> Anemia        | <input type="checkbox"/> Colitis           | <input type="checkbox"/> Hearing loss        | <input type="checkbox"/> Stroke         |
| <input type="checkbox"/> Arthritis     | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> High blood pressure |   |
| <input type="checkbox"/> Asthma        | <input type="checkbox"/> Depression        | <input type="checkbox"/> Hypoglycemia        | <input type="checkbox"/> Thyroid        |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Eczema            | <input type="checkbox"/> Kidney disease      | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Other _____   |  |  |   |

## Prenatal/ Birth/ Feeding History

Mother's health during the pregnancy with this child:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Age 35 +      | <input type="checkbox"/> Trauma/ injury       | <input type="checkbox"/> Alcohol consumption |
| <input type="checkbox"/> Bleeding      | <input type="checkbox"/> Stress               | <input type="checkbox"/> Drugs               |
| <input type="checkbox"/> Severe nausea | <input type="checkbox"/> High blood pressure  | <input type="checkbox"/> Smoking             |
| <input type="checkbox"/> Illness       | <input type="checkbox"/> Gestational diabetes | <input type="checkbox"/> Toxemia             |
| <input type="checkbox"/> Medications:  |   | <input type="checkbox"/> X-ray exposure      |

Term:  Premature  Full

Delivery:  Vaginal  C-section

Feeding of infant:

Breast fed \_\_\_\_\_ How long? \_\_\_\_\_

Formula fed \_\_\_\_\_ How long? \_\_\_\_\_ Which formula(s)? \_\_\_\_\_

At what age was cow's milk introduced? \_\_\_\_\_

Age solid foods introduced \_\_\_\_\_ Which foods? \_\_\_\_\_

Any food allergies or intolerances? \_\_\_\_\_

Any foods or food groups that are avoided? \_\_\_\_\_



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**Social History**

Parents: \_\_\_ Married or Common law \_\_\_ Separated \_\_\_ Divorced

Mother's occupation: \_\_\_\_\_ \_\_\_ Full time \_\_\_ Part time

Father's occupation: \_\_\_\_\_ \_\_\_ Full time \_\_\_ Part time

Other guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_

Others residing in home: \_\_\_\_\_

Pets: \_\_\_\_\_

Daycare/ Preschool/ School: How many hours each day? \_\_\_\_\_

# of days per week? \_\_\_\_\_

What is your infant's/ child's/ adolescent's disposition? \_\_\_\_\_

\_\_\_\_\_